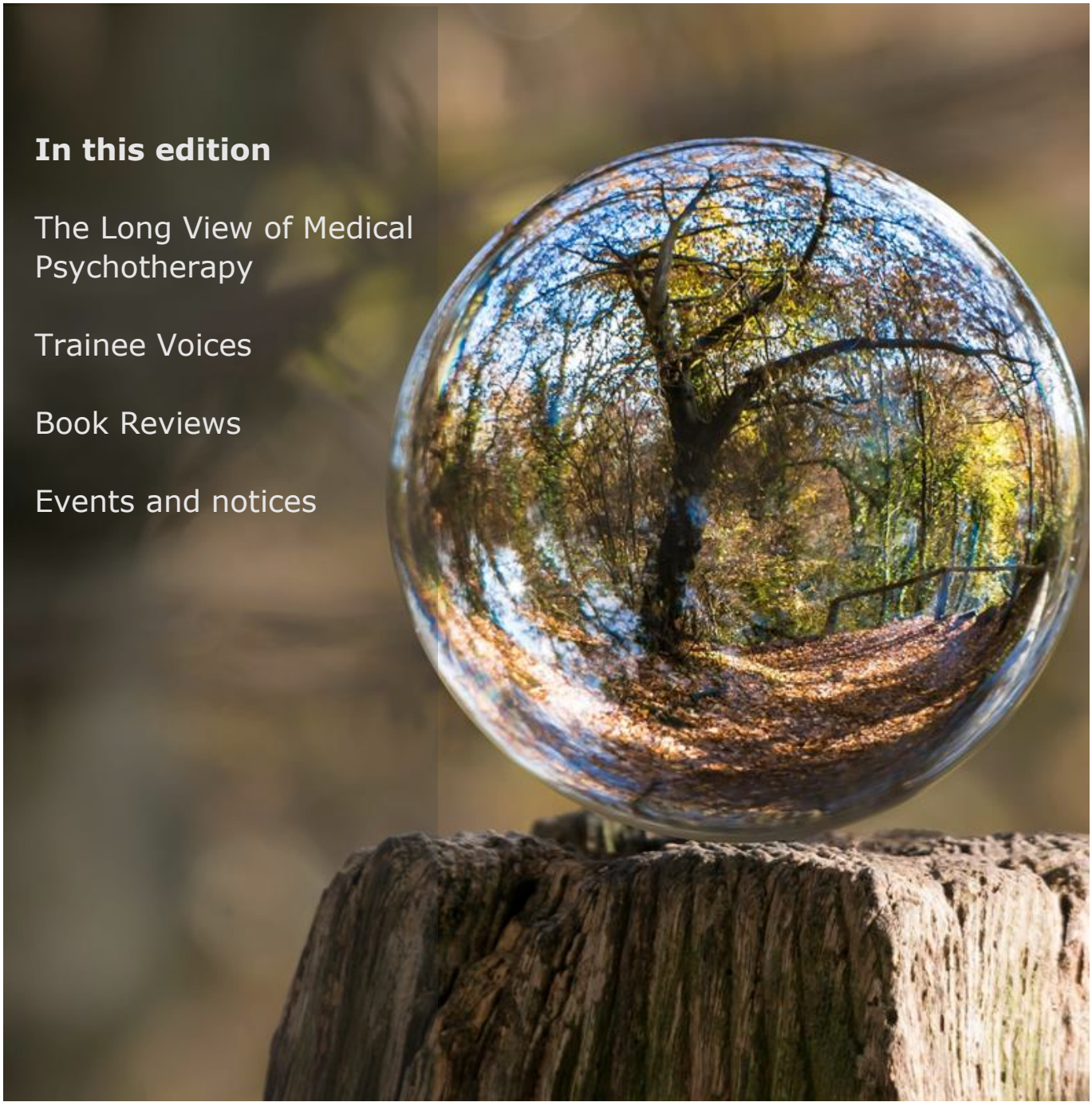
NEWSLETTER

FACULTY OF MEDICAL PSYCHOTHERAPY

Autumn/Winter 2021



In this edition

Contents

Editor's Welcome

Pamela Peters
Cambridge and Peterborough Foundation Trust

Warm greetings to all as the weather turns colder, leaves fall and we head into winter – with the prospect of further strains on the NHS, new Covid variants and measures to limit their spread; but also the season of goodwill and the festivities of Christmas to look forward to.

There are so many things we used to take for granted – good supplies of medicines and PPE, foreign travel, getting together freely with friends and family, good health, hugs and kisses… as Covid becomes endemic I no longer take anything for granted but hold on to whatever bits of goodness there are to be had whilst we negotiate the sometimes difficult lines between anxiety, rebellion, social responsibility and civil liberties.

I have been reflecting on the broad themes of the year, including, following our Annual conference and recently COP 26, climate change. It puts a different spin on the "season for giving" if giving lots of material goods is harming the planet. My most precious commodity at the moment is time. I have therefore started to think about giving time and acts of kindness to people close to me and to those in need over the festive season, in the hope that creating good memories is as meaningful as thoughtfully chosen gifts.

At work I have been conscious of a growing sense of irritability of the system, both in staff and patients. There is a greater acuity of mental ill health and aggression in my patients, especially those in the younger age group, who are doing more harm to themselves and others. There seems less goodwill and more fatigue in staff who are struggling to cope with repeated change and physical separation from each other, despite (or perhaps because of) the plethora of online meetings. Primitive defences are being enacted by staff teams and feel harder to contain. In this edition there are personal accounts and thoughts about online working and teamwork from trainees that make interesting reading.

It is a time of year when we look back as well as forward, and this edition of the newsletter takes us on a historical journey tracing the roots of our Faculty with Frank Margison, as well as looking at the centrality and importance of groups at our conferences with John Hook and Jale Cilasun. There is more recent news from the Faculty Exec, including, very sadly, the illness of our Chair, Steve Pearce. Our thoughts and good wishes are with him and his family at this time. Many thanks to Jessica Yakeley, our Vice chair, for her message to the Faculty.

As ever, the trainee voice is strong in our newsletter and our Faculty. It makes me feel very hopeful for the future of the Faculty that our trainees are so active and engaged. Thank you all for your contributions! And a happy festive season to all!

Message from the Vice Chair

Jessica Yakeley
Tavistock and Portman NHS Foundation Trust

I write the introduction to this issue of the Medical Psychotherapy Faculty Newsletter with feelings of great sadness in the role of acting Chair of the Faculty in place of Steve Pearce, who has had to step down as Chair due to ill health. Steve has worked tirelessly for the Faculty in the past few years, as Vice Chair and then Chair since 2018. His leadership has been incisive, inclusive and inspiring, and he leaves us with his vision of psychiatry for the future - ensuring parity of esteem for the 'psychological' within the bio-psycho-social model. This vision has been formalised into an overarching strategy for our Faculty, which we are taking forward with the College following a presentation by Simon Heyland, on Steve's behalf, to the College's Policy and Public Affairs Committee in June 2021 where it received unanimous support.

The background to this strategy is that in recent years the Royal College of Psychiatrists has rightly been engaged in activities seeking to ensure parity of esteem for mental health within the NHS to bring resources and services more in line with those available for physical health conditions. Central to this has been the promotion of psychiatry as a profession which takes a biopsychosocial approach in which all aspects of the patient's presentation and history are considered in understanding and treating mental disorder. However, some of us have felt that there has been a drift away from considering the psychological aspects of the patient's difficulties. Steve drew attention to at least 4 key areas in which arguably many psychiatrists lack the confidence and/or skills: constructing psychologically-informed formulations, being able to prescribe/recommend psychological treatments, being able to conduct psychological treatments, and engaging in psychological research. If we do not take the view that psychiatry is a psychological profession this potentially has profoundly negative consequences for clinical care, psychiatric training and retention, and the perception of our identity as psychiatrists by our colleagues, patients and the general public. We recognise that there are no simple solutions, and in the first instance we are recommending that the College surveys all their members for their views on this issue and what they would like to change. However, if this is not addressed, the risks are that neglecting the 'psychological' arms critics who view psychiatrists as pill-pushers and locker-uppers; and that if psychiatry doesn't fill the 'psychological' space others will, leaving patients with serious and complex mental illnesses without access to the high-level integrated care that they need.

Relevant to this strategy is the work that has been done within the field of personality disorder, following the launch of the Royal College of Psychiatrists' Position Statement on Personality Disorder in January 2020. The statement set out the College's views on how high-quality personality disorder services and care should be developed and implemented. Its recommendations included enhanced training of all psychiatrists in all aspects of

personality disorder; the appointment of a Personality Disorder Lead in every NHS Trust; ensuring that patients with personality disorder are not denied access to services; and developing services for children and young people that offer a range of specialist outpatient and inpatient interventions for those with emerging and diagnosable personality disorders.

Those involved in writing this statement recently convened for a meeting led by Oliver Dale and myself to assess its impact and think about next steps. It was agreed that the position statement remained current, and recommendations continued to be supported, but that it was premature to understand the statement's impact. Whilst there are anecdotal reports that the statement has been helpful in drafting up local care pathways and supporting the argument for service developments, there remain concerns about NHS England's commitment to ensuring that these recommendations are delivered, especially for those requiring specialist inpatient treatment. There also continues to be controversy and debate around the diagnosis of personality disorder, particularly in relation to stigma and the potential to cause harm; however, the statement's view that the diagnosis has brought benefits of better describing the impact of such difficulties on people's health and social outcomes, as well as the need to remain engaged in empirical research in the field internationally, leads us to recommend that the diagnosis of personality disorder should be retained. In the next few months, we will be working with Council to progress the statements' recommendations further.

Since the last newsletter, there have been other areas in which the Faculty has made significant contributions:

- William Burbridge-James, as Chair of the SAC, and his committee, have worked hard over the past year in contributing to the revised GMC curricula, both the core psychiatry curriculum and that for higher trainees in medical psychotherapy. I have also been involved in increasing the visibility of the importance of training in personality disorder within all of the curricula.
- We have made formal links with other faculties including General Adult Psychiatry, Child and Adolescent Psychiatry, Academic Psychiatry, Forensic Psychiatry and Eating Disorders faculties. The benefits of these links include having reciprocal members on both faculty executive committees and planning joint conferences.
- The appointment of champion roles for our faculty: the sustainability champions are Dasal Abayaratne and Nora Gribbin, and the equality champion is Michael Milmore.
- The publication of 'Seminars In the Psychotherapies' textbook, part of the RCPsych Seminar Series, co-edited by Rachel Gibbons and Jo O'Reilly.
- Two very well attended one-day conferences:
    - 'The Effect of Patient Suicide on Clinicians' on 22nd October, organised by Rachel Gibbons, as co- chair of the working group on the suicide group at the college
    - The Medical Psychotherapy Faculty's Annual Psychodynamic Psychiatry Day: 'The Mind, The Body and the External world: Understanding responses to fear and threat in everyday psychiatry' organised by Jo O'Reilly, on 12th November.
- The work of Sophie Atwood and Simon Heyland in mapping out all current consultant and trainee medical psychotherapy posts across the UK, the details of which will soon be found on the Medical Psychotherapy webpages on the College website. 160 consultants have

been listed so far which is well over the number of medical psychotherapist consultant posts that we were aware of.

Finally, I want to thank Maria Eyres for all her hard work as Academic Secretary for the Faculty over the past few years, during which she has organised, with her committee, very successful and well-attended conferences, including this year's one, which was held remotely.

