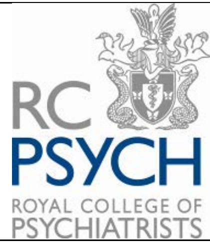
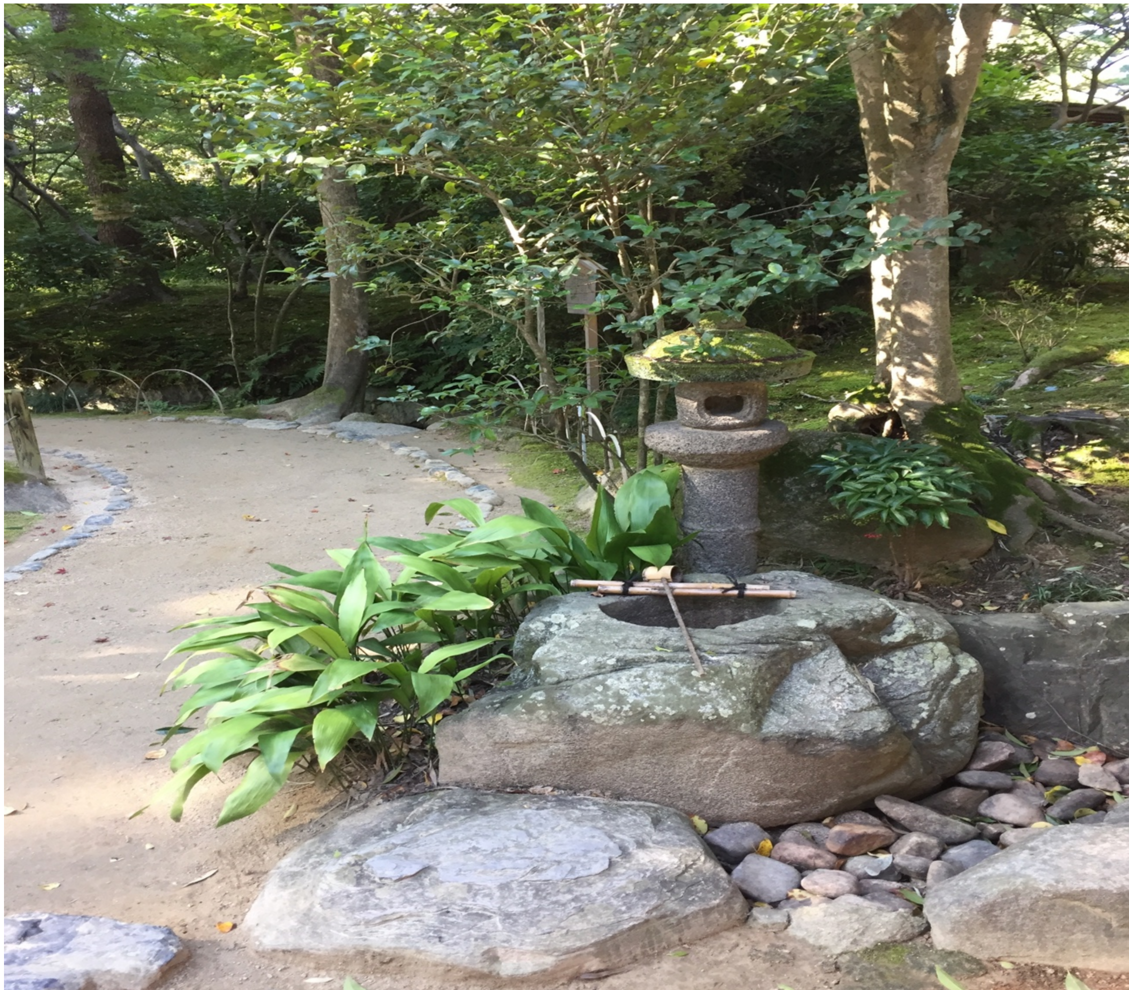
Winter/Spring 2019




