

The Newsletter

FACULTY OF MEDICAL PSYCHOTHERAPY



Faculty of Medical Psychotherapy Executive Committee

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Editors' Welcome

Maria Eyres and Harriet Fletcher



We are putting the finishing touches to this edition of the Newsletter at the time when the country is shaking off the remains of a long spell of 'proper' winter, which brought a mixture of beauty and joy as well as discomfort and suffering. Even those of us not working in the front line have been very aware of the winter pressures on the NHS which this year seem to have brought acute services nearly to breaking point.

How does this translate within NHS psychotherapy services? Our equivalent of trolleys in corridors seem to be steady rising waiting times resulting from increasing demand, disappearing/deleted jobs, CRES, cuts to administrative staff which leave us doing work which takes us away from our patients; the list goes on. Those waiting times can easily become a source of stress or even shame, a problem that we feel that we are failing to manage: the psychic pain of our patients feels as acute to us as physical pain and suffering feels to a physician. Sustaining ourselves in this time is vital and the Annual Conference is a place to come together and make space for thinking, to share both our difficult experiences and the solutions we have found. We hope to see you in Cardiff from 25-28 April.



The tragic case of Dr Bawa Garba has given rise to a huge wave of feeling within the medical profession, at a time when many doctors are working in over-stretched conditions and now have less confidence before that they will be treated fairly if something goes wrong. The long-term developments remain to be seen, but one area of particular relevance for medical psychotherapy is the concern around the implications for reflective practice, which has given rise to a range of responses both locally and nationally. We need to make sure that our work in this area with ourselves, our trainees and other professionals goes on.

As always, we are very grateful to all of our contributors for a newsletter which bring you a range of interesting articles. The Trainee Voices section has several articles which explore our role in reflective practice both within and outside mental health settings, and Alison Jenaway has written a fascinating article about the use of CAT in a general hospital, with both patients and with staff teams. We would particularly like to highlight a special article from the new President of the College, Wendy Burn, which again underlines our role as a specialty in promoting reflection and psychological mindedness, and the message from the outgoing Chair of our Faculty, Sue Mizen. We are sure that you will want to join us in thanking Sue for all the work she has done both within and outside the College. She has a huge amount of energy and a talent for enthusing others, getting things moving and bringing together groups of people from diverse perspectives to work together to achieve some impressive outcomes, most notably with the Talking Therapies Taskforce, which she talks more about in her article. This is only one of a number of projects that she has got started in the short space of four years that she has been our Chair, and which we now need to devote our energies to carrying on with the new Chair once they are elected. Goodbye (au revoir!) Sue - you will be much missed.

Our book review section continues to thrive under the editorship of Dan Beales and Andrew Shepherd and we have two reviews in this edition. Tiago Gandra continues his work as International Editor and is planning an interesting contribution to the next edition. We are saying goodbye to Alex Chatzgoriakis as Trainee Editor, since he has been successful in securing a consultant post, and we would like to think him for all the work he has done in conjunction with Anna Croxford his co-editor.

We would like to draw your attention to the Perinatal and Eating Disorders task group update which contains a link to a survey aimed at mapping cross-specialty training opportunities in these areas. The task group would be very grateful if you could complete the survey if you have expertise in these areas and would be able to offer special interest placements for trainees.

We are as always very keen to receive your contributions for the next edition of the newsletter, as well as any feedback and comments about this edition.

Happy reading!

Editors in chief: Maria Eyres, London Harriet Fletcher, Sheffield	Contributing editors Anna Croxford, Alex Chatzgoriakis, Trainee voices Tiago Gandra, International Andrew Shepherd, Dan Beales, Book Reviews Alison Jenaway, Members working outside Psychotherapy
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A special message from the President of the College

Wendy Burn



I am writing this on the long journey home from Brighton to Yorkshire. I have been speaking at the National Student Psychiatry Conference. This is an annual event hosted by a different Psychsoc each year. All the medical schools now have Psychsocs linked to the College and our careers team keep in close touch with them. This year it was the students of Brighton and Sussex Medical School who welcomed over a hundred delegates, all of whom are considering a career in Psychiatry.

As you would expect it was a lively and challenging audience and there was some thought provoking discussion after my talk. One of the questions was 'What is the future of Medical Psychotherapy?'. This was from a student who is already hoping for a career in your specialty. My answer was that apart from the obvious clinical need it is vital that there are Medical Psychotherapists to train psychiatrists.

We talk a lot about resilience in medical students and doctors. I am convinced that my own resilience is the result of psychotherapy training. At the time when I was a trainee it was expected that we would take on psychotherapy patients from the start of our training and treat them using an analytical model with weekly group supervision from a Consultant Psychotherapist. I usually saw the patients after 5pm and had the supervision before 9am. When I first started, I was actually paid overtime to do this. This early exposure to psychotherapy was indescribably beneficial to me and it is really important that current trainees are as fortunate.



Some of the medical students in the audience had experienced Balint groups, and all who had done so reported them as valuable. I hope to see these in all medical schools and will continue to campaign for this, to support the work that you are doing in this area and to mention it whenever anyone talks about resilience in doctors (which is frequently).

I would like to take this opportunity to thank you all for the work that the faculty has been doing. The faculties are the backbone of the College and I could not do my job without them

and the expertise they provide. A special thank you to Sue Mizen, your Faculty Chair, who has worked incredibly hard and successfully to promote medical psychotherapy and the benefit that patients gain from this.

Wendy Burn

President

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Message from the Chair of the Faculty of Medical Psychotherapy

Susan Mizen



This will be my last message for the newsletter as the election of a new Chair is imminent. It has been quite a four years! The College is an interesting place. I have been surprised by the level of interest and support there has been at a senior level and from other faculties. There are many opportunities to develop ideas and influence decision making. We have achieved a few things. The Faculty finances were not in a good state four years ago and are much improved now. This is thanks to a really excellent and energetic academic secretary and team (Mark Evans, Jo O'Reilly and Jo Stubley) who have put on a series of conferences with excellent speakers who have attracted an audience, and to the decision to hold our conference in London on alternate years with appeal to a broader psychiatric and non-medical audience. This and a burgeoning array of one day conferences have put our finances on a healthy footing, raised our profile in the College and built relations with other faculties. The medical student psychotherapy schemes have been an important development led by Jessica Yakeley and Peter Schoenberg supported by Simon Wessely. Balint groups are now running or in the process of being developed in an increasing number of medical schools.

There have been so many other developments it is difficult to know where to start, but I will say something about those projects I have personally been involved in. These include the development of the [Talking Therapies Task Force](#) . For the last eighteen months, I have chaired this organisation, whose purpose is to develop a national infrastructure to support the commissioning of Psychological Therapies for those with severe mental health problems. We have commissioned a health economic report with Michael Parsonage from the Centre for Mental Health on the cost of the most complex relationally disturbed patients to the

health and social care economy. This is the starting point for a negotiation with ministers and policymakers about how psychological therapies can improve care and outcomes for those with the most complex difficulties, and be cost effective. We have started collecting data for this study and hope to publish the report in a year. Our strategy day this January was spent learning about the current commissioning arrangements. We will be setting up a group at the Faculty to support members who are interested in developing services to understand the commissioning arrangements so they can make the most of the opportunities within them, as well as supporting the clinical working groups to translate their thinking about the clinical services which patients need into commissioned services.

The clinical working groups (Medically Unexplained Symptoms, Historic Childhood Sexual Abuse, Personality Disorder, Tier 2 Psychotherapy Services, Psychosis, Reflective Practice, Eating Disorders and Perinatal) are more firmly established and clearer about their tasks. These groups have been particularly active in developing training and one day conferences with other Faculties and thinking about training opportunities between Faculties.

I am pleased to have been part of the advisory group to the Gatsby Wellcome neuroscience curriculum and to have developed links with the London Neuropsychanalysis Group. With their help, we will be writing questions for the MRCPsych exam which will ensure that relational neuroscience is taught in the MRCPsych curriculum. We have a neuroscience interest group which meets around twice a term and a neuroscience interest day at the conference. We are thinking of developing a course in relational neuroscience for clinicians and researchers who have an interest in these developments.

I suppose I have long held on to the idea that psychotherapy is the heart of psychiatry, as one of the two modalities of treatment, and that the divide between biological and psychological / dynamic approaches was an artefact of the limitations of our understanding. I think we have tottered a little closer to a more integrated position. If we keep at it we might see psychotherapeutic psychiatry achieve parity with the biological perspective in terms of research, investment in services and training as we understand more fully how inextricably linked the mind and brain really are. So, I have had a great time struggling with all this, with a lot of dedicated and excellent people with whom I have had many very interesting conversations. I hope those who are interested in engaging in these conversations and trying to change some of the important issues in mental health will have put themselves forward for election to the Exec or the upcoming Officers posts (Chair and Finance Officer). A new Academic Secretary is sought to take on the task of organising the conference. Expressions of interest in this role would be welcome. Thank you to the Exec members who have worked so hard alongside me. It really has been a pleasure.

Sue Mizen
Faculty Chair

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Message from the Academic Secretary

Mark Evans



The annual Medical Psychotherapy Faculty conference of 2018 will be hosted at the Radisson Blu Hotel in Cardiff between 25th to 28th April.

The overall theme of the conference will be:

- Power and Humility, the Agony and the Ecstasy: 'Geo political issues,
- Neuroscience and Psychotherapy

Speakers will include Salman Akhtar (USA), Philip Stokoe (UK), David Nutt (UK), Michael Mithoefer (USA) and Ben Sessa (UK)

We will be running preconference workshops on Wednesday 25th April in the afternoon and the guest speaker slot on the Wednesday evening will be presented by Billy Hardy. As for the last two years, there will be a separate Neuroscience interest day on Saturday 28th April.

We are looking forward to what promises to be a fascinating and educational conference and hope to see you there. Please get the date in your diary!

Mark Evans

Academic Secretary

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Message from the Chair of the Specialty Advisory Committee (SAC)

William Burbridge-James



Last September I wrote about the pressures that trainees were under with the shortfall in recruitment. This coincided with the launch of the 'Choose Psychiatry Campaign' by the College supported by HEE (Health Education England) aimed at increasing the number of people applying for psychiatry. It focused on social media and a shareable video and seems to have made an impact; applications are up for the current round of core training applications.

The contrast between the image of business as usual and the harsh reality for trainees has been brought into sharp focus by the plight of Dr Hadiza Bawa-Garba, where the NHS trust admitted that systemic failures contributed to the tragic death of 6 year old Jack Adcock in 2011. The fallout from the GMC's legal proceedings resulting in the erasure of Dr Bawa-Garba from the medical register, and the implications for all practitioners continue to be the subject of wide commentary with concerns whether her reflections fed into in her trial led to her conviction for gross negligence and manslaughter (Dyer and Cohen BMJ 2018;360:k572). Balint and Case Based Discussion groups are integral to psychotherapy training and the development of reflective practice and reflective psychiatrists. Experience has taught me that the Balint group is a powerful reflective space where psychiatrists can be candid about their work and the complex dilemmas faced in their clinical practice that have evoked anxiety, and left them with uncertainty about their decisions. Colleagues in the group regularly seek to reassure the presenter that they have done a good job, while the presenter needs to work through their discomfort about their experience that has stayed with them. The significance of this will often only come to light when they are invited back into the discussion after the group have been working hard, and they have been able to reflect on the group's discussion while 'sitting back' ([A very short introduction to Balint Groups, by John Salinsky](#)). We need to be promoting the use of Balint and other work discussion groups for all psychiatrists to help sustain our practice, keep us attuned to the un-metabolised communications from our patients and colleagues, learn about our own emotional responses, and tolerate the complexities of working in a system that looks for someone to blame when things go wrong.