Message from the Academic Secretary 2018-2021

Maria Eyres
Medical psychotherapist in private practice

I am writing this on the last weekend in October on the eve of COP 26 conference which reminds me of our April Faculty conference with its three themes: climate change; issues relating to race and social injustice; and the pandemic. It is very clear that all three remain current and relevant today and I hope that those subjects are alive in all our minds too and will continue to inform the work of the Exec.

Those are both challenging and exciting times, with the Exec taking up the parity of esteem of biological and psychosocial strands of psychiatry in the College and attempting to negotiate a more equitable and productive coexistence in a shared thinking space. We can use our expertise in holding multiple perspectives in the wider system by applying it to social groups. This is much needed in our times of post-pandemic isolation, to help avoid further fragmentation and to moderate social injustice. Revisiting some of our discussion from the 2021 and 2019 conference on *Creative and Destructive Forces in Groups; Clinical Settings, Organisations and Society* may also come in useful in these tasks.

I would like to remind you that the group for consultants and higher trainees in Medical Psychotherapy will continue for another year, at which time it will be reviewed. Also, as reported in the previous Newsletter, we launched the Medical Student Psychotherapy Essay Prize in April with the deadline for submitting the essay recently extended to the 22nd of November. More information on these can be found in the Events section of this newsletter.

I would also like to report that the work on the College Position Statement on Historical Childhood Abuse co-chaired by Jo Stubley and myself is moving forward again after the summer break. We are hoping that the position will be announced at the beginning of 2022 so please watch out for it.

On a personal note, some of you will be aware that I have decided to step down from my role as the Academic Secretary in June. Parveen and Vikram have also now left the Conference Committee. I am very grateful for their contributions and wish them well. I really enjoyed my 7 years at the Exec, having started with editing the Newsletter with Harriet

Fletcher, moving to the position of Academic secretary and contributing to various working groups in addition to attending meetings. While I have learned a lot, I found working with colleagues the most enjoyable aspect of my time on the Exec. However, the work took a lot of space in my mind and after all those years it started to feel like it's important to make space for others. In addition to the HCSA group, I will remain involved in the working group on psychedelics chaired by Jo O'Reilly for the time being. I might decide to return to College work at some point in the future once I feel more invigorated and once my private life is more settled. It is so important that we look after ourselves too…

In the meantime, I wish my successor all the best and look forward to participating in the next Faculty conference as a delegate.

Message from the Chair of the Specialty Advisory Committee:

Maintaining the fundamentals of the setting for psychotherapy and a sustainable platform to enable trainees to meet their psychotherapy training requirements

William Burbridge-James
Essex Partnership University NHS Foundation Trust

I write as we turn into winter and autumnal yellows still pepper the trees and Covid 19 anxieties remain after a period of relaxation of the restrictions that were reinstated through the earlier part of the year. On the face of it much of day-to-day life has returned to pre-pandemic times with some limitations - cafés and restaurants are lively, theatres and cinemas are open, and sporting events are played out to vociferous crowds.

However, the NHS is struggling to keep up with a return to more face-to-face in-person contact. There is a complex interplay of factors related to this, including an awareness of the transmissibility of Covid and its impact, and the significant losses that have touched everyone, with consequent anxieties about a return to the situation that the NHS and acute care services were facing when we entered the 3rd lockdown. This slow transition back to routine work is also an aspect of large organisations where change is slow, except when motivated to adapt to an acute situation which has been essential in this crisis, when large group processes can predominate, reinforced by safety controls that have been put in place to protect us and our patients, but that can also become inhibitory.

This re-adaptation to an out-of-crisis mode, while understandably cautious, can also feed into an ambivalence to engage in the difficult day-to-day work of psychiatry and psychotherapy. Our work is caught up in therapeutic relationships and this is the essence of medical practice and all its specialties. Reports from colleagues regionally and nationally indicate how difficult it is to re-establish secure settings so that trainees can have the most basic external structures in place to allow them to undertake their psychotherapy work, for

example to have access to the same room, at the same time each week, alongside protected time and access to supervision. Trainees need to know this external setting is in place to help them feel settled and it is so important for our patients that have had unstable environments in their lives and early development, to give their psychotherapy the best chance of progressing and mitigating drop out.

This lack of institutional capacity to provide the material resources for containing clinical environments can be used as an added pressure to continue with virtual or phone contacts with patients. This is not a setting that enables trainees to have the total experience when starting in a psychotherapy.

I apologise if I am repeating myself from my previous newsletter contributions, but it is an on-going theme. COVID is impacting on the quality of training experience that trainees are having, even if it is not impacting on ARCP progression. So much of being with patients is their physical presence in the room and the observation of their presence in its manifest bodily representation, and then its impact on us as clinicians, and the evolving dynamic.
Resistance to enabling secure settings for clinical work needs to be addressed at an institutional level with management and the potential to facilitate a return to in-person encounters fostered, rather than the authoritarian approach that the government is taking with GP colleagues.

Resistance to this return is related to the ambivalence to being 'face to face' with disturbance. We know from Freud that ambivalence in the relationship to the lost object affects the mourning process. It is my impression that this unacknowledged ambivalence is contributing to the systemic institutional resistance to maintaining what is being lost from out-patient settings for clinical work, and hence trainee placements, including the setting for trainees seeing their psychotherapy patients.

The curriculum for psychiatric and psychotherapy training is also an aspect of the setting for trainees and trainers, which provides guidance and an external frame for training. The new core and higher curriculums alongside the proposed new structure for the curricula was approved by the GMC in October subject to some minor revisions. The change earlier in the year linked to GMC feedback reflected a move away from the training guides that the curriculum revision group had proposed alongside the curricula, to illustrate activities that trainees could undertake to achieve capabilities linked to higher learning outcomes, to 'Placement Specific Personal development plans' linked to psychotherapy training posts in core and higher training. The SAC is currently engaged in drafting these with the plan for a resubmission to the GMC in January and then a move to implementing the curricula from August next year and a gradual transition of trainees to the new curricula.

For the latest on the new curriculum and plans for implementation please follow the link:
https://www.rcpsych.ac.uk/training/curricula-and-guidance/curricula-review-project
The concern raised in the faculty exec is that that there is a lack of reference in the new curricula to personality disorder which, as indicated by Dr Jessica Yakeley, is a vital area of the work of all psychiatrists and the intention is that this can be captured within the new structures. This is an on-going aspect of the work of the SAC.

Historical Perspectives

The long view – have early hopes for the Faculty been fulfilled?

Frank Margison
Consultant Psychiatrist in General Adult Psychiatry and Medical Psychotherapy

This paper is based on a presentation given to the Medical Psychotherapy Faculty Strategy Day on 27th January 2021.

There is a remarkable similarity between the core issues faced by the Faculty today and the themes covered 20 years ago as I came to the end of my main involvement with the Faculty, and with 40 years ago when I first became involved with the College. In fact, many of the same themes can be traced back well over a century to the birth of modern psychiatry. This paper gives an account of those developing themes.

Historical context

The initial rules for the newly founded *Association of Medical Officers of Asylums and Hospitals* for the Insane, the early predecessor of the College, were drawn up in 1841.

> "At this first meeting members passed fifteen resolutions. One was that the terms 'lunatic' and 'lunatic asylum' be abandoned except for legal purposes and that the terms 'insane person' and 'hospital for the insane' be substituted, the first step towards 'parity of esteem' for mental and physical disorders.". (RCPsych, 2021)

The group became the *Medico Psychological Association* and petitioned to be allowed a Royal prefix in 1890. Having failed to receive royal recognition it was registered as an Incorporated Association in 1895. In 1926, following a petition to become a Royal Association, it eventually became the Royal Medico-Psychological Association [RMPA], reflecting the early links between psychology and medicine. It was not until 1971 after "complex negotiations" that the Association became a Royal College (RCPsych, op cit.)

The predecessor of the *Psychotherapy Faculty* of the College began relatively early in this process as the *Psychotherapy and Psychopathology Sub-Committee* of the RMPA. It was a sub-committee of the newly formed *Research and Clinical Committee* which began in 1927.

The formation of a specific *Psychotherapy Section* was discussed at the November 1948 Council Meeting, but the next step was when the Social Psychiatry Section was renamed the *Psychotherapy and Social Psychiatry Section* at the February 1949 Council Meeting.
This hybrid state continued until a separate Psychotherapy Section was formed within the newly formed Royal College of Psychiatrists. The Section was later known as a Faculty, and subsequently changed to its current name of *Faculty of Medical Psychotherapy*.

40 years ago

Through the 1980s and 1990s the Faculty (or Section as it was then called) had a view of psychotherapy developing as a specialty through regional planning, regional training schemes, and services integrated both by profession and by modality. Most large centres either had psychotherapy services or were developing them. There was a notable bias towards London and the Southeast in terms of number of consultants and number of centres, but a key vision was for all major population hubs to have centres of psychotherapy expertise, which in turn would develop and support local services within local towns in the various Regions and Boards.

The key tension at that time was how to maintain growth of specialist psychotherapy services while maintaining a psychotherapy culture within psychiatry generally. This tension has not eased over the last forty years.

There were also debates about whether we as a Section should be left to develop psychoanalytically-based therapies and leave CBT to the clinical psychologists. This view was not generally supported - certainly not by the few CBT therapists by then on the Committee, or by the majority who supported multi-modal departments. There were good arguments on both sides about maintaining a critical mass to maintain a culture of psychotherapeutic thinking, whilst trying simultaneously to reach out into other specialties within psychiatry in a variety of settings. However, a tendency to identify medical psychotherapy primarily with the psychodynamic therapies has remained an issue with surprising tenacity.

There were other key changes outside the Faculty in the development of new *integrative models*, for example, Cognitive Analytic Therapy [CAT], Dialectical Behaviour Therapy [DBT], Psychodynamic Interpersonal Therapy [PIT] representing the growth of psychotherapy research, and an ever-growing "Alphabet Soup" with different psychotherapeutic ingredients mixed with a stock based on "common therapeutic factors" (Frank & Frank, 1991). Surprisingly, despite internecine tensions, there were significant gains in acceptance of psychotherapy by the College as a whole, and the influence of medical psychotherapy grew in relation to the MRCPsych curriculum.

20 years ago

By two decades ago, in Autumn 2002, Jeremy Holmes as Chair of the Faculty wrote in our newsletter a "handover" to Jane Knowles as incoming Chair, stressing the gains that had been made within the College and in national policy:

- Establishing psychotherapy as a mandatory part of Membership
- Developing services for people with personality disorder
- Developing regional centres and departments in most large mental health trusts

There were still outstanding problems around the slow growth in the number of psychotherapy specialists despite the growth of services more generally. There was a constant vulnerability to arbitrary closure of services and the Faculty officers spent a lot of time lobbying to maintain services under threat. There was also the potential loss of posts when medical consultants retired, as other professions developed a key role in running and managing psychotherapy services, often subtly renamed 'psychological therapy services', rather than 'psychotherapy services'.

The policy front

During the period under discussion, there were two major policy documents from the Department of Health that shaped psychotherapy provision in the NHS and it is worth going back to the themes in those papers as they still influence policy today. The first of the two documents was *NHS Psychotherapy Services in England: Review of Strategic Policy* (DoH, 1996)

The over-riding theme of this policy review was to set out basic principles. Some now seem uncontentious: So, services should be

- Comprehensive
- Co-ordinated and user-friendly
- Safe
- Clinically effective and evidence-based
- Cost-effective

This reflected the growing themes of the time of Evidence-based Practice and the complementary Practice-based Evidence, but these principles were not uncontested, with frequent arguments about the limits of the evidence base available and its potential to be reductive in only measuring relatively crude parameters.