# The Newsletter

FACULTY OF MEDICAL PSYCHOTHERAPY



## Faculty of Medical Psychotherapy Executive Committee

**Chair:** Steve Pearce, Oxford
**Vice Chair:** Jessica Yakeley, London
**Financial Officer:** Mark Morris, London

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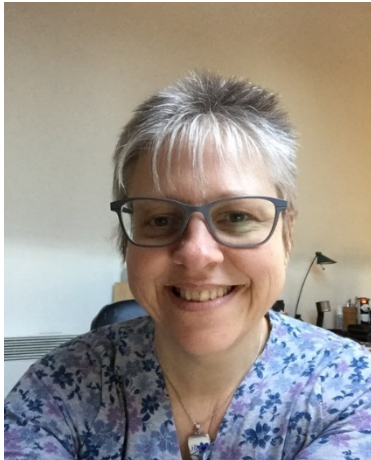
## Editors' Welcome

**Alison Jenaway**



This is my first Newsletter as editor and Maria and Harriet have set a high standard to follow, with photos, images, invited articles and updates from different aspects of the Faculty. I have already discovered that people do not always write what you have asked them to write or stick to the deadlines that you have set them! Who knew that people could be so complicated and unpredictable? Despite this problem, other people have spontaneously sent in interesting articles and so there has been plenty to be getting on with. This issue seems to have a bit of a group flavour about it, perhaps because of the recent isolationism of Trump and Brexit, we are all keen to think about group processes and the benefits of communities again? Maria Eyres the new academic secretary, and colleagues, have put together a great looking annual conference with a focus on group processes and we hope to see as many of you as possible at that event. Harold Behr has written about his practice of teaching psychotherapy skills to groups of medical students through the use of role play, John Hook reports on the small group experiences at the last annual conference in Cardiff and John Gossa has written in the trainees' section about introducing Reflective Practice groups in an adolescent secure unit where reflection appeared to be thin on the ground. Other aspects of psychotherapy are also represented, and in particular the day on Psychodynamic Psychiatry put together by Jo O'Reilly and Rachel Gibbons to appeal to those members of our Faculty who are not working as Medical Psychotherapists. These days are proving very popular and there will be more to come. I hope you enjoy this issue, and please do write in with any responses you have to the articles by the next deadline of 30th September 2019.


| **Editor in chief:**<br>Alison Jenaway, Cambridge<br><br>Contact the editors c/o<br>stella.galea@rcpsych.ac.uk | **Contributing editors:**<br>**International voices: Charles Le Grice**<br>**Trainee Voices: Alasdair Forrest and Michael Milmore**<br>**Book reviews: Daniel Beales and Andrew Shepherd** |
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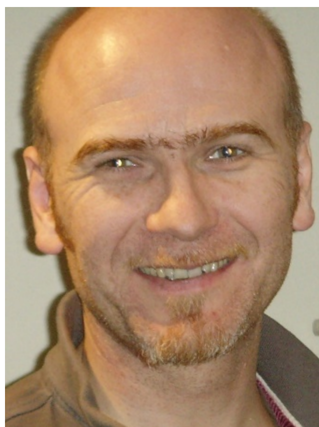
## Message from the Chair of the Faculty of Medical Psychotherapy

**Steve Pearce**



At the end of January, the Faculty executive held its annual strategy day. We were asked to test our assumptions about how our trainings should be organised. This was broken down into two questions: are we producing consultants capable of delivering, supervising, and researching evidence based, modern, mostly brief interventions, based on older more established models? And are we producing consultants capable of working in the range of contexts in which jobs are available?

To help us address this question we had a range of presentations in the morning on new, and some older but not so widely known, models of therapy delivery; and in the afternoon presentations on working in 5 different contexts as a medical psychotherapy consultant.

The contexts were:

1. A generic psychotherapy/psychological treatments service with a team;
2. A specialist psychotherapy service, in this case a PD service;
3. General psychiatry settings - CMHT (or its equivalent) and in-patient wards;
4. Working in specialist services where psychological approaches may be competing with medical approaches – in this case eating disorder services;
5. Lone working/ working with trainees;

The models of therapy we examined were:

- Mentalisation based therapy
- Transference focussed psychotherapy
- Dynamic interpersonal therapy
- Schema focussed therapy
- Mindfulness based cognitive therapy
- Dialectical behaviour therapy
- Compassion focussed CBT
- Acceptance and commitment therapy
- Psychodynamic interpersonal therapy
- Democratic therapeutic community treatment
- Group analytic psychotherapy

- Eye movement desensitisation and reprogramming
- Interpersonal therapy
- Cognitive analytic therapy
- Psychodynamic approaches to psychosis

The rapid development of the field, in areas derived broadly from cognitive and behavioural, psychodynamic or integrative roots, poses a challenge to the Faculty. How do we ensure that our higher trainees have the opportunity to obtain experience and training in a range of approaches? Historically one of the strengths of medical psychotherapists has been the breadth of their training and experience, not just as psychiatrists but also as psychotherapists. It has been common for MP consultants to take the role of broker between therapeutic approaches, a counterweight to therapists with experience in a single model who may feel ill equipped to recommend alternative approaches – or, worse, might form the view that the model in which they have trained is suitable for all patients in all circumstances.