I am pleased to report that the SAC was able to resubmit our application to the GMC for a new dual CCT Curriculum for Higher Specialty Training in Medical Psychotherapy and Child and Adolescent Psychiatry. This was approved in October 2017, and Deaneries are able to start developing posts. We also finished working on 'Best Practice Guide Psychotherapy

Training in Higher Specialist Psychiatry Training ST (4-6)', which is embedded in the newsletter. The final report from the 2016-17 U.K. Psychotherapy Survey is with the College publications department which I hope to be able to distribute at the Faculty conference in April.

William Burbridge-James

SAC chair

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EXECUTIVE COMMITTEE TASK GROUP UPDATES

Historical Childhood Sexual Abuse Task Group

Maria Eyres and Jo Stubbley

We presented our case to the College Council in October 2017 and have been asked to write a College Position Statement which is to be submitted to College Editorial Board in March 2018.

We have expanded the Task Group to include a trainee and an expert by experience. A review of current literature on the subject of HCSA is being undertaken by a subgroup within the task group.

Other activities of the HCSA group in the last six months include:

- Academic presentations at Barts in November 2017
- Legal links continue to be explored
- Links to Child Sexual Exploitation experts
- Development of a pilot questionnaire to assess current training on HCSA in Schools of Psychiatry in London
- Contribution to the link with the Intellectual Disabilities Faculty resulting in co-authoring their Newsletter article
- Chapter on HCSA by Jo Stubbley, Maria Eyres and Victoria Barker in Women's Voices in Psychiatry, edited by Gianetta Rands, to be published in summer 2018

Plans for the future:

- Strategy Day for the group in the summer
- Development of an HCSA CPD group at the College
- Liaise with HCSA survivor organisation
- Working with the College Officers to produce Position Statement
- Consideration being given to development of commissioning guidelines

Below we have reproduced the article on trauma informed practice in Intellectual Disability which has been co-authored by Jo Stubley and which is also being published in the Intellectual Disability Faculty newsletter.

Jo Stubley and Maria Eyres

Co-chairs

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The latest Intellectual Disability add-on: Trauma-informed Practice

Tom Berney, Jo Stubley, Allan Skelly, Noelle Blackman and Dr Ashok Roy

There has been a steady series of substantial changes in the care and education of people with Intellectual Disabilities (ID) over the last thirty years, the overall direction of travel being towards individual autonomy, domestic settings and the encouragement of closer, more stable and sustained relationships. For most, this is still an aspiration as, although more attention is given to family links, service limitations continue to face the individual with a kaleidoscope of personnel and placements. This is on top of a turbulent life where it is not unusual to be the focus of domestic turmoil involving parental separation or breakdown, drug and alcohol abuse, and violence. Many will have experienced multiple placements, sudden changes to living arrangements, bullying and harassment in school and in the wider community, as well as verbal, physical and sexual abuse. While some have had the resilience to recover from a complicated and turbulent life, most will need a compensatory approach to their care that recognises and acknowledges what they have experienced. This is the essence of a trauma-informed approach and Bowlby's Attachment Theory provides its theoretical underpinning.

A secure attachment, which requires some degree of constitutional sturdiness, as well as a good enough caregiving person or persons, is the starting point of normal development into an independent, confident adult who understands their past and can cope with adversity. On the other hand, deprivation or distortion of early relationships can result in an adult who is disturbed and has difficulty with coping with their current life and relationships. Their presentation will fall into ICD-11's new category of Complex Post Traumatic Disorder and, although it may take a variety of forms, can be similar to the characteristics of those with an innate neurodisability, such as autism or ADHD. Where these innate conditions are already present, they can make the person more vulnerable to the effects of adversity which, in turn,

may amplify their innate symptoms. In the end, the extent of their coexistence may only be clarified by their response to their management.

Central to their management is:

- 1) A safe and consistent placement where the person can develop long-term relationships and be reasonably confident that they are not going to be moved on, punished or rejected because the system (which includes where they live and those supporting them) cannot cope with their challenging behaviour. This stability requires a combination of physical, emotional and financial security.
- 2) Understanding the individual's perspective (even though its relationship to reality may appear tenuous) acknowledging it, and giving it due weight: the individual should feel heard and understood. Those supporting the individual need to appreciate the likelihood that they will have experienced trauma and have sufficient counselling skill to hear, understand and help them move on (recognising the fine line between encouraging disclosure and the development of false memories).
- 3) A training programme that includes staff at all levels as well as families and carers so that their knowledge and skills are sufficient to maintain the previous two points.
- 4) A number of specialist treatments, although, as yet, there is very limited evidence of their effectiveness when adapted for people with ID.

This approach, with its emphasis on relationships, complements the other initiatives in ID, notably community living, inclusion, advocacy and Positive Behaviour Support. It is not new; familiar to children's services in the management of Attachment Disorder, it is only recently that it has become a specific focus in adult ID. However, it is being taken up and developed by services as far apart as Melbourne (1) and New York (2) while Scotland has gone some way towards introducing this component of care across all care services (3). In retrospect, this line of thinking has led to a profound change in the way we think about child care. It seems inevitable that there should be a similar change in our perception of adult disability. However, more detail is available in a recent publication by the British Psychological Society (4).

References

1. Jackson AL, Waters SE. Taking Time – Framework: A trauma-informed framework for supporting people with intellectual disability. NSW Government: Family & Community Services, 2015.
2. Marcal S, Trifoso S. A Trauma-Informed Toolkit for Providers in the Field of Intellectual & Developmental Disabilities. Center for Disability Services, 2017.
3. Scotland NEf. Transforming Psychological Trauma: A knowledge and Skills Framework for the Scottish Workforce. 2017.
4. Skelly A, Anonymous (Expert by Experience), Fletcher HK, Flood A, Jones L. Incorporating Attachment Theory Into Practice: Clinical Practice Guideline for Clinical Psychologists working with People who have Intellectual Disabilities. The British Psychological Society, 2017.

Links

[Taking Time Framework – A trauma-informed framework for supporting people with intellectual disability](#)

[A trauma focused toolkit for providers in the field of intellectual & developmental disabilities](#)

[NHS Education for Scotland. Transforming Psychological Trauma: A Knowledge and Skills Framework for the Scottish Workforce](#)

[BPS: Incorporating Attachment Theory into Practice: Clinical Practice Guideline for Clinical Psychologists working with People who have Intellectual Disabilities](#)

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Dr Noelle Blackman, Chair, The RESPOND Charity for Trauma-focussed Psychotherapy for People with ID

Dr Ashok Roy, Consultant Psychiatrist for People with Intellectual Disabilities; Chair, Faculty of Intellectual Disability Psychiatry, Royal College of Psychiatrists

Perinatal and Eating Disorder Working Group

Anne Ward

Potential training links with Perinatal and Eating Disorders

The Faculty of Medical Psychotherapy has been working closely with other faculties to develop links and share training opportunities. In particular, we are working to find opportunities for our trainees to gain experience in Perinatal and Eating Disorders and for perinatal and eating disorders trainees who have an interest to be offered opportunities to gain psychotherapy experience relevant to their specialism during their higher training.

Furthermore, there have been recent changes to higher training such that all ST trainees now need to develop psychotherapy skills through their training which includes a requirement to

undertake on-going therapy cases and to undertake one SAPE per year. It is anticipated trainees will see cases related to their speciality, i.e. Perinatal trainees may see Parent-Infant work or work with the baby's parents (as a couple or individual work), Eating Disorder trainees may undertake individual therapy, family work or group work. Some trainees may want to do a one-year placement in psychotherapy as part of a general adult higher training or special interest session.

There have been conversations between the Eating Disorder, Perinatal and Medical Psychotherapy faculties about developing training opportunities between faculties for higher trainees i.e. a trainee in Eating Disorders might want some more in depth psychotherapy experience or a Medical Psychotherapy trainee might be interested in specific experience of working in Perinatal Psychiatry.

In order to facilitate these cross-faculty training experiences, we need a list of Medical Psychotherapy faculty members in the consultant grade who have expertise in those relevant areas. We are therefore undertaking a survey in order to find out who might have both expertise and ability to offer supervision to trainees so that we can direct trainees to match their interest to consultants with expertise in their local area. To this effect, we are asking if consultant medical psychotherapist members of the Faculty would be so kind as to complete the following quick survey. We hope Perinatal and Eating Disorder Faculties will undertake a similar mapping exercise survey.

[Link to survey](#)

Anne Ward

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CONTEMPORARY PRACTICE IN MEDICAL PSYCHOTHERAPY

Offering Cognitive Analytic Therapy for patients with Complex Medically Unexplained Symptoms referred to a Liaison Psychiatry Department

Alison Jenaway

This summary is based on a talk given to the Medically Unexplained Symptoms Interest Group of the Medical Psychotherapy Faculty in October 2017. The group is facilitated by Simon Heyland and Florence Dalton and meets every few months to hear about various aspects of MUS. If you are a member of the Faculty and you would like to join the interest group, then please email Florence via Stella Galea (stella.galea@rcpsych.ac.uk).

Introduction

The term 'medically unexplained symptoms' (MUS) refers to persistent bodily complaints for which adequate examination does not reveal sufficient explanatory, structural, or other specified, pathology (Guidance JCPMH, 2016). The term has been used increasingly over the last 10 years or so, despite criticism and the general public expressing preference, when surveyed, for other terms, such as Persistent Symptom Disorder, or Functional Symptoms (Marks and Hunter, 2015). MUS are a common reason for referral to Liaison Psychiatry services, and form a large percentage of patients seen by psychiatrists in a general hospital. Studies of hospital outpatients suggest that between 49 and 60 % of patients still have no organic explanation for their symptoms despite investigations (Nimnuan et al 2001). The overall annual cost to the NHS of treating these patients is estimated to be around three billion pounds (No Health Without Mental Health, 2010).

One of the problems with the term 'medically unexplained symptoms' is that it amalgamates patients with a wide range of severity of presentation under the same general term. This means that patients with short term, stress related symptoms which are likely to improve with education and reassurance, those with moderate difficulties who are still able to function in work and social roles, and those with severe and complex difficulties who may be bed bound, are all described as suffering from MUS. This can cause difficulties in the planning and commissioning of services, as those who see a large number of patients at the milder end of the spectrum, may omit to plan for the few patients who present at the more severe end and may cost the general hospital much more in terms of specialist referrals and investigations. In my experience, patients at the milder end of the spectrum are more likely to be aware of

their stress levels and more able to see the link between stress and physical symptoms. These patients are not too difficult to work with, as they are usually interested in learning how to relax and pace themselves. However, the patients at the more severe end of the spectrum tend to be out of touch with their feelings and have learnt to cope by blocking feelings. These patients are more likely to have experienced extreme trauma or abuse earlier in their lives and to have a tendency towards dissociation. These patients are perhaps more likely to present with obvious dissociative syndromes like non-epileptic attack disorder, or conversion disorder. They are more difficult to work with, as they often cannot perceive any link with stress or emotional distress, and it can take an experienced therapist several sessions to get them on board with the idea that their early life experiences are even relevant to the current problems. It can often be helpful to invite a close family member, perhaps a partner or parent, to join the sessions, as they can often point out the possible link between a worsening of symptoms and some stressful event that has just happened, even if the patient themselves is not aware of it. These patients can benefit from an explanation of the effects of trauma and dissociation, methods of relaxation, mindfulness and grounding. They may well need a trauma focused piece of work at some point.