Psychotherapy had grown in an *ad hoc* way so the policy document reconceptualised psychotherapy in the NHS as being in three strands:

- Type A: Integral component of mental health care (e.g., skills for CPNs in community mental health teams, and psychological treatment for psychosis)
- Type B: Eclectic psychological therapy and counselling (e.g., Counsellors in Primary Care, not necessarily linked to any particular specialty within psychotherapy)
- Type C: Complete treatment interventions following a therapeutic plan using a particular model (e.g., development of personality disorder services)

This latter led to joint teams with psychologists and psychiatrists increasingly able to provide a range of evidence-based therapies on a larger scale than had been seen previously. However, this was at the expense of some areas having almost no specialist services and others able to offer several different approaches from a single base. So, the policy paper recognised some long-standing structural problems. Psychotherapy provision was extremely patchy (for example, major differences between the North and South of England and very uneven provision of psychoanalytic therapies; well-established departments in big cities with little in surrounding towns; huge differences between the four countries of the UK in terms of provision; and almost no specialist psychotherapy provision for patients with severe mental illness.

Commissioning of psychotherapy services was also extremely variable and still based on local whim, and whilst Evidence-based practice was increasingly seen as valuable, there was very slow growth of routine measurement in psychotherapy.

Although the 1996 policy paper was influential, such initiatives need refreshing every few years leading a few years later to the second major policy paper *Organising and Delivering Psychological Therapies,* (DoH, 2004).
This policy paper recognised that psychological therapies were an essential part of health care with overwhelming evidence of efficacy for a wide range of disorders. There was also pressure from mental health service users to bring in talking treatments rather than just medication, and there was a growing trend of patients being assessed and then offered a range of treatments with significant patient choice, at least in the large centres. However, it was recognised that services were still very patchy and uncoordinated, and the paper was intended to push commissioners of services into providing at least basic services in every area. The main development to come from those discussions in the Faculty and elsewhere was the need for recognised "pathways" to care especially when resources were scarce. Looking back, a key element of service redesign was to see psychotherapy within a "stepped care" model.

The growth of IAPT
At about the same time as this policy paper Professors Layard and Clark began pushing for a radical overhaul in the form of *Improving Access to Psychological Services* [NHS England, 2021) to address the structural gaps on a scale never previously thought realistic. They argued for a massive expansion of simple, evidence-based treatments, based almost entirely on CBT for the part of the population suffering the effects of anxiety and depression, as these common conditions had not had any significant impact from the planned growth of psychotherapy services. This was a dilemma for the Faculty as the expansion was, of course, welcomed, but not the narrow focus of acceptable therapies, or the potential marginalisation of specialist psychotherapy services.

As things have developed, of course, it has been a mixed picture: IAPT has developed beyond just the initial focus on short term CBT for anxiety and depression, and some psychotherapy services are now better integrated with IAPT services within the same organisations, but that pattern is far from universal. Whatever views we hold about IAPT it now exists on an industrial scale: the latest figures available (for July 2021) show 142,485 individuals referred to talking therapies; 92% started therapy within 6 weeks of referral, the average number of sessions was just under 8; nearly 60% of clients completed their course; and just over half reported statistically defined "recovery", despite a significant increase in "internet-enabled therapies" during Covid (NHS Digital, 2021).

Of course, there have been objective, and sometimes critical, analyses of the impact of IAPT (for example, Lewis, 2012; Rizq, 2012; Parry et al, 2011), but the sheer size of the programme has to be acknowledged in thinking about the future of psychotherapy in the UK.

Some questions have not changed over 40 years

Some of the core questions that preoccupied discussion over the years are still as relevant today.
Is the Faculty about psychotherapy as a specialty within psychiatry or about psychotherapy as an activity across the whole College? To be relevant into the future we may need to continue to advocate for psychotherapy broadly as well as being a group of specialists.

A well-balanced psychotherapy provision for the future will probably require well-designed medical psychotherapist jobs with sessions across: clinical service; teaching the next generation of psychiatrists and others; organisational consultation; working with other psychiatric and medical specialties; and providing staff support.

Without these widespread roles we have less influence, but equally if we are spread too thinly, we risk becoming marginal. The degree of integration of medical psychotherapists with other psychiatric colleagues has often been expressed practically through job descriptions and job plans: are we still psychiatrists in the sense that we are on on-call rotas, maintain section 12 approval under the Mental Health Act and have expertise in diagnosis and medication? These issues were strongly contested in the past and are still markers for the degree of integration with other specialties within psychiatry.

As individuals, the ongoing relationships with managers and heads of service from other professions is crucial to our varied roles as psychiatrists doing psychotherapy, but it remains unclear how effectively we relate to other professions through the Faculty - for example, most dialogue is at College level with the equivalent bodies such as BPS, UKCP, BACP) and the Faculty does not engage directly with equivalent groups of practitioners from other professions.

Perhaps the one exception is the Talking Therapies Task Force where the Faculty of Medical Psychotherapy has made common cause with an interesting coalition of organisations. The group includes

- The Association for Psychoanalytic Psychotherapy in the NHS
- The British Association for Counselling and Psychotherapy
- The British Psychoanalytic Council
- The Psychotherapy Faculty at the Royal College of Psychiatrists
- The Society for Psychotherapy Research
- The UK Council for Psychotherapy

This group argues for a focus on more severe problems than IAPT has traditionally treated, for example, in personality disorder, historic childhood sexual abuse and long-term trauma-related problems, medically unexplained symptoms, and psychosis:

> "Why? We recognise, following development of IAPT, there has been investment in NHS counselling and psychotherapy. Having a health economic case, a national data collection system, a workforce development plan and an associated training programme have been essential in delivering a national programme.
> To date, the success of IAPT has been predominantly with those with mild to moderate mental health problems. We are now making the case for national investment in services for those with the most complex physical and mental health difficulties". (Talking Therapies Task Force, accessed 2021)

Reflection: *Plus ça change?*

As above, there has been a trend in psychotherapy to widen its scope to more complex needs - decades ago this was a hot issue about treatment of severe personality disorder and severe and enduring mental illness. The current debates are the same, but about different problems. Current preoccupation in service provision has been on complex PTSD and attachment disorders, autistic spectrum conditions, bipolar spectrum disorders, medically unexplained symptoms, chronic fatigue syndrome, and gender disorders among other emerging clinical presentations.

At the same time, the role of the medical psychotherapist has been broadening over the last decades, for example through increased links with liaison psychiatry dealing with "medically unexplained" complex presentations. So, one of the key questions posed earlier for the Faculty of Medical Psychotherapy is whether medical psychotherapy should become more focused on delivery of psychotherapy interventions in its own right to a wide range of conditions or should we focus on working directly alongside other specialties including liaison psychiatry, psychiatry of intellectual disability; working with mentally ill offenders, adolescents and young adults, eating disorders; providing psychotherapy to an older population; working with perinatal mental health, and providing effective therapies for dependence problems.

Framed that way we can see that medical psychotherapy potentially has a very wide role, and some medical psychotherapists have played key roles in these areas. But, at an organisational level we repeatedly revisit the discussions that arose when psychotherapy first became a Section and later a Faculty. The dilemma facing the Faculty of Medical Psychotherapy has remained unchanged: we have too few consultants to fulfil all the potential roles whilst simultaneously not being specific enough in our roles to be prioritised in service commissioning.

Despite four decades of work, medical psychotherapy is still a specialty that seeks to justify its existence and these reflections show that this position has existed throughout. So our position can be seen as both marginal and precarious, and simultaneously as holding some of the guiding principles within psychiatry. To close, I have presented these two aspects with the cliché of the glass half-full or half-empty.

Conclusion:

If we look at the progress made by the Psychotherapy Faculty with a "glass half-empty" mindset we see a blighted landscape with:

- lack of clarity of what psychotherapy is for
- continuing problems with the evidence base
- inter-professional tensions
- and a continuing structural bias towards white, middle-class, female clients with only marginal change in representation and diversity

but with the glass half-full we can see the same evidence from a totally different perspective where:

- the landscape has totally changed!
- there has been massive growth of provision overall with assistance from IAPT
- broader training and skills-based approaches are routine for psychiatrists training now
- we have better integration with other psychiatric specialties
- we are underpinned by a growing interface with neuroscience
- an increasingly diverse medical psychotherapy workforce working with an increasingly diverse population
- and finally, emerging into a post-Covid19 world there is a huge potential for us to develop services for traumatised individuals and families

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Medical Psychotherapy: the changing identity of a profession

Dr John Hook
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Dr Jale Cilasun
Consultant Medical Psychotherapist and Group Therapist in Private Practice, London/ Bologna

Abstract
Aims and Method: To review the history of changes in the Medical Psychotherapy Faculty and practise of psychotherapy in the NHS over 25 years using themes from a large group experience at the Faculty conference in 2019 as a reference point.
Results: There have been many significant changes over a relatively brief period which have created challenges to the Faculty, the role and status of Medical Psychotherapists and service delivery of psychological therapies. We believe the impact of these changes need to be better understood in order for the Faculty to develop a clear strategy for its work and engagement with its members.
Clinical Implications: To improve the well-being of Medical Psychotherapists and others working to deliver psychological therapies and improve delivery through clear priorities in service provision.

Aim
In this paper we describe significant changes that have occurred in the practice of psychotherapy and within the Faculty of Psychotherapy over a period of 25 years. We wish to open a debate about how these changes have impacted the profession of Medical Psychotherapy and in light of these changes what a strategy for development might include. We use a conference large group as a diagnostic tool which enables a particular view of the dynamic context, conscious and unconscious, social, professional and personal within which the profession of Medical Psychotherapy is currently situated.

Introduction
At the outset we acknowledge there will be differing accounts of what has transpired during this period and how events can be interpreted. Nonetheless given that we are all embedded in the same professional matrix we present this paper as one vertex from which events can be described and evaluated. Psychiatry is predicated upon the impact biopsychosocial history has on development. Organisations, no less than individual persons, need to know and acknowledge their history in order to be effective.

In 2019 large groups were re-introduced into the annual Faculty of Psychotherapy conference after an absence of nearly thirty years. Small groups had been re-introduced earlier in 2016 and 2018. In those conferences a dominant theme arising in the groups was the professional identity of the Medical Psychotherapist. Several key facets of a changing professional identity re-emerged strongly in the large groups in 2019. These included tensions between roles of psychotherapist, doctor, psychiatrist, within the identity of medical psychotherapist and relationships to gendered power and authority. This experience inspired us to consider the many significant changes there have been in Medical Psychotherapy in the intervening years.

The large group is a powerful tool to bring out and explore conscious and unconscious dynamics of the social context which influence a professional organisation. We suggest that awareness of these forces will enhance communication between leadership and membership of the Faculty, reduce confounding dynamics and can assist in developing strategy.

Large groups

The work of army psychiatrists at Northfield Hospital during the second world war led to key developments in the UK in the development of group theory and practice leading to the Therapeutic Community approaches of the Cassel Hospital, the Henderson Hospital, the Tavistock Clinic and Group Analysis. Large groups, defined as those with 30 people or more, began to be used in therapeutic communities, in organisational consultancy to business and education and in group conferences and training settings. Differing methodologies exist including psychoanalytic, group relations and group-analysis. The large groups in this conference utilised mainly group-analytic methodology which integrates psychoanalysis, systems theory and sociology. (Foulkes, Kreeger; de Mare; Wilke). Large groups in conference settings allow the whole community to work together and create a sense of fellowship.