Separately, but related, we asked how we ensure that our trainings prepare trainees for the range of contexts in which psychiatrists generally (in particular relevant for the CT curriculum), and medical psychotherapy consultants specifically, work. This problem is likely to be particularly difficult in areas in which training opportunities in specialist services are limited. We had very useful contributions from a CT trainee, and single and dual CCT ST trainees, who gave feedback on the structure of training, their views on how fit for purpose the current curriculum and competencies are, and the difficulties that can arise when local training opportunities vary around the country.

The curriculum is currently being updated (see report from the Chair of the SAC in this newsletter), and the Faculty executive is aware of the need to ensure the new curriculum at CT and ST level is fit for the future.

Training in medical psychotherapy, at least at ST level, can be seen as consisting of two parts. The first is what might be called a foundational model, consisting of a 'psychotherapy training'. It addresses attitude and base skills, includes an experiential element (normally personal therapy), and is long term, in the case of ST training 2-3 years or more. The second is applied medical psychotherapy, and consists of specific skills training, organisational theory and practice, and consultation and supervision skills. It equips trainees in recent developments and provides experience in specialist contexts. This generally comes after the foundational model is acquired, although it need not, and the two phases of training will often overlap. This model of training mirrors a two-segment model of psychotherapy trainings more broadly (suggested by Rachel Gibbons):

1. **Psychotherapy trainings**. Usually 3-5 years, lead to UKCP or BPC accreditation.
2. **Skills trainings**, last up to a year but can be a few days e.g. MBT, DBT, PIT. May be predicated on previous psychotherapy training and may or may not require a core mental health qualification.

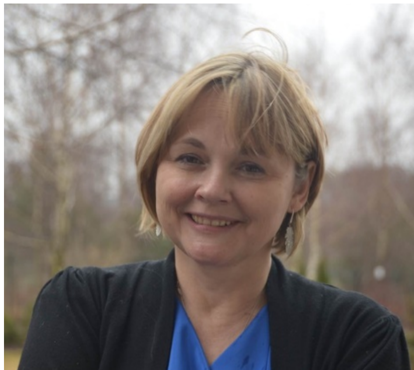
The Faculty executive recognises that some of the ways we organise training may need to be revisited, and along with the Specialty Advisory Committee (SAC) will be looking closely at this to ensure we train consultants who have the necessary skills, aptitudes, and (in the language of the College curricula and the GMC) competencies and capabilities to carry out their work in a rapidly developing field. It is unlikely that the way training has been organised for the last 30 years, conceived at a time before most of the specialist services and models had been conceived, is entirely fit for current practice.

The need to update our training strategy dovetails with work sponsored by the Faculty into management and treatment of high cost complex patients via the Talking Therapies Task Force, covered in this newsletter. There is an increasing awareness at policy level that the challenge posed by low volume, high cost, high risk patients must be met strategically rather than piecemeal, if effective intervention and management is to be made widely available, and costs controlled. Professionals skilled in the management and treatment of complex psychosocial and somatic presentations will be required to take this work forward. As doctors, psychiatrists and psychotherapists, medical psychotherapists are well placed to meet this challenge, but our training must equip the next generation with the skills to do so.