Psychiatric assessment in patients with MUS reveals that around 40 % of patients meet criteria for depression or anxiety disorders (probably higher the more severe the MUS (No Health Without Mental Health, 2011). Other psychiatric disorders that I have come across in referrals for therapy for MUS in our department are post-traumatic stress disorder, personality disorder, autistic spectrum disorder, eating disorder, substance misuse disorder and psychosis. All of these will have an impact on the therapy approach and the likely outcome of the treatment for MUS.

While there is some evidence that brief interventions in primary care (Edwards et al 2010) and Cognitive Behaviour Therapy (Nezu et al 2001) can be helpful to those with mild or moderate symptoms, there is little evidence of efficacy for therapy approaches in the more severe end of the spectrum, or those who have already had Cognitive Behaviour Therapy and report little benefit. A recent commissioning guide issued jointly by the Royal College of Psychiatrists and the Royal College of GPs suggests a multidisciplinary approach for these patients, which should include general practice, medicine, nursing, psychology/psychotherapy, psychiatry, occupational therapy and physiotherapy, with an emphasis on education and training of all staff (Guidance from JCPMH 2016). My standard advice to general hospital clinicians includes the following elements:

1. Explain possible mechanisms for symptoms rather than normalize them or say that “nothing is wrong”.

2. Limit further referral or investigations unless there are new signs, rather than just new symptoms. (More difficult if there is a comorbid medically explained physical disorder – in around 20% of our referrals).
3. Try to include psychiatric/psychological input to MDT discussions about complex patients.
4. Build consistent, trusting relationships with a medical team, and try to avoid rapid changes of clinical team or treatment approach, which gives inconsistent, confusing messages.
5. Work on restoring normal function and normal lifestyle, rather than focussing on the pathology (physiotherapy/occupational therapy)
6. Improve relationships, if possible (marital/family work)
7. Reduce dissociation and process trauma, if possible (trauma focused therapy)

In the absence of a comprehensive team approach, we have been offering Cognitive Analytic Therapy as an outpatient treatment for those with complex MUS attending Addenbrooke's Hospital, who have already had CBT with little benefit, or who obviously have personality and relationship difficulties as a focus. Referrals come from our Liaison Psychiatry team who see both inpatients and outpatients, and sometimes directly from general hospital clinicians who know about CAT, or have attended our teaching days. Sometimes the first few sessions of therapy may be carried out while the patient is still in hospital, with a view to engaging the patient before discharge. CAT relationship roles and patterns can become a shared language for the team.

There are some key points to convey:

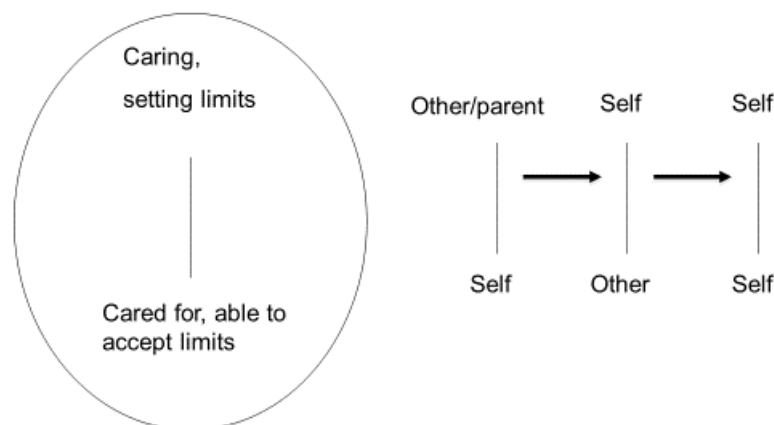
- The focus of the work is on how your past experiences have shaped the relationships which you have with yourself and with others (including healthcare staff).
- How does this link with your symptoms? If you can't talk about your feelings, is your body saying something that you cannot say?

Description of Cognitive Analytic Therapy (CAT)

Cognitive Analytic Therapy is a brief, semi-structured therapy, developed by Dr Anthony Ryle in the 1980s as an integrative therapy, drawing mainly on Cognitive Behaviour Therapy and Object Relations. It is time limited (8, 16 or 24 sessions) and usually 24 sessions are needed for complex patients and those with personality disorder. The therapy was designed to be used within NHS settings for patients who have complex emotional and relationship problems, but for whom there are not enough resources to offer longer term therapy. The patient is encouraged to think of the process as "learning to be your own therapist" so that the work can continue after the end of the formal sessions. The focus is on the relationship patterns that the person has experienced growing up and how these have become the 'template' for how they expect relationships to be. The memories of these patterns trigger

unhelpful patterns of relating towards others (including healthcare professionals and therapists). They also shape the way the person relates towards themselves and the way they self-care. So, for example, a child growing up with very critical parents will be learning what it feels like to be criticised and feel not good enough, but also learning how to be critical. The relationship pattern which starts as other to self, is internalised so that it can also be played out self to other, for example with a younger sibling, and then in the self to self-relationship (fig 1). As the child grows into adulthood, this reciprocal relationship of “critical to criticised” is likely to become a relationship pattern that they fall into with others, as well as with themselves, and which is likely to drive their behaviour.

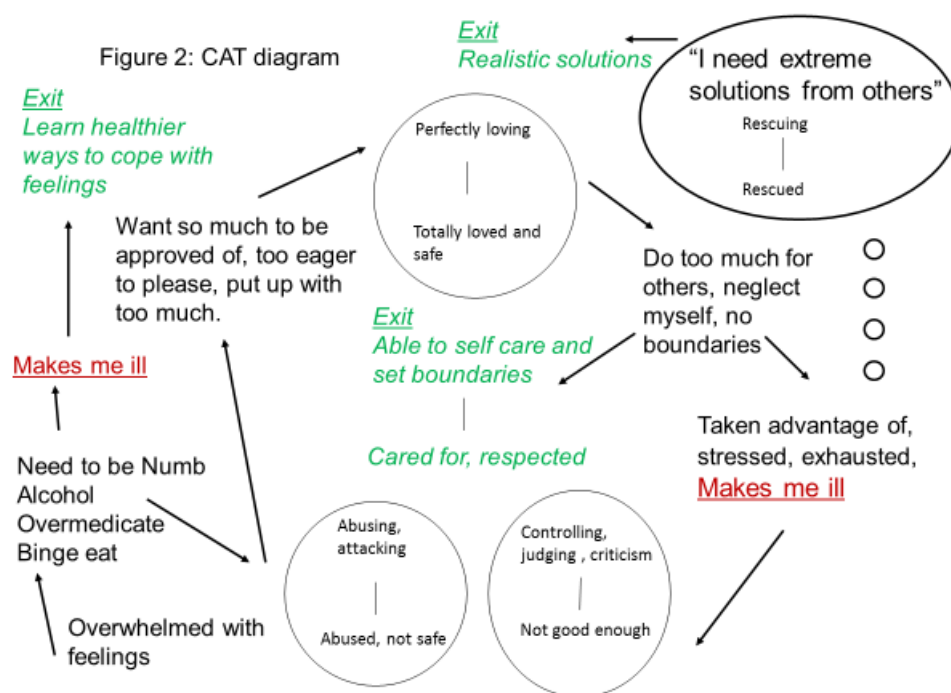
**Figure 1:
Reciprocal(Relationship) Roles**



Therapy involves the therapist and patient exploring collaboratively which relationship patterns the patient tends to fall into. These are summarised in a ‘reformulation’ letter and drawn out in a visual “CAT diagram”. In CAT, the process of drawing out these roles, using the patient’s own words and phrases whenever possible, and exploring the original relationships in more detail, is in itself a therapeutic process for many. It indicates a therapeutic relationship style in which the therapist is no more expert than the patient about how one role connects to another in their particular case. The therapist is curious, and interested in engaging in a joint struggle to make sense of why the patient reacts as they do. The therapist is modelling a compassionate ‘observing eye/I’ which is often added to the diagram, and which is hopefully internalised by the patient through using the CAT map regularly to track difficult feelings and interactions both in sessions and without. The message is clearly given that the patient’s behaviours can be understood, and makes sense once the past experiences leading up to the present has been explored. However, unhelpful

relationship roles are also expected to appear within the therapeutic relationship and to be challenged and reflected on, using the developing diagram.

This process leads to a 'map' of problematic thoughts, feelings and behaviours, where they happen and what triggers them. The map becomes a tool for reflection, both within therapy sessions and during the week, in the work of recognising unhelpful patterns and trying to find new, healthier ways of relating. At the point of recognition, it becomes possible to make a conscious choice to do something different, and these new alternatives can be added to the map as reminders of healthier options. At the same time, the therapeutic relationship is being experienced, and internalised, as a positive alternative way of relating and communicating, so that the patient often starts to notice a kinder, more compassionate way of responding to themselves and others arising spontaneously. An example of a full CAT diagram, with healthy exits added, is given in Figure 2. Although this looks complicated, it will have been built up gradually with the patient so that they should be able to follow new events around the diagram, and explain it to others.

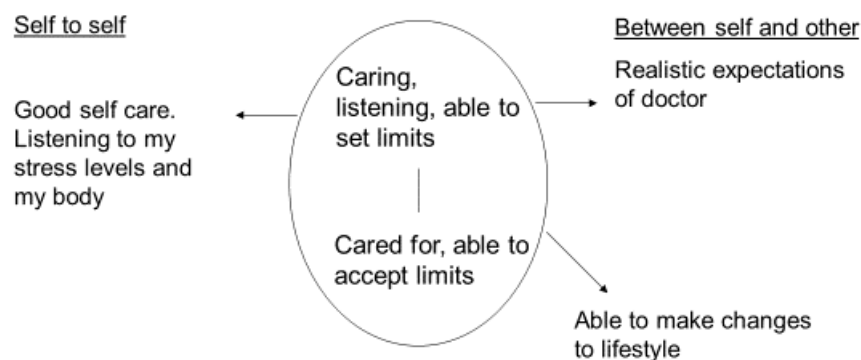


Relationship Roles expressed in the realm of Physical Health

A healthy, 'good enough' growing up experience, in the absence of significant trauma, should lead to relationship roles such as 'caring, listening and setting limits' to 'cared for, heard and able to accept limits'. This will affect the way the person responds to their body, to symptoms, and to those offering medical care (fig 3). For example, this person should be reasonably positive towards themselves, listening to their body and aware of their stress levels, pacing

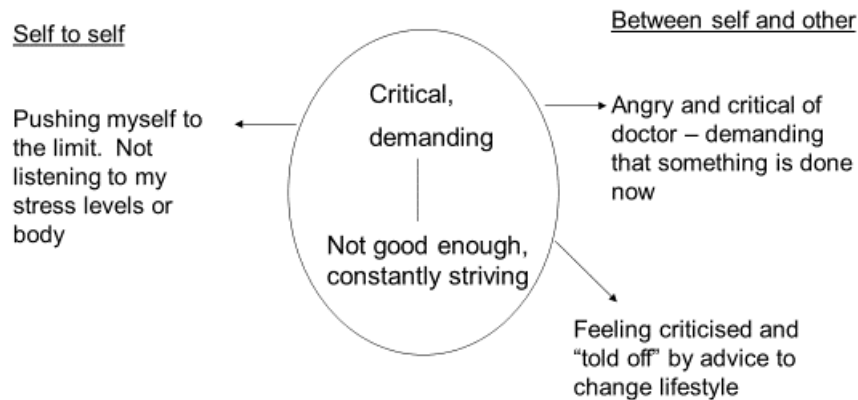
their activity when needed, so they should be less likely to suffer from stress related symptoms. They should be appropriate in their help seeking behaviour, with realistic expectations of the doctor, and able to follow advice and take responsibility for their own health. By contrast, the person who is constantly critical of themselves, and feels not good enough, may put themselves under extreme stress to perform perfectly, feeling unable to rest, leading to a higher likelihood of stress-related physical symptoms. They may avoid going to the doctor, for fear of being criticised or told to change their lifestyle. Or they may seek treatment, but then be unwilling to make the changes which are recommended (fig 3).