Professional Identity

The process of developing a professional identity is complex. Training is a socially sanctioned process, leading to identifying with embedded ethical and belief systems within a professional context. It is a group process of allegiances and affiliations which are incorporated into each individual's personal matrix of family, gendered and ethnic identifications, all constantly monitored by society. Elements necessarily become stable over time but perhaps more than we may acknowledge, identity is always in flux. This is perhaps no more true than of our current age when previous binary definitions are being overthrown in favour of multiple categories. These processes surface in large groups and is one of the very unsettling aspects of a large group experience when we experience identity as fluid.

A historical account of the Faculty of Psychotherapy conferences

Large Groups were part of the Faculty Conference programme in residential conferences held biennially in the late 1980's at Queens' College, Cambridge. In those first three conferences the programme consisted of lectures, small groups and large groups. The groups were conducted by Group Analysts. The large groups were held in the beautiful 15th century Old Hall, which provided a unique and awe-inspiring context. It was impressive to observe a maturational development in the large groups over time given there were only three groups (in each conference) every two years over a six-year period.

Later groups played no part as the conference programmes became increasingly academically focused. There were complicated political and other dynamic influences within a changing Faculty which influenced these changes. When groups were re-introduced in 2016 there was a significant change in theoretical approach in conducting the groups from a traditional open, experiential model to one with the aim of exploring the conference theme including emotionally . In 2019 it was decided to convene large groups only as room availability did not allow for small groups. We continued with the aim of the group to explore the conference theme: - "Creative and destructive forces in groups". We invited two convenors, male and female to provide gender balance.

The Faculty of Psychotherapy is a heterogenous group brought together by an interest in psychological therapies. It is the largest faculty in the College. A typical conference will include consultants in psychotherapy, other branches of psychiatry, trainees, medical students, other professions and Experts by Experience. The Faculty Executive on the other hand consists of Consultant Medical Psychotherapists, Experts by Experience, a trainee representative and representatives of other faculties.

Changes in Medical Psychotherapy Profession since the 1980's

Our aim in this description is to present some of the key changes that have occurred as far as possible without bias. The point is not so much whether the impact of these changes has been good, bad or mixed, rather that so many changes have happened in a relatively short period of time that following this large group experience the time is perhaps ripe for the Faculty, elected leadership and membership, to engage in an open debate about 'who' the Faculty is; who and what it represents and what it's aims are.

Size: In the 1980s the profession was smaller in number. There were some seventy consultant posts and less than twenty senior registrar training posts. In the late 1980's there was a large expansion in all medical trainings which led to approximately doubling the numbers of psychotherapy training posts. These were distributed by the Executive largely to centres where there were only one or no trainees.

Geography: A significant proportion of training posts were attached to London teaching hospitals and the Tavistock Clinic. Other centres included Manchester, Oxford, Cambridge, Birmingham and Newcastle, Edinburgh and Glasgow. The expansion in training posts led to trainings being more widely dispersed across the country (with the exception of Wales where there were no Consultant posts).

Training Orientation: However, these changes also had a profound impact on the orientation of training overall. Many posts were now no longer in reach of the traditional psychoanalytic or group-analytic trainings. Training became more diverse although still mainly psychodynamic in its orientation. In London where the majority of Consultant posts were part-time, held by psychoanalysts also practising privately the orientation was psychoanalytic/psychodynamic, individual and group. Elsewhere many consultant posts were full-time with some opposed to private practice. New NHS-based training courses in the Midlands and the Southern Counties were more eclectic in orientation. Whilst experience in other modalities e.g. CBT, CAT, Family Therapy was included in the training programme none of these was considered a 'main' modality. It wasn't until 1986/7 that Consultant posts held

by psychiatrists trained in CBT were recognised as part of the Faculty and CBT was included as a main modality.

This led to significant shift in the dynamics of the Faculty Executive and was a factor in how the annual conference programme changed. Some CBT consultants did not value the experiential group component. This view coincided with some psychoanalysts who were against being members of groups in which their trainees or analysands may be present. Experiential groups thus ceased to be part of the programme.

Training length: Around 2007 a significant change in training occurred with the shortening of trainings from four years to three. This particularly impacted trainees undertaking psychoanalytic and group-analytic trainings, making it more difficult to synchronise external trainings within the timeframe of an NHS training post.

Gender: Consultant posts, in contrast to the lay psychotherapy profession were mostly held by men, with notable exceptions. (N.B. It has not been possible to obtain figures from the College about gender and ethnicity of the membership of the Faculty).

In summary it would not be inaccurate to describe Medical Psychotherapy then as a London-centric, psychoanalytic and male hegemony. This is far from true now.

Relationship with lay profession: In 2018 the Faculty was instrumental in forming the Talking Therapies Taskforce with the Association for Psychoanalytic Psychotherapy in the NHS, the British Association for Counselling and Psychotherapy, the British Psychoanalytic Council, the Society for Psychotherapy Research and the UK Council for Psychotherapy to develop a national infrastructure for psychological therapies for people with complex mental health needs. This raises an important question about the role Medical Psychotherapy has to play in the wider profession as a leader for e.g. contributing to the current competencies framework for counsellors and psychotherapists in working with complex mental disorders.

Changes in title: Until 2005 the professional title (as recognised by the GMC) was Consultant Psychotherapist. There was increasing unease about how psychotherapy was viewed in the wider College. It was a major undertaking over several years for psychotherapy to be fully represented in the training of psychiatrists and curriculum of the Membership examination. There was a view that psychotherapy occupied an ivory tower and saw less complex and difficult to manage patients. The title was changed to Consultant Psychiatrist in Psychotherapy to emphasise psychotherapy as integral to psychiatry. In 2011 it was changed again to Consultant Medical Psychotherapist, this time emphasising the link to medicine. Partly this followed an increasing interest in psychosomatic disorder. Many psychotherapists appear to continue to refer to themselves as Consultant Psychiatrists in Psychotherapy, which may signal continuing unease or confusion about the role and its place in the hierarchy.

Other significant changes

Experts by Experience: Experts were included on the Faculty Executive in 2010. They have become increasingly influential.

Psychotherapy services: were then almost all led by medical consultants with notable exceptions run by psychoanalytically/psychodynamically/group trained psychologists. Other

major changes have been in the NHS structure in 1991 leading to a management-led organisation; the reorganisation of mental health services into teams; the development of combined psychological therapies services; the development of CBT as an evidence-based therapy recognised by NICE in contrast to the relative absence of evidence for the psychodynamic and other therapies; development of new therapies and the demand for shorter therapies within a financially poor environment. These have led to significant threats to the maintenance of psychotherapy services based solely around longer term individual and group therapies and to changes to the status of consultants.

There has been a long-running debate throughout this period about the role of psychoanalysis in the NHS. Changes in NHS practice of the psychotherapies towards new and shorter models mean this debate may appear to have been superceded, yet echoes remain with those who continue to argue for a return to a psychoanalytic base whilst others have trained in and practise from a broader base.

Perhaps the issue now needs to be more pragmatic about which models are relevant and valuable. What range of therapies ought to be part of a modern Psychological therapies service? What research do we need to support to answer remaining questions about the efficacy and effectiveness of the psychotherapies? A vital question with the pressure towards shorter treatments is, 'which interventions are effective for those who only partially respond or do not respond to shorter interventions?'.

The conference large group 2019

This discrete large group experience took place in the context of conferences over 25 years and as such captures aspects of the developmental history of the Faculty. There were 105 conference attendees registered each day with about 50% attending both days. Consequently, the membership of the two large groups was different but with a degree of overlap contributing to a sense of continuity across the two days. There were around 80 participants in each meeting. Formal and informal feedback at the conference and the atmosphere generated in each group suggested that the experience was appreciated.
What follows is a necessarily condensed description of the material related specifically to the theme of identity and presented to disguise as far as possible the identity of the participants.

Thursday group

A dominant theme in the small groups at the previous conferences had included aspects of identity of the Medical Psychotherapist. This re-emerged through a fascinating and rich exploration of the College crest which adorned the lectern.

Figure 1[1]

Attention was drawn to this early in the first group when a member commented on the butterflies on the crest which he had never noticed before! There followed associations to the symbols on the coat of arms, snakes, butterflies, the staff of Aesculapius. A member pointed out the words for medicine and poison in Greek are the same. Creation and destruction being interlinked was commented on with an image of the snake eating itself. The conference had heard presentations about both destructiveness of war and creativity of novel forms of trauma therapy.

A concern was raised about the lack of jobs in the specialty outside London and feelings about the privileged position of London-based professionals. This was followed by sadness about the premature loss of senior colleagues through retirement and grief for colleagues who have died. The group finished with the image of a snake laying eggs only after it has changed its skin and butterflies emerging from their cocoons, images of transformation.

Friday group

The presentation prior to this group was of a mother and baby group. A video showed a baby wanting to be held and being repeatedly pushed back by his mother to stand on his own feet. In subsequent sessions capacity of the mothers to care for their infants increased, mediated through the care of the group by the group analyst. The conference group was moved by this demonstration of what therapy can achieve in demonstrable change in the mothers' capacity to care for their children's needs. The group voiced a 'feminine' aspect to the work of psychotherapy, linked to feelings, nurture, creativity and a 'masculine' aspect concerned with service provision, employment, intellect.

Group cohesion turned to frustration and anger with reference to a conflict the day before between two senior members. Someone wondered if anxiety about expressing anger might be due to fear of action. This appeared to reduce anxiety and perhaps allowed an Indian member to express anger about the speaker the day before who had intended to show a picture of Lakshmi, goddess of wealth, but mistakenly presented one of Shiva, god of destruction.

Another theme was the legacy left by the older generation. Alongside the earlier grief were complaints that the older generation have in some ways failed the younger. This was linked to a question of whether the Faculty has been clear about its tasks over the years, perhaps too focused on having to fight for recognition within the College and for psychotherapy services under threat within the NHS. Disappointment and anger as expressions of failed

[1] The coat of arms incorporates the traditional serpent-entwined rod of Asclepius symbolic of medicine, and butterflies associated with Psyche. Previous to the grant of these arms, the Medico-Psychological Association had used a device showing the seated Psyche with butterfly's wings. The arms were originally granted to the Royal Medico-Psychological Association in 1926 and were confirmed to the College on its formation in 1971 by the College of Arms.

dependency at many levels were briefly expressed but left unexplored. The group ended with some acknowledgement of mourning losses and of appreciation for the experience.

Discussion

Questions of identity are always present at the early stage of any group, especially a large group. The image of the Coat of Arms and the 'mistake' replacing 'feminine wealth' with 'male destruction' can be thought of as functioning as 'condenser effects' holding and making visible as a condensed image the concerns of the group hitherto not acknowledged. The issue of medical identity is traced back to Aesculapius, the first celebrated doctor of Greek civilisation, the root of European culture. The butterflies representing soul or psyche hold in addition the specialisation in the mind, (the College was named originally the College of Psychological Medicine). The 'mistake' between the Indian gods holds confusion and competition between genders, creativity and destruction. Also implicit are ideas around colonialism, multicultural society and western medicine based on Greek culture excluding eastern influences.

Much has changed within psychiatry and NHS psychotherapy since the 1980s to which the profession has had to adapt. This was not explicitly discussed but the focus on identity including legacy implicitly raises the questions, 'In what ways have these changes impacted upon the profession? What has been learnt? What has been lost and what gained? Which anxieties have been and are being defended against? What are the tensions between therapeutic modalities, with other professional groups, and the demand for short-term solutions to long-term problems?'

We could think about the dynamics of the groups in terms of various kinds of collective trauma in the field of psychiatry and in the College leading to a sense of failed dependency on the leadership who are caught up in the same processes - problems of envy and jealousy associated with guilt and shame; difficulty in mourning senior colleagues; the 'loss' of the 'purity' of the psychoanalytical model versus multiple and adapted psychoanalytic and other models; difficulties in collaboration and coming to a productive consensus with agreed tasks.

Conclusion

Large and small groups, separately and/or together, can be emotionally and practically invaluable, even when held once a year, in helping us understand more about the dynamics of our professional lives and the organisations we belong to. They can provide a space where we can explore the current dynamics within the Faculty and profession as well as personally. This can improve dialogue between the membership and the elected leadership and guide it in its work. They can provide a forum where unconscious resistances can be voiced and explored and enable transformation of hatred of reality into communication. It is a potential space wherein we can challenge the prediction of failed dependency and work towards delivering new ideas fostered through hope of responsibility residing within the whole. This could be recognised officially and made explicit in the purpose of the large group and the agenda of the Executive committee.

These groups were permeated with archetypal imagery around the conference theme referencing amongst other matters gender dynamics, multiculturalism, power, authority,

failed dependence. They occurred within a context of much anxiety about resources for the NHS, a rise in mental health problems and Brexit amongst other major issues.

We suggest understanding how these dynamics impact our professional identity helps us as individual persons and as a profession to manage ourselves in the highly stressed NHS context with competition for limited resources and it seems an increasing sense of isolation and relative lack of support from experienced colleagues. Such understanding may help at different levels from personal to organisational to develop strategies which maximise effectiveness and guard against well-known harmful outcomes for doctors reducing stress and burnout.

Transformation through the group was reported at the time and in the feedback. One of the feedback comments described the group as "the beating heart of the conference". Change happening in two sessions is encouraging. This may be a particular moment in time when the remaining members of the early conferences are on the point of retirement, when reflecting on our history is a necessary function in enabling future development. The conference theme of creative and destructive forces in group, was understood better through the group experience. We hope we have been able to convey that this form of learning can have broader outcomes which can be expanded and monitored through similar ongoing experiences, locating our work both in history and the current context.

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Trainee Voices

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SAVE THE DATE! – Friday February 22nd 2022 – POSTER IN EVENTS SECTION

Introduction:

Disease

Alasdair Forrest

We have all been learning a lot about what causes disease. It is an interaction. A pathogen, no longer confined where it once was, enters the island or the country or the body, and meets a system whose equilibrium changes in response to it. Stages then occur of response to it, and a new state is reached. The disease is the whole response: physical, behavioural, and social. COVID-19 is not SARS-CoV-2, just as depression is not its apparent cause. Reactions, personal and social, to the same pathogen vary so much. Sometimes, the reaction is worse than the pathogen itself, and needs to be dampened down. Sometimes, prevention of any exposure to the pathogen is better than cure—but not always. Sometimes, we need to be exposed to the pathogen, but in a safer way.

The contributions to this newsletter are about physical, psychological, social, and organisational responses to a disturbing moment. Dr Chloe Warner writes in a poem about her experiences. Dr Ally Xiang writes about work on a ward, where the system must respond in a helpful way to the people who come into it, and attend, too, to itself.

Ally Xiang reminds us that this is team work. Our faculty, too, relies on team work—and that team changes naturally. Dr Alan Baban and Dr Josie Fielding will be starting as National Psychotherapy Trainee representatives. As they join, Dr Marion Neffgen and Dr Judith Mirsky are stepping down, and are due the thanks of the Faculty.

For us, as doctors, disease must be central to our idea of ourselves—even unconsciously. I think Sir Luke Fildes's 1891 painting, "the Doctor", is part of our view of ourselves, too—often shown to medical students: often alive in doctors' minds. It might be the height of Victorian, medical, and patriarchal arrogance. It may be the most idealised picture possible. But it has stayed alive in the imagination, and discussed, for example, in the BMJ.

Sir Luke Fildes. The Doctor (1891). (C) Tate. CC-BY-NC-ND 3.0 (Unported)

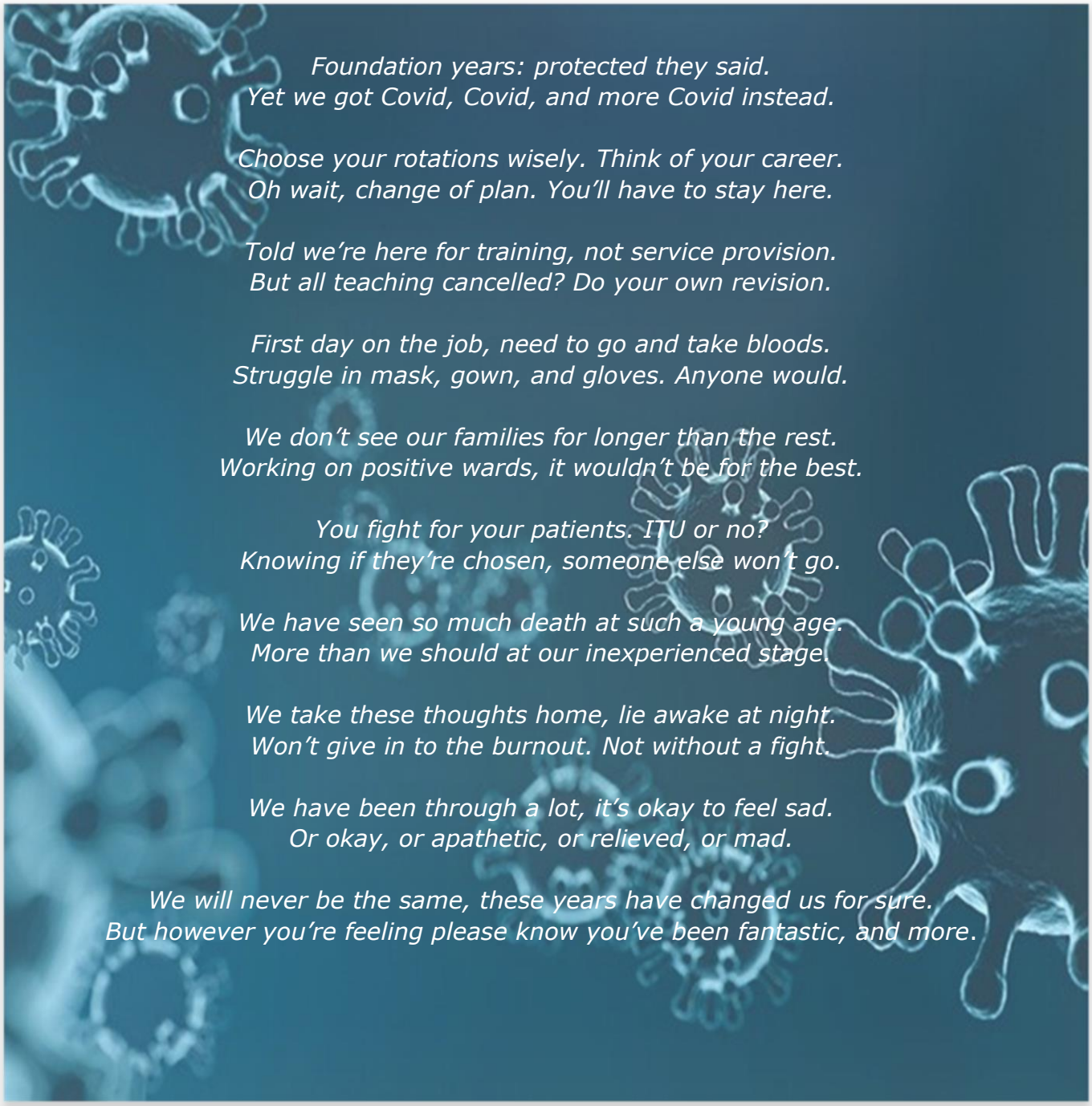
In it, the doctor is waiting for the fever to break. The parents look on—the mother distraught, the father wary but with some trust in the doctor. The doctor has either done all he can and is waiting, or is doing all he can *by* waiting.

As medical psychotherapists, however active or passive we may seem in our stance, I think so much of the time we are attentively waiting for the fever to break. A pessimistic view on that is that we do nothing. A more realistic view, I think, is that we can do a lot—even if we are waiting for the natural course of the disease to pass. Doing that, though, means that we can ease the way, and attend to regressions and worsenings. In that way, more than any other, our work is the heart of Medicine.

A big thanks to Alasdair who is stepping down from Trainee Voices co-editor after many years (and successful CCT- congratulations!). Please let Catherine Langley know if you are interested in joining in this joint role.

Foundation Years

Dr Chloe Warner
CT1, RDASH NHS Trust



Foundation years: protected they said.
Yet we got Covid, Covid, and more Covid instead.

Choose your rotations wisely. Think of your career.
Oh wait, change of plan. You'll have to stay here.

Told we're here for training, not service provision.
But all teaching cancelled? Do your own revision.

First day on the job, need to go and take bloods.
Struggle in mask, gown, and gloves. Anyone would.

We don't see our families for longer than the rest.
Working on positive wards, it wouldn't be for the best.

You fight for your patients. ITU or no?
Knowing if they're chosen, someone else won't go.

We have seen so much death at such a young age.
More than we should at our inexperienced stage.

We take these thoughts home, lie awake at night.
Won't give in to the burnout. Not without a fight.

We have been through a lot, it's okay to feel sad.
Or okay, or apathetic, or relieved, or mad.

We will never be the same, these years have changed us for sure.
But however you're feeling please know you've been fantastic, and more.

Reflections on working on an acute female inpatient psychiatric ward during the Covid pandemic

Dr Ally Xiang
ST7 Dual Gen Adult/Med Psychotherapy, West London NHS Trust

Dear ward,

Thank you for inviting me to feed back. I did not just want to give a list of things that worked well and things that did not from my perspective. You may know that not only am I a general adult psychiatric higher trainee, but I am also a medical psychotherapy higher trainee. I could not help seeing the ward and my work with these two lenses. So what you will hear in the following are my personal reflections from working on the ward, with psychodynamic and social dynamic aspects. When I speak of processes, these are largely unconscious, and nobody is at fault. I wish to describe the perhaps unseen processes occurring between people and society. I hope you find it is helpful and provides food for thought and I welcome your own thoughts and reflections on what I will say.

Despite having previously worked on an acute female inpatient psychiatric ward when I was a core trainee, I still started the placement with anxiety and fear. The fear was not unfounded - as a doctor, I read of the incidents that occur - patient assaulting staff, patient assaulting another patient, or patient damaging property. I have been fortunate to not have been harmed physically so far. Maybe I am particularly vigilant or cautious. The guidance given to always see a patient with a nursing colleague and carry an alarm phone is immensely helpful and reassuring. It is never safe to skip this vital preparation. I wish to thank the staff for keeping me safe throughout my time there.

Induction to the ward helped familiarise a little the setting, the staff and the patients. The ward surprisingly was a lot smaller than expected and during my time, there was increasingly a sense of claustrophobia for patients and staff alike. This was made worse by the restrictions imposed on us by the COVID pandemic. Our ward-round room was a room for everything: staff safety huddle, handovers, ward-round reviews, professional meetings, reflective practice and the informal chit chat and planning in between. It helped build a strong team camaraderie, but I felt we were having to negotiate, both the space between ourselves physically, sharing finite and precarious information technology hardware; and also the blurring of boundaries and to create space in my own head. It was frustrating that there was no doctors' office on the ward to base oneself. This reflects the whole ward in a way: staff and patients having to share spaces and time together. Nevertheless, the patients and permanent staff members had their own rooms to retreat to, so it isn't without envy on both sides - one has the office or desk to call one's own but the other can leave when the placement is over.