Figure 3: Responding to unexplained symptoms with healthy roles



Patients with more extreme relationship roles, who have experienced significant neglect, rejection or abuse in childhood, are unlikely to be able to care for themselves adequately. They may be unable to regulate their emotions, using self-harm, food or drugs and alcohol in order to block out feelings. They may struggle to relate in realistic ways with health care staff, desperate for rescue and appearing to present as a helpless victim of their illness. Staff can be pulled into extreme responses, some to rescue, others to reject, leading to the CAT explanation of splitting in teams (fig 4).

Figure 4: Responding to unexplained symptoms with less healthy roles



The question of causation

One advantage of CAT is that it is not designed for use with a specific diagnostic group, and therefore it is not necessary to ask the patient to definitely accept that their symptoms are medically unexplained. Both explained and unexplained physical health problems can be explored in the same way, and the process of therapy would be the same whether the symptoms have an organic basis or not. It is therefore also possible to use it when patients have a comorbid organic condition alongside suspected medically unexplained symptoms. This was true of around 20 % of a recent audit of referrals in our service in Cambridge. This can be a way of avoiding repetitive arguments about whether the patient's problem is 'genuine' or not, or whether you 'believe' them or not. I have developed various ways of explaining that, in my view, symptoms are always both organic and psychological. Even if I have broken my leg, the way I respond to it, how much time I take off work and so on, depends on my psychological response, and will affect my recovery. Talking about the construct of 'man flu' is often an easy way to remind people that everyone responds to the same physical symptoms in different ways! In addition, many patients with complex MUS do not just complain of their physical symptoms. For example, one recent patient of mine presented with chronic pain, PTSD, longstanding binge eating, and problems in parenting her two children. Such a variety of problems are seen as the surface problem (the branches of the tree), developing from an underlying relational problem procedure (the roots of the tree). Understanding and attending to the 'roots of the problem' should start to show improvements in all the surface problems. In my view, this makes CAT a more powerful therapeutic option for these complex patients than a therapy designed specifically to focus on the MUS.

Secondary Gain

Often, once patients have been ill for a long time, their whole life and their relationships are built around their illness and disability. Their financial security may depend on them staying ill, or they may be going through the process of trying to get compensation through legal means. I tend to try and talk about these factors up front by drawing a seesaw and talking about the various factors which are likely to be “pushing you towards recovery” and the other factors that may be “keeping you ill”. In a sense, if the patient is chronically ill, then those factors are likely to outweigh the pressure to recover and the therapeutic task may be to try and tip the balance in favour of recovery. Of course, this is often not possible, but it feels better to me to have this discussion early on in the process of therapy, rather than at the end when nothing has changed. In CAT, it often becomes clear as you draw out the diagram that the illness is providing some of the reciprocal roles that the patient is longing for. This may be ideal care, knowing that the caring person will never leave, not being able to bend over backwards to care for others, and so on, and this can be discussed at the time. Is this what they long for an unrealistic thing to want? Are there other ways of saying “no” so that your body does not have to say it for you?

Including Intimate Others

The collaborative nature of the therapeutic relationship in CAT means that partners, parents or other family members can be invited in to sessions to help them understand the patient’s relationship patterns, and think about how they might be pulled into unhelpful ways of relating. The patient can be encouraged to share the CAT diagram with the family member and together they can explore new ways of relating which do not follow the same unhelpful patterns. At times, this may require some exploration of the family member’s early life and relationship patterns. These can be added to the map or written out on a separate sheet to keep in mind the interactions with the roles of the patient. One patient I worked with, who had an unexplained painful paralysis of her arm, made worse by emotional upset, brought her husband along to one session. We were able to explore how he had grown up with a dismissive, emotionally avoidant family and tended to immediately dismiss her emotional distress, leading to the pain and paralysis getting worse. As he learned to validate her feelings, the symptoms improved.

Working with Staff teams

The CAT model can also be used as a consultation tool with staff teams who are trying to manage challenging patients, both in mental and physical health settings (Kellett et al, 2014). In our service in Cambridge we have offered CAT consultations to individual staff teams around particularly difficult patients that they are struggling with. It is possible to draw out the relationship roles of a patient just by listening to the staff team describing their different relationships with the patient. It is important to aim for everyone to see that the patient is

not either “very needy” or “lying and manipulative” but may be both of these, at different times, in response to different pressures. The aim is to increase understanding and empathy through joint mapping of the patient’s problematic relationship patterns. The staff can then think about ways of not doing what Tony Ryle described as “joining in the dance: that is, not responding to the pressure to join the patient’s reciprocal role (for example ‘rejecting to rejected’). We are also developing a standalone case discussion day, where staff from all disciplines can come together and think about relationship roles in their patients and start to recognise the different “dances” that they are invited into with complex patients.

Outcomes

A recent look at outcomes in terms of CORE scores before and after CAT in 32 MUS patients seen by qualified CAT therapists in our department, showed that 8 patients were either not able to engage properly, or dropped out at a later stage (25%). Of the 24 who completed CAT, only 21 had before and after CORE scores completed. These patients had a reduction in CORE scores from an average of 1.87 per item at the start of therapy, to 1.09 at completion, which was a clinically significant change but not a statistically reliable change. Patients had an average of 17 sessions, and 8 were referred on to a Post-CAT support group at the end of therapy. This was usually because patients were very isolated, continued to have significant MUS, or requested to meet other patients with similar problems. We plan now to start collecting outcome data using the Brief Illness Perception questionnaire in addition (Boadbent et al 2006).

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‘Best Practice Guide for Psychotherapy Training in Higher Specialist Psychiatry Training (ST 4-6)’

The link below is to the recently published document from the Medical Psychotherapy Specialty Advisory Committee. The inclusion of mandatory psychotherapy competencies in the most recent version of the General Psychiatry higher training curriculum was a huge step forward and this best practice guide builds on this achievement, providing a more detailed account of how these competencies can be gained in an individually tailored way to enhance each trainee's career development.

[Best practice guide for psychotherapy training in higher specialist psychiatry training \(ST4-6\)](#)



TRAINEE VOICES: MEDICAL PSYCHOTHERAPY TRAINEES SECTION

Anna Croxford and Alex Chatzgiorkis

Welcome to the 2018 winter edition of Trainee Voices, a space for discussion within the Faculty newsletter dedicated to trainees with interests in Medical Psychotherapy.

This edition gives us a taste of some of the broad ranging psychotherapeutic work trainees have been engaged in and committed to across the world in the context of austere political times, and in a variety of diverse systems and institutional organisations, whilst thinking about some of the pressures and conflicts within and external to these systems on both conscious and subconscious levels.

The application, translatability, and value of various individual, group and multi-disciplinary psychotherapeutic techniques, including therapeutic interventions and experiential learning modalities, are emphasised within and across various broad learning and clinical environments. Bridging interfaces between specialities seems an extremely rewarding, complex and difficult task at the best of times, and it is interesting that these themes have arisen in trainee articles when there is ongoing discussion around the future of borders of the UK with Europe and beyond.

The importance of experiential and reflective learning on both a personal, professional and societal level are emphasised, thinking about the impact of cultural diversity, otherness and sameness, and the anxieties, conflicts, projections, and also reconciliations, empathy and understanding that can arise amongst groups in turbulent times.

Something that clearly comes across in these articles is an openness to engaging in learning experiences novel to the individual trainee (including to engaging in thinking on a deeper level), and also to facilitating the sharing of translatable and clinically beneficial techniques, both new and established, throughout psychiatry and medicine, with the wealth of knowledge and understanding that this can bring.

Trainee Articles Introduction

Dr Alex Chatzgiorkis, returning from the Academy of Consultation-Liaison Psychiatry (ACLP) Annual Meeting in southern California, highlights the potential for use of a variety of psychotherapeutic approaches in various aspects of Liaison Psychiatry and medicine. He takes us through some of the approaches discussed at the conference and highlights how these may be more widely used and taught in clinical practice in the UK in the future.

Dr Beth Hamilton, medical intern in Australia, shares a thoughtful, interesting and emotive account of her experience of being present at the International Balint Conference in Oxford this summer, themed 'exploring diversity', and also having the privilege to present her essay, with which she won the International Balint Award for medical students, to a diverse audience.

Dr Ching Li takes us through the Interpersonal Dynamics Consultation Project, which aims to make team psychodynamic reflective practice accessible and translatable to patients treated by medical teams, including the importance of such reflective practice, how the model is practically applied and highlights some of the benefits experienced thus far by medical teams using the model.

Dr Benji Waterhouse brings a rather humorous read of his experience of the 5-day Group Relations Conference at the Tavistock and NHS Foundation Trust in December entitled 'Intuition, Authority and Leadership in Turbulent Times'. His light-hearted account highlights some of the process that can occur when a group of individuals is given the experiential opportunity to form and participate in a temporary organisation and learn from reflection on events as they occur.

Dr Peter Wilkinson reminds us of the Summer Trainee Psychotherapy Conference last year – a one-day Group Relations Conference. In contrast to Dr Waterhouse's article, he introduces a taster of the uncertainties, anxieties and other emotional responses attendees may experience, and highlights some themes that may arise during what can be an emotionally tiring but informative, enjoyable and valuable learning experience.

As always, we look forward to seeing you at other upcoming events (listed at the end of the newsletter). In the next edition, we look forward to reading about a trainee's experience of completing the Interpersonal Dynamics Consultation Project, in addition to the pieces we anticipate receiving over the next 6 months.

In the meantime, please continue to send your contributions and suggestions for the next newsletter - submissions [c/o stella.galea@rcpsych.ac.uk](mailto:c/o_stella.galea@rcpsych.ac.uk) . Without your contributions, the conversation would not continue!

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Palm Springs, Psychosomatic (Medicine), and Psychotherapy

Alex Chatziagorakis

Or Can Psychotherapy Be Part of Liaison Psychiatry?

Palm Springs, a desert resort city in Southern California's Coachella Valley, is not only famous for the Coachella Valley Music and Arts Festival, currently held each April, but is also home to the world's largest rotating aerial tramway, which connects the valley with the San Jacinto mountain. It is also the place where the APM 2017 Annual Meeting took place last November, and where the 1,500-member Academy of Psychosomatic Medicine (APM) voted to change its name to the Academy of Consultation-Liaison Psychiatry (ACLP).

This name change successfully captures what the APM 2017 Annual Meeting was about: Consultation-Liaison Psychiatry, or simply Liaison Psychiatry as it is known in the UK. Glancing at the meeting's schedule, one immediately notices the wide breadth of topics, which in turn reflects the wide breadth of the clinical, organisational and even geographical context where Liaison Psychiatry lies: from the Emergency Department (e.g. self-harm assessments and management of the intoxicated patient) to the general hospital wards (e.g. management of delirium, Wernicke's encephalopathy, or depression in patients with Coronary Heart Disease) and from out-patient specialist clinics (e.g. Neuropsychiatry, Psycho-oncology, and HIV Psychiatry) to the community (Collaborative and Integrated Care).