I guess it is inevitable that over the time I was there and settling into the job, I became more immune to the unpredictable and fast paced nature of the ward. The infection control measures became second nature, we became used to seeing each other only through masks and little of each other's whole faces. When our masks were occasionally removed, the common response tended to be surprise at seeing the other's full face, having probably filled in a different face in our minds. It was difficult at times to maintain perfect infection control measures when the patients were chaotic and the environment not conducive to maintaining sterility, reflecting the messy reality of life.

It felt like we were constantly getting to know new patients and it often felt difficult to know all of them, or to know each patient in detail. The ward works at a fast pace for the demands of the service, but this also seems to work in favour of the patients who do not wish to be there or know themselves, and staff who day-in day-out have to be in contact with difficult emotions, behaviours and histories. Personally, I think there are frustrations with the lack of continuity when patients are moved around without thinking, and we as a team had to start afresh. It often felt like the ward was powerless to the pressures of bed management and felt "done to". A similar dynamic to how the patients often felt throughout their lives too.

Despite this, the staff soldier on and do a good enough job on many occasions. The patients have been interesting and I have learnt a lot from them. It has been a privilege to help women, even those who consciously did not want our help but unconsciously benefited from our care and attention. It felt right to be serving the often perceived less privileged sex, who frequently had horrendous histories and abuses that led them to develop mental health problems. One issue that particularly angers me is that the ward does not have a seclusion room. We often had to seclude our patients on other wards. This really tests the ability of nursing staff to de-escalate the situation as much as possible before resorting to seclusion. However, there seems to be a message from the institutional viewpoint and wider society, a sense of misogyny, that again women patients do not have the same protection and need as the male ones, as evidenced in our mental health unit where all the male wards have seclusion rooms but our one female ward does not. Infrastructure is particularly difficult to change, but the way the unit was designed and constructed probably unconsciously mirrored society's attitudes and its lack of regard for women.

Overall, I highly recommend working here, it has been immensely interesting precisely because of the challenging nature of the work and environment. We work as a team and it has been fascinating diagnostically to figure out patients with my doctor colleagues. I commend each and every one of you in dedicating yourself to work with such difficult patients in crisis, with finite resources and in challenging conditions. The mix of race particularly, but also gender in the team, represents the patient population we serve. We have a crucial and necessary function within mental health services: a place for patients and family, for respite and safety when they are at their worst. Finally, reflective practice has allowed the space and time to get to know some of you better, to slow down and have thinking space and to hear and work out together the difficulties and feelings arising from this incredibly difficult and demanding work.

Thank you all very much

Reflections on psychodynamic psychotherapy supervision styles

Dr Sian Holdridge
CT3, South London and Maudsley NHS Foundation Trust

I am in the fortunate position as a psychiatry trainee of having had the experience of three different medical psychotherapy supervisors overseeing my psychodynamic cases. This is due to taking on additional cases, and for choosing the medical psychotherapy rotation which is available at South London and the Maudsley in CT3.

It is from this vantage point that I am able to reflect on the differing styles of supervision. Having sought some feedback from peers in a similar position by way of a survey, it became clear that a positive supervision experience is important not only for the benefit of the patient, but also for the impression made on the trainee as to whether or not to choose this as a career. One trainee wrote "*my experience of supervision has been very positive and this has been a factor in wanting to continue with psychotherapy in my career".* But what about the style of supervision? Is this important, and does it differ between therapists?

At the start of my first exposure to psychotherapy supervision I was under the impression that the format was similar regardless of supervisor.

I recall asking, before I started seeing my first case, what I considered to be a wholly practical and mundane question that in my mind did not require any interpretation. The question was "what should I say if the patient asks me about something personal, like my qualifications?". The answer from the supervisor was "why do you think you are asking that?". I remember at the time feeling quite irritated that my simple question could not be answered in straight-forward manner. I was looking for some practical advice, yet my question was 'bounced back', and I was left feeling dissatisfied.

After getting over my initial frustration, and as supervision continued in a similar vein, I realised the importance of my questions being answered (or rather, not answered) in this mode. I realised she had very astutely detected my anxiety about starting the case and my subconscious inferiority complex. After all, in my mind, the patient was being short-changed and had been dealt a trainee, not a 'real' therapist. This supervisor had opened my eyes in a very tangible way to the concept of counter-transference. I would not have appreciated the lesson in quite the same way had it not been taught in this style. It started to dawn on me that every interaction between the patient and myself, even when dealing with administrative tasks outside "the room", may have links to the crucial patient -therapist dynamic.

This supervisor also made a space in supervision for thinking about my own counter-transference in a way that felt safe and non-judgemental. She often asked "how did it feel in the room?", thus reminding me of the importance of tuning into the non-verbal cues and the feelings coming from and towards the patient. Other trainees have described similar experiences of a being in a safe, informal space - *"Our supervision took place in a relaxed and non-judgmental environment. The sessions were loosely structured so that we were given space to talk".*

Towards the end of therapy, one of her last questions was "how do you 'do' endings?". This floored me. I had been so preoccupied with how the patient was feeling about the end of therapy that I hadn't stopped to consider my own feelings. It prompted me to examine how I have dealt with endings in my own life. To me, this demonstrated the symbiotic nature of psychotherapy. One trainee commented - *"my supervisor was incredibly insightful in helping us understand not only our patient but ourselves, through our responses to our patients".* Psychotherapy not only 'gives' to the patient, it also gives to the therapist, and both are changed by the experience.

I assumed that the techniques used by my next supervisor would be similar. I discovered this was not the case. One of his first comments, when talking about the patient, was - "I think she's operating from the depressive position". I became anxious. How could I tell him I didn't know what this meant? I felt out of my depth, like an amateur amongst experts. However as I became more familiar with his approach, I found myself becoming more and more familiar with these terms. I found myself researching the literature, and 'testing out' how I could apply these concepts in the room with the patient. Although the sessions felt in some ways more formal than what I had been used to, this supervisor used praise more readily than others I have come across, and when starting to see patients as a core trainee this was invaluable in building my confidence.

I began to 'borrow' a selection of phrases or questions used by my supervisor that I could apply to patients in my own practice and started to build up my own library of vocabulary. This is something that one cannot learn in the classroom. It requires being exposed to this type of language in practice.

As I moved into CT3 level I began to attend the seminars and conferences on the topic of psychoanalysis which are part of the academic programme for higher trainees. I started to become more familiar with the theoretical frameworks, the foundations of which had been laid by my previous supervisor. It is true that a certain amount of psychoanalytic theory is incorporated into the core training programme and the Royal College exams. However many trainees feel that it is not enough and would like to see more of this during the core training programme.

Having said that, there have been times when I have felt "bogged down" and have struggled to keep up with the complex analytic theory taught in these seminars. At these times I have been comforted by being reminded by higher trainees that ultimately, therapy is about two human beings being together in a room. By turning up for the patient week after week, holding them in mind, showing compassion rather than judgment, the patient can make a positive attachment and feel the lasting benefits of this.

My third supervisor employs a combination of all the techniques described above in a style that is arguably less 'purist', although some of the patients we discuss are being seen for extended assessments rather than pure psychodynamic work. When I ask a 'practical' or 'administrative' question it is usually met with a straight-forward answer, rather than another question. At first I found this confusing, as it felt as though the boundaries between psychodynamic psychotherapy and psychiatry were being blurred. However, I have learnt that techniques need to be adapted depending on the patient sitting in the room. Perhaps when needing to use a more 'psychiatric' approach, we are dealing with a patient who is not yet suitable for the psychoanalytical type of therapy. Or perhaps their risk issues have changed, and thus the technique needs to be modified. In supervision, there are times when

we think about the theoretical framework of the material. At other times we think more practically about medication, and at other times we think about how it feels in the room.

In conclusion, although it feels like a cliché, I would say that there is no 'right or wrong' technique in supervision. I don't think there needs to be a generic or standardised approach that a supervisor takes. From speaking to other trainees, the feedback has been that having a mixture of supervisors is beneficial. Undoubtedly, if a trainee takes a particular interest in psychotherapy they will be exposed to a variety of techniques, and I think their practice will be all the richer for it.

Conferences

Bringing suicide out of the dark

Personal reflections on the conference 'The effect of patient suicide on clinicians'

Dr Becky Cunningham
ST5 in Gen Adult/Med Psychotherapy, Birmingham and Solihull Mental Health Foundation Trust

On the 22nd October the college held a conference titled 'The effect of patient suicide on clinicians'. This was first of its kind and in my opinion, long overdue. As a member of the working group for the effect of suicide and homicide on clinicians (ESHC) I had the privilege of seeing the conference shape up and of being a co-facilitator in one of the afternoon group reflective sessions. I can't take any credit or mention all individuals who helped shape both the working group and conference, but must pay heed to the group's Chair, Rachel Gibbons, whose passion and steely determination really proved to be the driving force behind pulling off such a successful conference. So successful in fact, that over 500 delegates signed up, with over 300 attending live on the day. I feel this reflects both the appetite for a conference of this kind and the thought and care that went into the planning of such a wonderful, rich and diverse programme.

The day was chaired by Jo O'Reilly, whose warmth, thoughtful reflections, and calming presence really held and contained the conference and its attendees. This role was something that felt particularly important, given the nature of the topic and its profound effect on many, if not all delegates. Jo began by highlighting how we have likely all had experiences of suicide, not just in our professional lives, but also often in our personal lives, perhaps even having experienced our own suicidal states of mind, all of which have profound and far-reaching effects.

The first main speaker was our President, Adrian James, who kick-started the day with an important remark about the need to look after clinicians in order for clinicians to care for those with mental illness (although perhaps this dividing line isn't always so clean!). Adrian asked why there isn't as large a financial, social and political response to the suicide crisis and mental illness in general as there is to physical health or has been to the Covid pandemic.

He outlined the College's three-year strategic workforce plan which incorporates the wellbeing of our members. We heard about the sad consequences of not nurturing and looking after each other after events such as patient suicide, including clinicians sometimes leaving the mental health sector altogether.

During the next session we heard from Professor Keith Hawton and Karen Lascelles from Oxford University Centre for Suicide Research. Their research in this field looks particularly at the emotional impact on clinicians after patient suicide and the effect on clinical practice. It was quite striking to hear that the average older Psychiatrist has experienced 4 patient suicides throughout their career. Being (hopefully) closer to the start of my career than the end, this felt like a sobering prediction of what I might expect. Also food for thought was the low proportion of those taking time off; is this because we feel able to carry on as normal or is it perhaps a reflection of our inability to recognise our own suffering after losing a patient to suicide?

After a coffee break, we moved on to hearing from Rachel Gibbons and Dame Clare Gerada (president of the Royal College of GP's and founder of the Practitioner Health Programme) in a session titled 'The Truth about Suicide'. Both speakers shared their thoughts and understanding based on their wealth of experience running groups for those bereaved by suicide. Clare runs a group for families of doctors who have died by suicide and Rachel, for Psychiatrists who have lost patients to suicide. One of the many things I will take from this lively and honest discussion is that we cannot know with any great degree of certainty why someone has died by suicide. However, as humans, we create narratives to try and understand why someone has taken their own life. These are of course not fact, but something created in our own minds to try and gain control, meaning and understanding out of an act so un-understandable, destructive and tragic.

Before lunch we were privileged to hear some poignant and moving reflections from clinicians (Dr Rachel Gibbons, Dr Nora Turjanski, Dr Nisha Shah and Dr Camilla Tamworth) about the impact of being in a reflective group for clinicians affected by patient suicide. We heard how the group can provide a supportive, valuable and more benign space to construct narratives away from the often more persecutory experiences and feelings of guilt and being blamed in the external world. Camilla presented some of her research into what makes a group like this work. After this we watched a video in which a consultant Psychiatrist candidly opened up to another Psychiatrist about her own struggles with her mental health following losing a patient to suicide. This hit home that as doctors we aren't infallible but have normal human vulnerabilities.