But, with Liaison Psychiatry being so broad (and busy), is there a space for Psychotherapy? At the APM 2017 Annual Meeting, at least, there was. This included the 3 hourly sessions on "Mindfulness Skills for Psychosomatic Medicine", the 90-minute workshop on "Teaching Psychotherapy Skills on the C-L Service Using the 3-Step Supportive Psychotherapy Manual", and a presentation of a "Review of Three End of Life Therapies".

Mindfulness Skills for Psychosomatic Medicine

Every morning at 7am, Dr Paul Jones presented strategies for incorporating mindfulness into daily life and into work with medically ill patients and provided experiential training in both formal mindfulness practices (such as guided seated body scan, guided mindfulness of breathing meditation), as well as in informal practices (such as mindful pausing using the STOPP technique).

Teaching Psychotherapy Skills on the C-L Service Using the 3-Step Supportive Psychotherapy Manual

Supportive psychotherapy is a psychodynamically-informed psychotherapy which uses aspects of various theories, including psychodynamic, CBT, attachment and learning theories. Focusing on the present situation, in light of past experiences, it is not as exploratory as psychodynamic psychotherapy and involves minimal interpretation of transference, unless negative transferences are promoting symptoms. It can help decrease symptoms by improving ego function, improve or restore self-esteem, and improve adaptive skills and behaviours. It may therefore be the primary intervention needed for patients in the acute medical setting. This is not the only reason why Liaison Psychiatry services provide a rich learning environment where supportive psychotherapy skills can easily be taught (e.g. to psychiatry trainees). Brief psychotherapeutic interventions are already an integral part of the assessment and management of patients on the medical/surgical services; in other words, Liaison Psychiatrists have already acquired these skills and utilise them with their patients. Moreover, the service infrastructure allows for close supervision of trainees as they learn and practice these skills. Last but not least, teaching psychotherapy skills in Liaison Psychiatry services can also reinforce the concept that psychotherapy and psychodynamic thinking is not restricted to the outpatient setting and increase the staff's comfort with using psychotherapeutic approaches, whilst requiring a minimal amount of didactics/supervision.

The “3-Step Supportive Psychotherapy Manual” was originally developed by Deborah Cabaniss as a teaching resource for busy clinical settings such as the Emergency Department or the Liaison Psychiatry services and provides an easy-to-follow stepwise approach, with suggestions for each step. The three steps are:

1. Evaluation of the patient's ego function (and formulation).
2. Setting goals for treatment (these may include understanding their own feelings and feeling understood by others, making sense of what brought them to this current crisis, mobilising more adaptive coping skills, maintaining self-esteem during this crisis, effectively relating the family and/or team, and/or planning for the short term).
3. Developing a plan for treatment (this includes establishing a therapeutic alliance, setting a frame and boundaries and using an empathic approach with a supportive psychotherapy focus).

The manual essentially provides a clear structure for psychiatrists to discuss case conceptualisation, establish a treatment frame, and plan interventions (the use of which adds very little time to the supervisory or patient care encounter, which therefore makes supportive psychotherapy ideal for use in the busy Liaison Psychiatry settings); it also provides a clear basis for teaching concepts about supportive psychotherapy and how to provide

supervision, while at the same time it can also help supervisors hone their own skills and knowledge.

Liaison Psychiatrists frequently assess and manage terminally ill patients; end-of-life psychotherapies may therefore be of significant value to these patients and their treating teams. Unlike supportive psychotherapy, however, these psychotherapies are more structured and would be better delivered by therapists with training and expertise in their use. Here is a brief review of these psychotherapies:

1. Brief Psychodynamic Intervention in Crisis, whose theoretical underpinnings are based on Erikson's stages of development, is a brief and unstructured therapy that may be done at bedside. It is often used in physically ill patients with depression. Using the "life-narrative" technique, the focus of this therapy is to recognise essential and current issues and to capture the patient's experience and emotional meaning of illness, which may result in finding the meaning of their illness within their life context and may help in alleviating their distress and restoring their self-esteem.
2. Dignity Therapy is often used in patients with life-threatening illnesses and allows them to maximise dignity-conserving perspectives of generativity (a concern for the future) and legacy. There is more structure to this therapy than the previous type; overall, there are four therapist-patient encounters where the therapist records the patient interview and subsequently transcribes and edits a generativity document.
3. Meaning-Centred Psychotherapy, based on existential concepts and Frankl's "Man's Search for Meaning", is an individual therapy consisting of seven structured one-hour sessions which include scripted didactics, writing prompts and homework. It has been adapted from a group therapy (eight 90-minute group sessions) and can be used in advanced cancer patients with limited prognosis (less than 6 months) presenting with demoralisation and despair. It can help them understand various sources of meaning in their lives and has been shown to improve sense of meaning and decrease hopelessness and despair.

Returning back to the UK and reflecting on the APM 2017 Annual Meeting, it seems that Psychotherapy can (and should) be an integral part of Liaison Psychiatry. Psychologists have been employing brief therapeutic interventions in emergency departments for the last decade, as much to upskill and build resilience in staff as to directly help manage emotional distress; but these initiatives are not widespread. Liaison Psychiatrists, being more at home in busy emergency departments could do much to spread and embed such ideas. From employing mindfulness strategies at the patient's bedside to using our skill set to deliver supportive psychotherapy, and from supervising trainees in providing supportive psychotherapy to delivering structured end-of-life psychotherapies, it seems that there is a large enough place for psychotherapy within Liaison Psychiatry. Integrating Psychotherapy

and Liaison Psychiatry will be beneficial not only to the patients (provision of better and more holistic clinical care that includes effective psychotherapeutic interventions), but also to the staff (better learning experience for trainees, including teaching and practising Psychotherapy skills) and the services (increased effectiveness, which in turn may not only result in better patient experience but could also potentially reduce length of stay). The question is therefore not whether Psychotherapy could or should be part of Liaison Psychiatry, but how we, as Liaison Psychiatrists, can ensure that Psychotherapy is situated firmly as part of our role and of the service we deliver.

Dr Alex Chatziagorakis

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We are pleased that since attending the conference Dr Chatziagorakis has started his first consultant post as a Liaison Psychiatrist with a special interest in psychotherapy, in West London Mental Health NHS Trust.

Dr Alex Chatziagorakis would like to thank the following consultants for thinking about and commenting on his article. All contributors received a bursary from the Royal College of Psychiatrists to attend the conference.

Dr Alice Ashby, Consultant Liaison Psychiatrist, South London and Maudsley NHS Foundation Trust

Dr Anna Fryer, Consultant Liaison Psychiatrist, Pennine Care NHS Foundation Trust.

Dr Aaron McMeekin, Consultant Liaison Psychiatrist, Manchester University NHS Foundation Trust.

Dr Parashar Ramanuj, Consultant Liaison Psychiatrist, Royal National Orthopaedic Hospital NHS Trust

International Balint Federation Congress Report – An introduction to Balint

Beth Hamilton

The 2017 International Balint Federation Congress was held in Oxford at Keble College from the 6th to 10th September. I had the privilege of attending the Conference as a first-year doctor, and one of the recipients of the Ascona Prize - a reflective essay competition open to medical students around the world. After a long journey from Australia I pulled in at Oxford train station, and made my way down the cobbled streets in light rain to Keble College. It was in sharp contrast from the town in regional Queensland that I had travelled from, where it exceeds 30 degrees most days and rain was a precious scarcity! On arriving at Keble College,

I was met with smiles from various strangers, and my nerves were immediately calmed. I quickly learnt in the opening plenary session that these strangers heralded from 29 countries around the world, spoke many different languages, and would soon become my Balint colleagues.

The Introductory Lecture was titled "Where there is silence, let there be story", presented by Padraig O Tuama, an Irish Poet. He talked about his work at Corrymeela, Ireland's oldest peace and reconciliation organisation, which was founded to facilitate people of different religions, national and political identities in friendship and understanding, argument and civility with each other. He eloquently drew parallels between poetry, storytelling, and the doctor-patient relationship and started to explore the theme of the Conference, "Exploring Diversity". He talked about the idea of "otherness" and of "sameness and strangeness", discussing identity, territory, religion, conflict and how he uses storytelling to explore these ideas. Poetry was spattered throughout the address, the audience were invited to participate at various stages, and by the end the room felt united in embracing the theme of diversity. Indeed, this thought provoking introductory lecture, combined with the setting that is Oxford, inspired a sense of being part of history, of learning and knowledge, of asking those questions and having conversation that supersedes oneself.

One of the most rewarding parts of the conference were the daily Balint Sessions- five in total were held over the duration of the conference. This was my first Balint experience. I was rather nervous, unsure of what to expect and of whether I'd be able to contribute satisfactorily to the group. I found it fascinating listening to the insight and intellect demonstrated by my group members, and was witness to a level of emotional and social intelligence I have rarely encountered. This was only enriched by having people from such a diverse range of backgrounds, experience and skills. I eventually worked up the courage to share one of my own doctor-patient experiences and was overwhelmed by the support I received, and found myself approaching the scenario I had outlined to them in a different way. I had initially been disappointed in the way I had handled in the situation, and felt as though I had let the patient down. By listening to my colleagues input in a removed, safe sense, I was able to see the scenario from the patient's perspective, and begin to appreciate the complex factors at play, far beyond the scope of our single encounter.

I also had the opportunity to be a part of the parallel "student day" on the Saturday of the conference, where we completed two Balint sessions. It was interesting to compare this to wider group Balint sessions. I noticed there were many additional factors relating to the medical student's role in scenarios discussed, where they are often the "third person" in the room, serving roles as an advocate, as an observer, as a moderator, as a pupil. We also discussed the challenge that arises in identifying your role in each scenario and the impact it has on the medical student-patient relationship and the doctor-patient relationship. I found

this very interesting to dissect, considering my medical student experiences were still very fresh from a few months earlier, and I was transitioning into learning my role as a junior doctor.

There were plenary sessions held each day, where key papers were presented in Lecture form, on the theme of Diversity. Among many presenters, we heard from Nina Arzberger, who described the first Balint group in Pakistan. She discussed the challenges they faced establishing a relatively liberal group that is Balint, in a highly conservative society, and the role of socio-cultural variables in Balint. Associate Professor Jeffrey Sternlieb delivered an insightful presentation about his paper "Discovering my white male privilege: becoming an ally- continuing my education", where he described his own personal white privilege awareness journey, including examples and challenges for Balint leaders to consider in their own personal explorations.

In addition to engaging in these lectures, we also had the opportunity to participate in workshop breakout sessions. There were eight workshops centred around the theme of diversity, providing an opportunity to learn and engage in an area of your interest in a smaller group. I attended the second workshop called "Balint Theory and Practice: Exploring the Introduction of Balint Groups for Health Practitioners with People from different cultural and ethnic minority groups", hosted by two fellow Australians, Dr Bambi Ward and Richard Fejo, an Aboriginal Cultural Educator from the Northern Territory. They discussed their Australian experience of Balint groups with Aboriginal cultural educators for doctors working in Australian remote communities, the challenges they faced (such as cultural safety and vicarious trauma) and benefits of the program. We learnt from each other, as people from across the world contributed their experiences working with different cultural and ethnic minority groups in their region.

On the final evening, I had the opportunity to present a condensed version of my first prize essay "Meeting Margery". I was truly a world away from the small town of Warwick in rural Australia, where I had perused the email from my medical school advertising the "Ascona Prize" and first put pen to paper. What made this evening particularly special was listening to the two other students present their essays before me, and reflecting on the similarities between our diverse experiences literally across the world- Israel, America and Australia. It was such a special opportunity to share my story, and Margery's story, with a group of people I had the privilege of getting to know over the Conference, and I left having this final sense of validation. In addition to the academic schedule, there were also social events every night, which ranged from watching films to listening to a wind quartet in Keble College chapel, and of course the final night where we came together for a night full of singing and laughter in the dining hall.

I found myself reflecting on the conference experience while sitting in a coffee shop in the Undercover Markets before making my way to the departing train. I was surprised by one of the major concepts that stood out to me, perhaps planted in my mind by Patrick the Poet. Silence. There was a lot of sound at the conference- discussion, questions, laughter, singing, musical instruments, the list goes on. However, there were also periods of silence. I found myself initially very uncomfortable with this. Sitting in silence for minutes at a time in Balint Groups, only interrupted by the distant sound of traffic. I found myself deeply analysing it, often being the one to break it for I felt it needed breaking. By the end of the conference however I found myself observing the silence. There is a powerful form of communication which silence facilitates, uniting people across their differences and language barriers.

Fast forwarding to the present- I have recently completed my internship at Townsville Hospital. The Balint experience is always close to me, and has an impact on the way I interact with patients on a daily basis. I try to remain cognisant of the experience of the patient and their family, and take the time to reflect on my own practice and factors that impact on it.

Beth Hamilton

Medical intern, year 2, at Townsville Hospital in Australia.

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Making Psychotherapy Applicable to Hospital Medicine – The Interpersonal Dynamics Consultation Project.

Ching Li

The Importance of Reflection in Clinical Practice

As clinicians working in an era of the mechanisation of healthcare and outcome-based payments we cannot help but feel engaged in a battle to keep psychotherapeutic practice within the clinical mainstream. Most of us working in this field understand the importance of the ongoing translational work of making psychotherapeutic thinking understood and valued as a tool within the current climate of the NHS.

We find ourselves working at a time of austerity, increasing institutional complexity and ever-present pressures and challenges; it feels that the need for a reflective space for thinking about these difficulties is as important as ever.

Since the breaking of scandals such as Mid Staffordshire and Winterbourne the prominent rhetoric within the NHS has been that of accountability, improved team working, and compassionate patient-centred care. In looking beyond the headlines and thinking about the underlying systemic factors that might cause individuals, groups and institutions to lose sight of their primary objectives of care, a more complicated picture emerges. As the response by the Royal College of Nursing to the Francis report points out:

‘The NHS often sets up good people to do bad things; through constant change, chronic under-staffing and unrelenting pressure, staff have kindness and compassion eroded from them...more must be done to tackle the burnout associated with the constant emotional labour of caring and to support staff who chose to give their working lives to our NHS.’¹

It is a chilling reality that the institutions that we work within can become mentally unhealthy and toxic, fostering acts of neglect and abuse. These scandals act as a salient reminder for us to understand the power of emotional and interpersonal processes arising in our work as healthcare professionals.

Consulting to Chaos – An Approach to Patient-Centred Reflective Practice

In Prof. Gabriel Kirtchuk, Dr David Reiss, Mr. John Gordon and Ms. Maggie McAlister’s book, ‘Consulting to Chaos’², the authors use their experience of working with forensic patients to highlight how the illness of these patients can become projected onto the team. They describe the process by which these powerful projections can be identified with by clinicians and permeate the institutional structures responsible for their care. These cases have the propensity to create splits within the team, paralysing professionals in their clinical thinking and ability to act.

The authors acknowledge the complexity of working in organisations such as the NHS, with its multiple aims and pressures. The nature of our work produces emotions that spread into our teams and institutions, and result in the formation of group defences antithetical to the primary task of caring. These defences can lead to the emergence of critical ‘blind spots’ in clinical care, where essential information and reasoning around treatment and risk management is obscured and boundaries can become compromised.

The book highlights the importance of reflective practice in clinical work as a tool for allowing the system to hear the communication of the patients and attend to these ‘blind spots’. They warn against the potential of iatrogenic harm if these communications are not attended to, and propose the power of reflective practice as a vital element of comprehensive care planning for the patient. Because patients may behave differently towards individual members of the team, by involving the whole multidisciplinary team (MDT) in this form of reflection we are able to gain a more holistic understanding of the patient. The authors

developed the Interpersonal Dynamics Consultation (IDC) as an instrument to facilitate this form of reflective practise. The IDC model is a systematic and structured tool to understand the transference and countertransference processes that occur within the patient–team interaction.

The consultation includes the whole MDT and usually takes place across two sessions, each lasting for one hour. It begins with an exploration of the patient’s background, significant relationships and their current relationship to help. It breaks down the patient’s core relationship patterns into the following four perspectives:

- How the patient experiences others
- How the patient experiences themselves
- How the staff experience the patient
- How the staff experience themselves (in relation to the patient)

This is followed by a formulation that highlights the patterns that exist in the patient’s way of relating. Once these core dynamics are identified, an extended formulation incorporates the past experiences of the patient, and links these experiences to the dramatic repetitions currently being re-enacted with the team. Finally, the team has the chance to review the treatment plan in view of these new insights.

The Interpersonal Dynamics Project for Medical Teams

Whilst the IDC model has been used successfully for many years in mental health, in particular in forensic settings, our current project aims to apply this model to general hospitals. Funded by Health Education England and supervised by Prof. Michael Maier, Prof. Gabriel Kirtchuk and Dr David Reiss, the project has been running for the last 18 months and has been cited as an example of good practice.

We have been training psychiatrists from various specialities to facilitate this model of reflective practice for medical teams within acute hospitals in London. The model focusses on the universal applicability of simple psychoanalytic principles, whilst avoiding the dense and less accessible aspects of psychoanalytic theory. This allows us to deliver the training succinctly, in four three-hour sessions, with regular follow-up supervisions.

The idea of adapting and embedding the IDC model within mainstream medicine speaks to the growing recognition of the importance of working at the interface of mental and physical health. It is an acknowledgment of the importance of reflective practise for effective team working and in the prevention of burnout.

This model has been well received by our medical colleagues, who inevitably find themselves working in a structure with fewer opportunities for reflection. Cases for which teams have appreciated consultations include: patients with psycho-somatic complaints, personality disorders, aggression and addictions. There is also a cohort who may not reach the threshold for psychiatry liaison referral yet have chronic problems in engaging with their medical treatment, and result in disagreements and splits within the team.

By going through the four perspectives and allowing members of the MDT to express their thoughts, viewpoints are shifted, repeated cycles of behaviour become apparent and new insights come to light. When conducting the IDC we do not position ourselves as the authority; instead we facilitate a discussion that allows the team to reflect and generate its own personal understanding of the patient. In guiding the team through a structured approach we find that participants arrive at their own answers about what needs to change.

We hope that this project will contribute to the ongoing work of making psychiatry and psychotherapy more embedded, translatable and relevant to the rest of medicine. As mental health professionals it feels important to try to step beyond treatment of 'our patients' in 'our hospitals' in order to fulfil more of a consultative role for those of neighbouring professions.

Final Thoughts

Whilst the IDC model starts with a focus on patients and the emotions that are engendered in the role of caring, in 'Consulting to Chaos'², Kirtchuk, Reiss and colleagues remind us of the additional difficulties that arise from team dynamics and institutional pressures of working within the NHS.

This makes the case for reflective practice as vital, not only for our patients' care, but also for the functioning of our teams and institutions. Under increasing pressures that clinicians encounter to defend and evidence, what can become split off in our way of working is this space for thinking.

The IDC model is an example of the transferability of psychotherapeutic ideas to the rest of medicine. Drawing upon fundamentals of psychoanalysis, the gift is one of reflection that is not couched in opaque language but is immediately relatable and engaging.

The aim is not really to supply our medical colleagues with something new, but rather a different perspective what already exists. It is to offer the space to think, rather than tell them what to think. The hope is to create an engagement where one can relate their own experiences to that of their patients, and arrive at their own answers.

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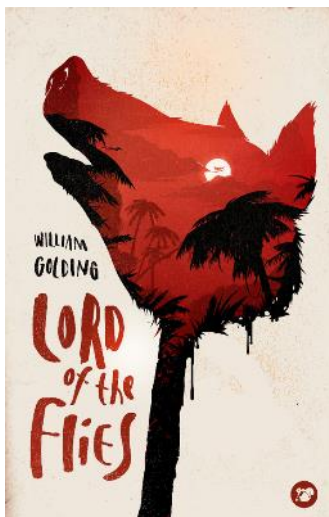
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Lord of the Flies with coffee breaks

Benjamin Waterhouse

Report from the Tavistock and NHS Foundation Trust, Group Relations Conference: *Intuition, Authority and Leadership in Turbulent Times.*



1 William Golding's classic portrayal of British schoolboys' rapid descent into savagery

Day 1

I'm at the world-famous Tavistock Centre in North London attending an immersive experience entitled: "Intuition, authority and leadership in turbulent times". 100 strangers forced together in a room from 9am-6pm, for 5 days, trying to form a society. In this largely unstructured learning laboratory, members are free to reflect aloud on the conscious and unconscious dynamics which 'play out'. The purpose, the brainchild of Bion, devised in the aftermath of WWII, is to examine why humans behave oddly in groups.

We'll be supervised by the largely silent 'management' who will occasionally throw in curve balls to stoke the flames, whilst having the authority to pull the plug on the social experiment if things go too far.

Before attending I read the disclaimer; “this conference is not suitable for anyone suffering from serious personal or psychological problems”. But I’m sure I’ll be fine. It reminds me of those warnings at the foot of theme park roller coasters; “do not ride on ‘Paralysis’ if you have spinal problems”



The stony-faced ‘management’ line up directly opposite us in suits, explain we’ll be working in ‘big’ and ‘small’ groups

2 Our (concrete) jungle

before saying ‘now how would you like to begin?’ After looking at my shoes nervously I break the silence by saying it feels like “we’re about to go into war against them”. It gets a laugh of relief but someone scolds me for ‘acting out’. Already identifying an *us* and *them*, to give myself identity to a tribe, and it’s only 9:16am.

We return after coffee to find the sullen organisers have rearranged the chairs into a spiral, a single chair in the middle. No one dares to sit there, leaving the humiliation for a late girl called Chloe. People ask why she sat there and she says someone told her to, pointing to a Mabel. The pack smell blood and demand, “what’s your name?” ‘I’m not saying’ replies the scapegoat. She is the vehicle for all the groups’ uncomfortable feelings.



3 The welcome session

After lunch there’s an empty seat, Mabel has left. I wonder if the management will later remove her chair, as cults do when non-believers leave, to give the illusion that everyone’s still totally on board with drinking the Kool-Aid.

Next, we’re told to silently form ‘small groups’. Despite our make-shift society being a near 50/50 mix of white/BAME members I’m mortified to discover I’ve gravitated to a predominantly white group. Am I a monster? Then a member called Joshua joins, which increases our number of black members, and I heave a sigh of relief.

In my group are a nice psychologist called Tim, a family therapist call Jennifer, Joshua the toned, charismatic psychotherapist and myself, a (usually) peaceful Quaker psychiatrist, with a gentle nature. Joshua is the natural authority and as a potential rival for the leadership, I instantly dislike him. He hates me too, or is that just my projection?