This was followed by a further roundtable discussion from previous speakers with the addition of Professor David Mosse (social anthropologist, Open dialogue practitioner and father who lost his 23-year-old son to suicide). David runs a "Survivors of bereavement by suicide" group. In this session we thought about the effect of suicide on families and the dynamics that can be created between clinicians, organisations and those bereaved after such a profound and life changing event. We heard about the struggles of families to make sense of something that makes no sense, and at times maybe a need to project a sense of guilt, anger and blame onto an external agent to maintain and protect the love between the family member and the lost loved one. There was thinking around systems and organisational dynamics in relation to a division that can often occur between families and clinicians involved and how we need to create space for a more inclusive and open dialogue. We heard how blame is a normal part of the grieving process but equally isn't concrete reality and can

become problematic if it becomes stuck or identified with too strongly. The audience, including myself, were clearly touched by the generosity and openness of the clinicians in all of these sessions.

The afternoon group gave a more immersive and participatory experience as the very large group was split into breakout rooms with facilitators, before finally coming back together for reflections and a final plenary and panel discussion with concluding remarks. The groups were an opportunity for reflections, thoughts and responses to the material. Just prior to the group we heard from Rachel Gibbons (Chair of the working group), Dr Jon Van Niekerk and Professor Helen Killaspy (members of the working group) about the work of the 'Effect of suicide and homicide on clinicians' working group in trying to change the culture to be more open and supportive following a patient suicide.

It is not possible to go into actual material discussed in the groups due to confidentiality. However, on personal refection it was a very enriching experience to be immersed (albeit virtually) with others. Whilst some shared very personal stories and experiences, others preferred to listen thoughtfully. This coming together and sharing felt very profound and as my co-facilitator, Jan Birtle reflected afterwards, something more hopeful came out of something often so hopeless. I agree wholeheartedly with this reflection, and being a fan of Jung, it reminded me of his concepts of the 'wounded healer' (in particular in reference to the analytic or therapeutic space when two or more wounds can come together to form something new and creative) and related to this, the 'coniunctio' (the alchemical term referring to chemical combinations, or psychologically, points of union of opposites and the birth of new possibilities).

And so, to my final reflections. The conference was rich, informative, evocative and, I would like to think in some ways, a paradigm shift in being able to talk openly and honestly about such a difficult and painful topic. Anger, shame, blame, helplessness and failure were some of the emerging feelings and themes from the day. However, being able to talk about and share in these emotional experiences felt creative and in some ways healing. An ethos of the working group is 'To help a truly suicidal person you have to approach them with an open heart' (Chaplain of Beachy Head). And, in order to have an open heart we need to keep having these conversations and sharing our experiences. There needs to be a shift away from blaming and shaming, towards a more supportive approach, with mental health and training organisations improving the duty of care towards their employees.

As a trainee, I feel that the curriculum is too focused on very objective risk assessment. This can give an omnipotent fantasy that we can predict and control what happens to our patients at all times. This in turn leads to greater shame and a sense of failure in our omnipotence when a patient dies by suicide. If being in the working group and attending this conference has taught me one thing, it is that this isn't true and this way of thinking can be counterproductive, leading to defensive practice, or indeed, approaching patients with a closed, or even shattered heart. We need to see a change in the curriculum and training on the effect of suicide on clinicians embedded right from the start. A good start has been the recent addition of many resources available on the College's website including the new booklet 'If a patient dies by suicide – A resource for psychiatrists', videos and the upcoming trust guidelines, a very welcome addition and one for all to check out! ***https://www.rcpsych.ac.uk/docs/default-source/members/supporting-you/if-a-patient-dies-by-suicide/when-a-patient-dies-by-suicide-a-resource-for-psychiatrists-2020.pdf?sfvrsn=10e72fdc_2***

Feedback from attendees was very positive and attendees' comments reflected how the space to share difficult and distressing experiences was highly valuable and empowering, reducing a sense of isolation and allowing a frank and open dialogue to begin to flow.

I'd like to finish by paraphrasing Jo O'Reilly's concluding remarks: *"The covid pandemic has increased a sense of urgency in needing to connect with each other, and suicide is a lightning rod to guide us in terms of the importance of the need to be contained in our places of work and a need to reach out to each other."*

Book Reviews

Editors:
Dan Beales
The Iris Centre, Devon Partnership NHS Trust
Andrew Shepherd
Greater Manchester NHS Mental Health Foundation Trust/ University of Manchester

Tavistock 100 years Review

The Tavistock Century: 2020 Vision. Waddell, M. and Kraemer, S., (Editors) Phoenix Publishing House: London (September 2020)

Dan Beales

Margaret Waddell and Sebastian Kraemer - both themselves with distinguished and innovative careers at the Tavistock - have done a heroic job of marshalling the many contributions to this celebratory centennial volume that presents both a historical review and essential resource for anyone interested in applied psychoanalytic approaches, and the part that these can play not only in mental health but also in broader healthcare settings, and in wider society. The fact that the praise on its cover ranges from an Archbishop of Canterbury (Rowan Williams) to a President of the Royal College of Psychiatrists (Simon Wessely) via a twice Booker Prize winner (Hilary Mantel) gives some indication of this.

At nearly 400 pages, and with eight parts and 44 chapters, this volume is a bountiful smorgasbord of applied psychoanalytic thinking, and is unrivalled in the breadth and depth of its coverage (and as such relatively cheap at around £30). I can't do full justice to this in a brief review but there is much that trainees will be able to gain from this volume, and important points of interest for all medical psychotherapists and other specialties.

The Tavistock Clinic, founded in 1920, continues within the National Health Service as the Tavistock and Portman NHS Foundation Trust, and its national and international significance intellectually and culturally, and as a training resource, is richly explored in this volume in a

wide variety of contributions ranging from parent-infant psychotherapy to group relations, from Balint groups to the "psychopathic mind". Some chapters concentrate on, or are written by, important figures who have worked at the Tavistock – ranging from John Bowlby to John Steiner, David Armstrong to Caroline Garland. The figure of Wilfred Bion also looms large, despite his relatively brief period at the Tavistock. Sebastian Kraemer's Afterword interestingly explores some of the tensions evident in, and between, both Bowlby and Bion's contributions and how these have resonated within the organisation and more broadly.

Some of the chapters on the history and internal aspects of the Tavistock have less general relevance, although they do provide interesting glimpses "behind the scenes", but the overall depth and range is striking in its creativity and importance to the development of applied psychoanalytic thinking. One question prompted by this is how an organisation can foster and facilitate such creativity, and the nature of the containing space that the Tavistock has been able to create in order to sustain this.

In his Foreword, Anton Obholzer, a senior clinician who became its Chief Executive, describes "the Tavi" as a "worldwide community of people", but also refers to its continuing "battle" for survival in the context of "the pressure to conform" within the modern NHS. There are interesting parallels here to the place of medical psychotherapy in psychiatry and the wider NHS, and the recurring existential anxieties that the speciality has to tolerate and engage with.

There are some areas where recent events suggest that some of these challenges are not only external. For example the chapter on the child and adolescent gender identity service by Domenico Di Ceglie gives an account of the development of this innovative service but is a historical paper and thus not able to explore how recent developments (high-profile media coverage and legal actions) and internal dynamics (whistleblowing and significant disagreements about clinical models and theoretical approaches) provoke challenges to how psychoanalytic models negotiate and engage with the complexity of the modern world, something that is only hinted at elsewhere.

There is a relative lack of representation of the Portman Clinic's work in forensic psychotherapy, but there are other sources where this is described.

The role of the Tavistock and Portman in the pathologisation of homosexuality isn't considered in this volume, but perhaps it is unreasonable to expect this in such a volume and the Tavi's (or Portman's) "shadow" would require a different book.

This shouldn't detract from what is a fascinating volume, full of accessible contributions, which will richly repay study, or repeated brief incursions.

Seminars in the Psychotherapies

Edited by Dr Jo O'Reilly and Dr Rachel Gibbons

Dr Josephine Fielding, Specialty Trainee in Medical Psychotherapy and Gen Psych, West London NHS Trust

As Dr Kate Lovett, Dean of the Royal College of Psychiatrists, describes beautifully in the foreword to this book, there is a deep emotional impact for all of us who work with patients in mental turmoil and distress. To work successfully and sustainably in psychiatry, she writes, having "paradigms in which to examine and explain our own reactions, at the sharp end of this work, is essential in containing our own anxiety and maintaining a sense of well-being". This second edition of "Seminars in the Psychotherapies" not only gives an engaging and readable introduction to ways of understanding our patients' inner worlds, but also provides a way for clinicians in mental health to make use of these paradigms to think about ourselves and our organisations. It also makes a compelling case for the importance of all of us practicing in mental health to be psychodynamically-informed (though as I am a medical psychotherapy dual trainee, this may reasonably be called preaching to the converted).

The book starts with an overview of the theory and practice of psychodynamic psychotherapy, with an introduction to important thinkers in the development of psychoanalytic theory and to its key concepts (useful for those preparing for MRCPsych examinations). Jo O'Reilly sets out a psychodynamic approach to psychiatry, and how this can help us understand the meaning of otherwise mystifying symptoms such as delusions or self-destructive behaviour. Case vignettes bring this to life, showing how psychodynamic thinking is not just an optional extra for enriching our understanding of symptoms, but is essential to inform team decisions and reactions to patients. Helpfully, this section of the book includes a chapter on the referral process for psychodynamic psychotherapy, something we are not often explicitly taught as trainee psychiatrists. Referral is conceptualised as a living, multifaceted process, rather than as a hurdle to be cleared, with guidance on important considerations for those referring patients, and discussion of when referral may be counterproductive or unhelpful. The chapters on the consultation process and formulation will be valuable for those starting their higher training in medical psychotherapy, whilst the final chapter of this section, on psychodynamic psychotherapy practice, is particularly useful for those in Core Training about to embark on their long case.

The book then broadens to consider other forms of psychotherapy, including cognitive behavioural therapy (CBT), brief psychodynamic psychotherapies, cognitive analytic therapy (CAT), group analytic ideas and systemic therapy, and mentalizing in psychiatric practice. These are huge topics to summarise, and some of this part of the book suffered from this, feeling rather more like a textbook at points. Although still useful for those wishing to gain a brief overview of these specific therapies and their history, some chapters here were less readable, and it was notable how those which incorporated clinical vignettes, such as those on CAT and group analysis, felt richer and more alive.

The second section explores how psychotherapeutic thinking can be applied in a range of contexts in everyday practice, with chapters on approaches to clinical problems such as

affective disorders, psychosis, personality disorder, suicide and homicide, as well as an overview of forensic psychotherapy. It then moves to thinking about the wider organisational context, as well as other settings for treatment such as therapeutic communities. Rachel Gibbons writes vividly about the powerful effects on teams of working with patients with psychotic illness, including projection of psychotic processes into the team – something very recognisable to those who have worked in acute settings. Maria Eyres discusses the vital importance of reflective practice groups, as well as considering what is needed to set these up successfully and the dynamics which so often lead to teams resisting these kinds of spaces.