Tim says excitedly we could ‘literally do anything’ although management are observing us like superego CCTV to keep a lid on things and stop us satisfying our primal ID’s. That evening I meet my friend Amy for dinner and tell her of my fantasy to kill Joshua and eat his muscles

for dinner. I say all this whilst eating my vegetarian curry. She asks if I'm ok.



Day 2

Still in survival-mode and fearing punishment if I'm late, I barge in front of an old lady to squeeze onto the busy tube. "It's survival of the fittest, Doreen", I say under my breath.

In the 'big group' a white member criticises a black member for note taking. Someone hits back saying it's a thinly veiled attack on difference and diversity. There's rally-like

clapping and whooping, to and fro, as though people have picked teams. Like in Question Time when you get Tory and Labour supporters who just cheer the panel member in the blue or red tie, irrespective of what they say. "Universal basic income for cats!" **rapturous cheering and applause**

At lunch there's a canteen split, a predominantly black half and a predominantly white one, of educated people, like it's the 1920's. I go elsewhere because you can't be racist eating a footlong Subway on your own. And everyone knows the backbone of the civil rights movement was inaction, right?

As I chomp on my sandwich I remember learning in psychology A-level that prejudice starts once children start to notice difference. My girlfriend's sister has told me some of the uncensored things her 4-year-old daughter innocently broadcasts on busses; 'Why do I have brown skin?', 'why do they only have 1 arm?' and 'look mummy, he's pregnant like you!'

Studies have shown children have a preference for playing with children based on shared similarities, be that clothing or skin colour. In later life, this bias can manifest as discrimination. US psychologist Gordon Allport's 'contact hypothesis' suggests that familiarity with the outgroup lessens this (after all ignorance breeds hostility) and thus the recipe for ethnic, tribal or religious harmony is intergroup contact. The theory being that we recognise the 'other' isn't so alien and see our common humanity.

Day 3

Alarmingly there are lots of empty seats today, people are dropping like flies. A lady I've become friendly with suggests we implement some values for our organisation. Someone attacks her saying 'who the hell do you think you are?!' Cool as a refrigerated cucumber she replies, "I'm Monika". It certainly seemed unprovoked and disproportionate and was interpreted as a racial attack from a white woman to a black one. Emotions flared with people

storming out and shouting about 'what's not being said'.

After lunch, we break into our 'small groups' and go to our 'territory' which we decide to call 'Roomy'. We agree to a left-leaning, open door policy for new members. One group has named theirs slightly less invitingly 'No Room' and another 'Do Not Come In'. Paranoid-schizoid much?

I go to the vending machine for another chocolate bar and coming back notice that 'Photoluminescence' have marked their territory. This is the start of war, like Hitler moving into Austria. I report back that they're humiliating us with their A4 poster. 'That's it. We need some A3 paper!' we all agree.

Joshua punches his fist saying he wants to 'make something happen' which I hear as "this town ain't big enough for the both of us". I ask him if he wants to fight and he says 'maybe'. On leaving at 6pm the air is thick with paranoia; "I asked management to remove her but they won't", I overhear. Someone else wonders "what'll they do if a fight spills into the corridors?" adding "when does this stop being educational and just plain damaging?"

I meet my partner Esther in a nice Peruvian restaurant to say goodbye before Christmas. There's piano music and candles and it's very romantic. Esther asks how my day's been and I tell her I want Joshua's blood. She looks concerned, says my eyes are 'wild' and not to take it so seriously. Like when Zimbardo's partner begged him to stop the infamous Stanford Prison Experiment after just 6 days. She says, "it's not real life" and I agree with her before we part company so that I can get an early night so I have enough energy in case I have to fight Joshua tomorrow.

Day 4

A meeting is arranged between the 10 'small group' leaders. The rest of the membership silently watch from outside the inner circle. Disturbingly every elected leader is Caucasian.

Back in the 'big group' there is a second seemingly random attack on Monika. She's so strong and assertive but why didn't I stick up for her? I was sitting right next to her. I tell her I'm sorry and feel an overwhelming emotion to cry.

This week has effectively held a mirror up to my murkier nature. I have noticed, when under stress, the people I more naturally gravitate towards, my feet moving faster than my brain can; based on class, gender, occupation and ethnicity. They tend to be the people who are most like me.

On the subject of race, I found acknowledging these unattractive, unfashionable and

untweetable inner biases brought me closer to people of colour and led to deeper, more constructive talks on how to repair the visible divisions in our lab-society. More helpful anyway than defensively declaring 'I'm not racist' and joining your tribe in the canteen. I used to tell myself the progressive line 'I don't see colour' which makes about as much sense as saying "I don't see jumpers". More perniciously it avoids any accountability. Like a police officer waving traffic on past a motorway pile-up saying, 'there's nothing to see here'. It's important that we *do* see race in order to observe who benefits and who is discriminated against, in our multi-cultural society. The 'small group' leaders meeting was analogous with the structural racism we see in the upper echelons of power in this country, from CEO boardrooms to Premier League football manager's offices.

My thoughtful previous consultant once told me 'we're all racist'. Not overtly in the right-wing, St-Georges-flag-waving, violently nationalistic way, but more subtly in the ways we unconsciously treat people differently based on their ethnicity. My partner may be Singaporean, my sister-in-law Kenyan, but I still notice myself doing different handshakes based on a friend's skin colour.

Day 5

Today is the final day. Joshua approaches me during a break and says, "I'd like to work with a psychiatrist like you". His generosity, twinned perhaps with my fear of intimacy, makes me feel like it's just the right time to admit: "I've been having murderous thoughts towards you, mate. But it's just a primal caveman, alpha thing. Umm... ok see you later mate!" before running off for a cuppa hoping it'll be ok because I called him mate a lot.

Recalling the story to Monika over a herbal tea I realise it's not hate that's been driving this desire but *envy*. She thinks that without mentioning that detail saying you want to kill someone 'might seem a bit abrupt'. So I track him down, fill in the gaps, and we hug.

The art of psychoanalysis, on an individual or group level, is to free associate, to say 'whatever's on your mind' however reprehensible. It's about coaxing the unconscious out. Society (superego) makes us suppress a lot of our most base wishes. But in this open atmosphere I've been frank about my more cardinal desires for food, sex and violence. We may well queue in Post Offices and complete tax returns, but we're still basically just chimps in clothes.

The last session in the 'big group' is calm. No one wants to open a can of worms. Few people speak, the others fearing they may reveal their inner ogres or get attacked. I look around; we've lost a lot of people along the way. The management haven't removed the empty chairs. This isn't a cult. *We* have done this. Just enough humans in a room with nothing to distract them.

Finally, we moved into the canteen for a drinks reception. “Is adding booze, the petrol that fuels weekend brawls, a good idea?” I wonder. I’m relieved to see we have plastic glasses.

Glugging wine I notice there’s a healthier distribution now. On saying goodbye people are exchanging emails, and not even that fake email you give to McDonalds to use their wifi. I’d like to keep in touch with Joshua and Monika but I’ve had intense bonding experiences that don’t go anywhere. Like when you drunkenly tell someone you never speak to at the work Christmas party you should ‘totally hang out more’ and then spend the rest of the job trying to avoid eye contact. Plus, I barely even have time to call my Mum.

Joshua bounds over ‘Benji there’s something I have to tell you, it’s been eating me up for days’. I brace myself. ‘You look just like the footballer Christian Erickson’. You really never know what other people are thinking.



As we laugh he says some of my spit accidentally landed in his eye. I say it’s social convention not to comment and he reminds me I said earlier that I wanted to murder him, which is fair enough. I give him a handshake from my repertoire of two, give Monika a big squeeze and walk back into the real world.

As I pull my travel case to Kings Cross station I call my friend Alex to tell him about the most intense week of my life. He jokes “well at least your family Christmas’ are relaxing”. Ah yes, the festive time of peace and goodwill. And also, the time when you’re statistically most likely to murder a relative. I’ll try extra hard not to throttle my Dad with tinsel.

This week I have glimpsed John Locke’s ‘state of nature’, and its freedoms. But on the busy Friday-before-Christmas train up to Newcastle I feel happy to have returned to the cushioned bubble of society. It’s niceties that oil the cogs of civility to ensure we all get along. A man plays tinny music through his phone in the ‘quiet coach’ and people bite their tongues. A Virgin employee runs over my toe with the snack trolley and we both apologise. An elderly lady gets on at Peterborough and I give her my seat.

NB. Examples have been slightly altered and names changed to preserve anonymity

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“Group Soup” – Reflections on the Trainer-Trainee Group Relations Day in Exeter

Peter Wilkinson

Take sixteen psychiatrists, trainees, therapists, nurses and students, some with pre-existing professional connections and others entirely unknown to one another – these are your “members”. Introduce them into an aptly subterranean psychotherapy department and stir gently. Meanwhile preheat the setting with some balmy July weather. Next add four group facilitators and an assistant, termed the “staff”. Agitate the mixture by using unexpected chair arrangements and holding back on usual social pleasantries. Using succinct yet slightly ambiguous instructions, fold in as much uncertainty as you can whilst sieving out any overt sense of a task. In this vacuum allow your participant-blend to congeal and separate, before liquefying again. Then bring to the boil, simmer and wait...

Just as people trying out a new recipe will respond in various ways, difference was a key theme emanating from the group relations day in Exeter. In being asked to form groups (without speaking), then being set a “networking” scenario after lunch (in, crucially, different groups), members were taken along an experiential journey that provoked different emotional responses in us – responses about ourselves, about conformity versus rebellion, about boundaries and trust.

We all seemed to have wide-ranging reactions to the formation (and reformation) of our groups – groups that many of us went away feeling more strongly about than we might have imagined. I found myself feeling variously apprehensive, motivated, at sea, comfortably familiar, concerned, irritated, and just plain worn out by the end of it all.

There were personal learning points. I surprised myself by just how uneasy I felt when the boundaries and frame were challenged. In the smaller groups, I found myself thinking I was doing something “good” in trying to tease out others’ feelings about the group, but was I just being competitive and trying to win the approval of the staff, the authority in the room? I certainly found myself filtering what I had going on in my head, and I kept a deliberate lid on any of my own vulnerability. There were a brave few, however, who were more genuinely expressive about their fragility and the event was all the better for their openness and honesty.

I hadn’t tried group relations before, but after this first taste I’d like to go back for seconds.

*Thanks to Tom Palmer for the title.

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REMEMBER YOUR CONTRIBUTIONS TO TRAINEE VOICES ARE ALWAYS WELCOME!

We encourage you to contribute to the dialogue. Please send contributions for the next newsletter to Anna c/o stella.galea@rcpsych.ac.uk



Photo by Alison Jenaway

BOOK REVIEWS

Dan Beales and Andrew Shepherd

Treating People with Psychosis in Institutions: A Psychoanalytic Perspective

By Belinda S. Mackie

Karnac Books, London, January 2016

In this fascinating book, Mackie attempts to consider the possible role of a psychoanalytic perspective for modern clinical institutions in the support of individuals with psychosis. Building on work completed in her PhD studies, Mackie draws primarily on a Lacanian framework in her exploration.

The book's opening section considers the historical interaction between psychoanalysis and psychiatry in approaches to the support, or treatment, of psychotic experience. In developing an historical perspective Mackie outlines the groundwork for the remaining material in the book; that is, an observation of the manner in which *history* and *culture* within institutions can be seen as informing current practice.

The middle bridge section links the theoretical concepts previously outlined and considers how they may inform a psychoanalytic understanding of the work of recovery, within institutional settings. The theoretical perspective is broadened here, to take account of group dynamic processes alongside individual ones.

The majority of the material represented within the book focuses on a series of case studies of hospitals and other institutions where a psychoanalytic framework has been explicitly adopted, or can be seen as directly informing current practice. These examples include: hospital based individual treatments, institutions oriented to Freud and Lacan, therapeutic communities and institutions approaching work with children or adolescents. In each case the strengths and difficulties displayed by each mode are considered.

Mackie concludes by identifying two principle common themes from her review:

1. The essential requirement for conceptual models to orientate the work within institutions;

2. The importance of ethical and psychoanalytical reflexivity within institutions.

For me, it is this last point that delivers the key message running through the book, since it highlights the complexity of the work involved in supporting psychotic experience and the intense demand that this process places on professionals, other caregivers and the patient themselves. In the absence of a sufficiently reflexive process, institutions become vulnerable to being torn apart by intense pressures, demands and group processes - as Mackie demonstrates through her consideration of “failed institutions” and the process of their demise. The importance of these messages resonates today, in a healthcare system that experiences extreme pressures, both external and internal, that threaten to stifle work and care through a process of traumatisation for the workers / carers within.

This book is therefore highly recommended for the historical and theoretical lessons that it offers, allowing a different form of reflection on the challenges and rewards of modern healthcare work and providing some thoughts about how this can be better promoted.

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Psychoanalysis, The NHS, and Mental Health Work Today.

Psychoanalytic ideas

Publisher Karnac Books, London 2017

Editor Alison Vapse

This is a timely and thoughtfully written book that brings together psychoanalytic themes as applied to the work of mental health services in the contemporary NHS.

The book does this by gathering together authors working in a variety of NHS settings. Primary care GP services, a specialist trauma service, child and adolescent mental health services, women’s intensive care services, a specialist personality disorder service, and organisational consultancy. The authors illustrate the rich understanding a psychoanalytic perspective brings to our clinical work with complex mental health problems across the lifespan, and the psychological impact mental health work has on frontline staff and their organisations, and consequently the importance of having reflective spaces.

The book is divided into two sections. The first five chapters focusing on psychoanalytic work with patients and the second on staff needs and organisational challenges.

Core psychoanalytic themes weave threads through the book and provide continuity of thought to the authors' narratives. In the first chapter the reader is introduced to varied understandings of the notion of 'containment', incorporating Bion's original theorizations of the concept (1962), that help an MDT team in a general practice setting to cohere around in their regular reflective practice meetings. This process helps improve their collaboration, reduce professional isolation, identify social defences, thus reduce guilt and set limits with a more realistic view of what they are able to achieve for their patients.

This theme of containment reverberates through the book. For Bion this was how the mother, the container, made sense of the unspoken communications from her infant- through a process of reverie; digesting the communication and then communicating this digested communication back to her infant in a way that shows the communication has been received and understood. This process of reverie that the mother undertakes links to the other fundamental concept of countertransference (Joseph 1985), and that a receptive awareness of which can fundamentally inform our clinical and organisational work. This is movingly illustrated in the clinical examples from the work of the specialist trauma service at the Tavistock clinic by Jo Stubley, and the pressures that the clinician is placed under to take up particular roles in the transference when working with traumatised patients. 'Trauma maybe viewed as a failure of containment whereby the overwhelming of existing structures and defences against anxiety attacks the links between self and other. The repetition compulsion pushes for what cannot be thought about to be repeated instead, over and over again' (P27). This includes the relationship with the psychiatric, health and social care system.

Shuttleworth and colleagues in her chapter on 'Thinking Psychoanalytically about CAMHS' describes how with the 'business management approach' (P40) to the re-organisation of CAMHS services with the reification of treatment protocols, the importance of being able to establish a relationship with young people who may not have 'the capacity to express need, but only what is noticed and felt by the clinician in their presence' (P44), can be threatened. The effect is a loss of understanding for the young person seeking help, with an experience of not being heard, with potentially lasting consequences.

Careful observation of her unit, a female PICU, and attention to her emotional reactions (countertransference) and those of her nursing staff shines through in the writing and work of the late Siobhan O'Connor. She explores gender differences in the expression of aggression, and how what might be more 'uniquely feminine characteristics have not been fully recognized or incorporated into the psychoanalytic literature' (P79). She relates this to the developmental challenge that little girls have to navigate in expressing their aggression while maintaining their tie to their mother. O'Connor returns to a theme that she had explored in an earlier paper that in the PICU environment the threat of physical violence would take precedence over countertransference and nursing colleagues 'would suddenly drop interest in our more thoughtful discussions' and she compares this to the nurses having the attitude of the 'vigilant mother with her child' to maintain the safety of their patients and themselves. It is helpful reading, and the acknowledgement that due to the sparsity of female

PICU units this may create more transitions in the care pathway and ignore the importance of relationships as an agent of change.

The theme of applied psychoanalytic thinking and its relevance to everyday psychiatric practice is continued in the chapter 'Reflective psychiatry'. Mills and Smith, 'psychoanalytically minded psychiatrists' illustrate this through clinical vignettes of familiar scenarios and pressures to act, that psychiatrists are often faced with and how good psychiatric practice is informed and complimented by psychoanalytic understanding.

Christopher Scanlon's chapter 'Working with Dilemma and Disappointment in difficult places' is more demanding of the reader as he outlines his notion of 'the dilemmatic space' that opens up when conversations about things that 'do not fit together' occur, as he attempts to show the tensions that arise in teams and organisations, when working with traumatised people and the 'disappointing-disappointed' dynamic that occurs for both practitioners and their patients. This is from his experience of 'reflective practice team development' consultancy, working with people at the margins of society. His focus is on helping teams and their members take up their professional role through active participation in reflective conversations, that can consider parallel processes and 'isomorphic resonance'(P124) across different sub-groups within systems of care.

Wilhelm Skogstad's experience of being 'an observing participant in a therapeutic institution' may bring up familiar themes for readers. In the chapter, he vividly conveys how in his role as head of service of the Cassel hospital -an institution that faced a threat to its survival paralleled by the patients' struggles with severe self-harm and suicidality - he had to keep in mind the dynamics of the 'total system', rather than being drawn into focusing on one aspect; for example, at an individual patient level. He illustrates this by describing the effect of the moving on of his close senior nursing colleague, coinciding with a number of other losses and changes in make-up of the patient community, and a subsequent investigation of the service by trust management. Observing his own anxiety and that of staff, patients and trust management, and being able to digest and respond to this in a thoughtful rather than defensive way allows for the possibility of containment, rather than enactment. He cites Britton's third position when the child can recognise the link between its parents and thus 'the capacity for seeing ourselves in interaction with others and for entertaining another point of view'.

The theme of working within an organisational context is illustrated in the editor, Alison Vaspe's own chapter and her experience of providing an in-house psychotherapy service for staff. She powerfully illustrates the complexities of the therapeutic task with a staff member who is subject to a long enquiry into her practice following the death of one of her patients. The death of her patient and the investigation has powerful personal resonances for the staff member, but also brings pressures that her therapist is faced with understanding in order to be able **to** help her patient in the context of wider systemic failings. (This is a fine balance which seems very pertinent given the current fate faced by Dr Bawa-Garba and its

implications for openness and reflection when things go wrong). Tim Dartington, in his chapter, expands on the dynamics and defences against anxiety that exist in organisations providing care. He defines and explores anxiety, and the societal context for social defences 'becoming institutionalised and acculturated' when systems are faced with the fear of 'real contact with a deprived and helpless population'. He makes the case for 'intelligent kindness' and reflection, rather than regulation 'without insight', to manage the failings and cruelty that can occur when faced with working in an under resourced system.

The last two chapters take the book back to where it started in primary care. Firstly, a dialogue between Clare Gerada and Marilyn Miller where Clare Gerada talks about her long experience of general practice and working with doctors in need, during a time of massive re-organisation of the NHS with 2012 Health and Social Care Act and the pressure faced at different levels within the health care system. Marilyn Miller expands on a 'spatial (ABC) model' of these levels; clinical practice; the locality; and national level. She comments on the dialogue between her and Clare Gerada, returning to the theme of containment in a fragmented 'postmodern' system where more is expected for less driven by perverse incentives where competition between providers is favoured over collaboration.

It's difficult to condense all the contributions of the book into 'a review' as each chapter has much to commend in its own right. I would recommend this excellent book to colleagues; it is rich in its contributions at a patient, team and institutional level, as it aims to be. It illustrates that applied Psychoanalytic work and thought is integral to providing caring, thoughtful and effective contemporary mental health services.

William Burbidge-James

London January 2018

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EVENTS, NOTICES AND DATES FOR YOUR DIARY

Specialty Doctors' Committee Vacancies

Vivine Muckian

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Are you keen to contribute to the psychiatric community, gain invaluable networking opportunities by working on behalf of the Royal College of Psychiatrists AND boost your CV? Would you like to [get involved](#)?

There is a current vacancy for a Specialty Doctor/SAS Doctor to represent the Medical Psychotherapy Faculty.

If you have any queries, please do not hesitate to [contact us](#). If you are interested in applying, please [read](#) the job descriptions and forward a copy of your CV to the Specialty Doctors' Committee Manager, [Vivine Muckian](#).

We look forward to hearing from you.

Vivine
Specialty Doctors' Committee Manager

Potential training links with Perinatal and Eating Disorders Faculties

Here is the link again to the training opportunities survey which the Perinatal and Eating Disorders working group would be very grateful if consultant medical psychotherapists could complete. [Link to survey](#)

Faculty of Medical Psychotherapy Annual Conference 2018

Dates: Wednesday 25 - Friday 27 April 2018 (Faculty conference), Saturday 28 April 2018 (Neuroscience day)

Venue: Radisson Blu Cardiff, Bute Terrace, Cardiff CF10 2FL

[Information and registration](#)

Date for Diary

CPD Day: Psychodynamic Psychiatry – working with disturbance, suicide and the effects of abuse within mental health teams.

Date: 8 November 2018

Venue: Royal College of Psychiatrists, 21 Prescott Street, London E1 8BB

YOUR CONTRIBUTIONS TO THIS NEWSLETTER ARE WELCOME

We are always keen to receive articles, book reviews and photos and invite you to send these by **30 June** for the next edition.

A note of Jizo...



Photos by Alison Jenaway, Faculty executive committee member

These photos are from a recent trip to Japan, travelling around the “Inland Sea” in the south of Japan, visiting art galleries, stunning gardens and temples, both Shinto (the original religion of Japan) and Buddhist. In the Buddhist temples, we were struck by the statues often having knitted hats, scarves or babies’ bibs on. This is a surreal image when there are rows and rows of them, all dressed up for winter. The statues are often versions of Jizo, who is a Bodhisattva and guardian of children, travellers and other voyagers. A Bodhisattva is a being who could have become a Buddha, but chose instead to stay on Earth to help others. Jizo is believed to protect children before birth, throughout their childhood and after death, helping them travel between life and death. He can appear in many forms, often holding a baby, or in the form of a young child. People leave candy, toys or fruit at his feet, as offerings, hoping for fertility and easy childbirth. In the 1970’s he became a focus for a ceremony for parents who had suffered from a miscarriage, stillbirth or a termination of pregnancy and some shrines have thousands of tiny statues of Jizo. These are a very moving sight and must make for a less lonely experience, as you place your tiny statue with all the others. People who have lost children often make garments for Jizo as a way of accruing merit for the afterlife and for the safe travel of their child after death.”

CONTACTS

Contact the Faculty and any of the contributors c/o Stella Galea, Faculty & Committee Manager stella.galea@rcpsych.ac.uk