I particularly enjoyed the final section on contemporary developments, which deals with some innovative approaches such as Open Dialogue and psychedelic-assisted psychotherapy. It includes an admirably clear introduction by C. Susan Mizen to the complex but fascinating recent developments in neuropsychoanalysis, exploring the potential of neuroscience to enhance our understanding of traditional psychoanalytic theory (such as the corroboration found for Freud's understanding of dreams) and even update and challenge established psychoanalytic theory. William Burbridge-James closes the book with a thoughtful and compassionate reflection on our psychotherapeutic development as psychiatrists, recalling Shakespeare' seven ages of man and the periods of growth and, at times, stagnation we all go through in our working lives. He considers the reasons why we may be drawn to this field, and the need for a triangular space for all clinicians to keep thinking and curiosity alive, to help prevent a retreat into defensive responses and burnout.

For me, one of the real strengths of this book is its presentation of psychodynamic thinking as interwoven within mainstream psychiatric practice and highly relevant to all aspects of psychiatry, rather than situated as something separate, mysteriously apart, or even in opposition to other ways of working. It is written very much from a clinically informed perspective, and refreshingly combines theoretical knowledge and research evidence with the practical realities of working in frontline NHS settings. As a dual trainee in medical psychotherapy and general psychiatry, it can at times feel a struggle to navigate the disparate elements of our professional identities, and find a way to integrate the different aspects of training into a coherent whole. This book provides a convincing argument for why this integration of thinking is so vital in caring for our patients as full and complex human beings. In a time when it can feel there is a huge pressure to retreat to binary divisions, taking either a primarily biological or a psychological approach, it manages to resist this temptation and keep the contributions of both in view. For me it highlighted the vital importance to medical psychotherapy as a discipline of communicating our ideas accessibly to colleagues across the whole spectrum of mental health work; and emphasises the huge relevance and ongoing value of the specialty.

Whilst the book will undoubtedly be useful to those in Core Training wishing to prepare for their MRCPsych examinations or psychotherapy cases, or those undertaking medical psychotherapy training and wanting an overview of the specialty, it also has a wider applicability. It speaks to those who are working in mental health and wish to expand their knowledge of psychologically-informed ways of thinking to enrich their everyday practice. It is also relevant to those training or working in medical psychotherapy, in thinking about how our specialty fits within psychiatry as a whole, and as a reminder of how much we can and do contribute to keeping curiosity and thinking alive. It feels particularly relevant at a time when services can feel increasingly fragmented, and the need for this kind of holistic and integrative thinking is more pressing than ever.

Call for future book reviewers and contributions

We are looking for contributors and fellow bookworms to contribute reviews to the newsletter, as a guide around 1,000 words but this is flexible.

We are keen to hear from you if you have an idea for a review, want to share books you wouldn't do without/ classics revisited/ hidden gems; a series for discussion or other contributions to make.

We have made contact with a number of publishers in the field and are able to negotiate access to review copies in many cases. Please therefore, if this is something you are interested in helping to take forward, send an email to Dan and Andrew via Catherine Langley.

Review idea:
The following has been sent through as a suggestion - if you would like to review this, please get in touch.

Social Defences Against Anxiety: Explorations in a Paradigm (Tavistock Clinic Series) Paperback – 19 Nov. 2014

Publisher: Routledge; 1st edition

Eds: **David Armstrong, Michael Rustin**

The book's contents can be seen on opendialogueforpsychosis.com and it has been endorsed by the President.

Spotlight on... film

Parvinder Shergill,
ST in Psychiatry, CNWL

My name is Dr Parvinder Shergill, I am an SpR in Psychiatry, CNWL. I am also a film director. From a young age, I have always wanted to work in the film industry, however I knew that as a female South Asian it would be a struggle for me to get work in the industry, and that I would need to bring life experience and skills to the table.

I was also fascinated by literature and started writing my own fictional stories from about the age of 14. I decided I would first gain a degree I could get work with anywhere in the world and support myself financially as I funded myself in film. I enjoyed science, and so it made sense for me to do a Philosophy Bsc and Medicine. Once I graduated, I lost myself temporarily in the world of training, and I fell upon psychiatry, which I truly felt passionate about. I took a year off in my CT training to pursue writing and I started to write pieces concerning mental health, and articles on what it was like to be a female south Asian doctor in the modern day. I also was part of a mental health podcast that won a prize with The Royal College of Psychiatrists, and we were invited to Parliament to record an episode. After my CT training, I took some time working as a speciality doctor as I funded myself through acting school. I left acting school in 2019, feeling frustrated with the industry having poor opportunities for women of colour. I decided to take matters into my own hands, and wrote my first play, HER, which was a dark comedy about mental health with LGBT themes. I directed-produced-wrote and starred in it with a female cast. It was incredibly well received, and on occasion is on tour in the UK and now in Greece.

I then, in 2020, moved on to Film work. I wrote a number of short films, that had elements of mental health in them to showcase mental health storylines in a cinematic way, with a diverse cast. One of my short films, was a comedy about COVID which was aired on a BBC platform and I won best actress and best Romance film at film festivals. Another film, PHANTOMS, was an LGBT horror about pseudocyesis, with an all-female cast of colour.

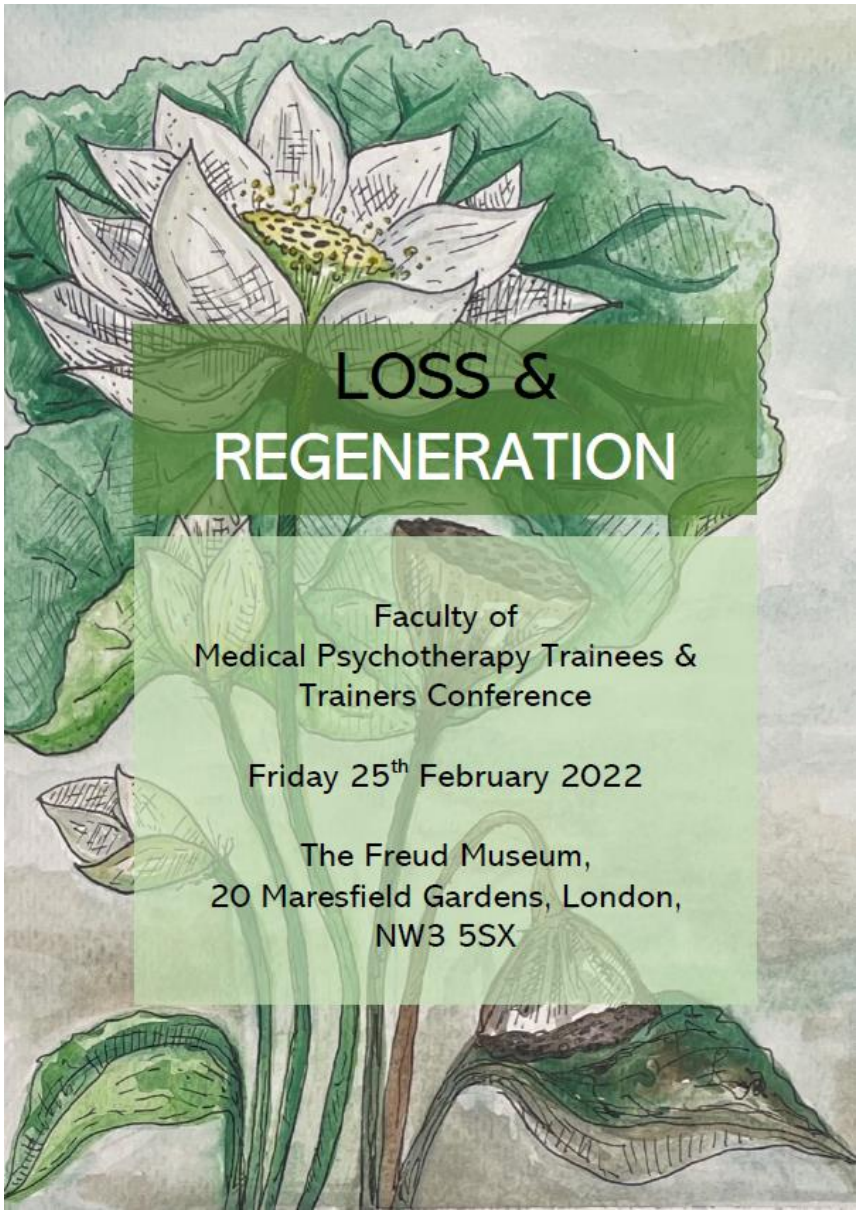
I then moved on to feature films: THE LINK is the first mental health thriller series with an entire cast of colour, that I wrote-directed-produced and starred in. This is the first of a trilogy which we have showcased at the CNWL film event and is currently streaming on Amazon Prime. The second feature film I was commissioned for, called DADDY BLUES, highlighting the mental health of fathers, is also on Amazon and gaining interest from BBC journalists.

I am also currently involved with many other film projects concerning mental health. I find the film industry is not well equipped with educational content concerning mental health, which I feel is really important to address. That's why all of my films have an element of mental health, as I want to educate the audience in specific mental health illnesses through

a unique film story not yet seen on the screen, whilst also staying true to my ethos of offering women more roles in the crew behind the camera, as well as always having a lead actor of colour in my films. I really hope to be part of the change in reducing mental health stigma, gender stigma, and ethnic stigma in the film industry, and amazingly I have been BAFTA recommended which is a huge honour.

I don't know where the future will take me, but for now I am enjoying working both in the NHS in mental health, but also the film industry in paving a way for mental health films to be taken seriously whilst trying to a make a stand for diversity.

Events, Notices and Dates for your Diary



Faculty group
The group for the consultants and higher trainees in Medical psychotherapy is set to continue for another year. Chris Holman steps down from his facilitator role next year. Diana Menzies continues in her role for another year and will be joined by a new co-facilitator. We are very grateful to them both for taking this on, and for their sensitive and thoughtful approach; the group is highly valued and well attended. Our thanks to you both, and to Mark Morris who kindly organises and administers the group.

The group meets on the last Thursday of the month at 5.30-7pm. If you would like to join, please contact Catherine Langley so that your email address can be passed to Mark Morris.

Contributors wanted: Working group on EUPD and Eating Disorders: Jan Birtle

A working group has been set up looking at the needs of patients with eating disorders who have co-morbidity with either personality disorder or autistic spectrum conditions. Services are very limited in what they can currently provide leaving many patients bouncing around the system with multiple rejections from services.

Tony Winston is chairing this, supported by NHSE with clinicians from a range of backgrounds, experts and carers by experience contributing actively to this.

Q1 We would like to know if there is anyone - either Consultant, Higher trainee in MP or SAS specialist who would be interested to contribute to a literature review on EUPD plus ED? It would be an interesting project to write up and potentially publishable. They would be very welcome to join the working group.

Q2 Is there anyone in the group who is up to date with training developments for EUPD – i.e. what's happening with the KUF - Knowledge and Understanding Framework, and/or interested in contributing to develop this further to include a module on co-morbid EUPD and Anorexia Nervosa? Again there would be a place on the working group to contribute and the plan is to co-produce training if this is taken forward.

Q3 Is there anyone working in secure services managing ED and challenging behaviour who could contribute to the working group?

If you are interested, please contact Jan Birtle at janbirtle@nhs.net.

CBT in Practice Series of educational seminars, running from 16th March to 11th May: a series of 3 workshops held at the Royal College of Psychiatrists in Prescot Street, London. The speaker is Paul Blenkiron, NHS consultant psychiatrist and CBT trainer for RCPsych and RCGP, accredited member of the BABCP.

Call for submissions

Thanks to all who have contributed to this newsletter. Please continue to send in contributions over the next few months for the spring edition. The deadline for submissions is 30th April 2022.

All contributions can be sent to me c/o Catherine Langley at Catherine.Langley@rcpsych.ac.uk.