**Steve Pearce**
**Faculty Chair**
**Contact Steve c/o** stella.galea@rcpsych.ac.uk

## Message from the Academic Secretary

**Maria Eyres**



It has been less than a year since I took over the job of an academic secretary from Mark Evans and the learning curve has been steep. The organisation of our annual conference starts as soon as the previous one is over and I have been very lucky to be supported in this work by my excellent Conference Organising Committee; many thanks to Jo O'Reilly, Haroula Konstantinidou and Matteo Pizzo. With the first proposed conference theme for this year not working out due to the lack of availability of the potential speakers, we had to think fast. The second theme of *Creative and Destructive Forces in Groups* has been more successful; we had a wonderful response from the colleagues we have approached and I hope you will enjoy it. Group therapy has been of key importance in NHS psychotherapy services, and also has a key role in the development of therapeutic communities and personality disorder services. With the NHS relying increasingly on group treatments due to scarcity of resources, increased demand and our growing understanding of the importance of relationships for our patients, it feels like an important area to explore. Please see the abstract of the conference below, which also highlights the importance of the groups in a wider context; in our organisations and the society. We are living in politically troubled times and understanding the process which might be at work is vital. Please book the conference early to avoid disappointment.

Jo O'Reilly and Rachel Gibbons organised a CPD event for psychiatrists on 8th March 2018. The theme was psychodynamic psychiatry with talks from psychoanalytically trained psychiatrists working in a range of NHS settings and I was delighted to be asked to contribute to it this time. This was the third successive year that Jo and Rachel have run this event and it quickly sold out. A further psychodynamic psychiatry day is planned for 1st November 2019. This is an important interface between the Medical Psychotherapy Faculty and our psychiatrist colleagues working in a range of mental health teams.

My other highlight has been a joint conference between our Faculty and the colleagues from the Eating Disorders Faculty; many thanks to Parveen Baines who was an organizer at our end and for asking me to chair the morning session; it was a thought provoking and informative day and the communal spirit between the members from both groups was

encouraging. We agreed to continue to collaborate which is great; please see Parveen's report in the next Newsletter for more details.

If you are planning to attend the International Congress, please watch out for Jo O'Reilly and Rachel Gibbons presentation on the Psychodynamic Understanding of Psychosis and Psychiatric Breakdown on 4th July 2019.

We also have a joint conference in the pipeline between our Faculty and the Perinatal Faculty which is being organized by Mary Murphy Ford.

It all feels exciting and creative and I feel very lucky to work with so many passionate and knowledgeable colleagues who put a lot of time to ensure that our Faculty's way of thinking is disseminated across the College and that we are also learning from our colleagues.

**Conference abstract**

**We continually interact with and relate to others on multiple levels throughout our private and professional lives. The powerful feelings evoked by being inside/outside of a group are steeped in meaning and applicable to us all. As psychiatrists and therapists, who also work within organizations and teams, we witness the harmful effects of social isolation and exclusion affecting many of our patients and understand the importance of relationships and social contact in the healing process. Group therapy can become a source of real transformation.**

**Wednesday evening will address group processes at their most destructive and violent, with talks from leading military mental health professionals, examining the impact of war on the mind. New treatment models for complex trauma in military veterans and in civilians will be discussed.**

**This conference will explore the power of group processes and their ability to be both creative as well as destructive in clinical settings, in the workplace, in society and on the world stage, including those around Brexit. There will be an experiential aspect of group work with a large group on both Thursday and Friday, with the focus on ourselves followed by a plenary.**

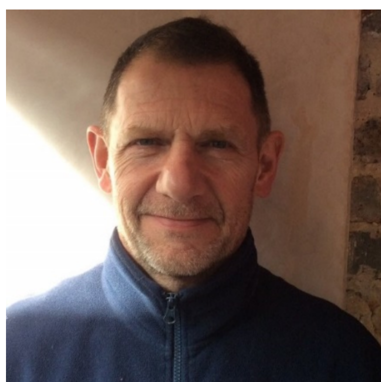
**Programme Available**

The programme is now available to download

**Maria Eyres**
**Academic Secretary**
**Contact Maria c/o** stella.galea@rcpsych.ac.uk

## Message from the Chair of the Specialty Advisory Committee

**William Burbridge-James**



The rewriting of the core and specialty psychiatric curricula continues to pre-occupy the work of the educational committees at the College.

The driver behind the rewriting of all medical Colleges' curricula was the 'Shape of Training' report by Professor David Greenaway (2013) which said that 'Patients and the public need more doctors who are capable of providing general care in broad specialties across a range of different settings. This is being driven by a growing number of people with multiple co-morbidities, an ageing population, health inequalities and increasing patient expectations'. While the report acknowledged that 'we will continue to need doctors who are trained in more specialised areas to meet local patient and workforce needs', it also stated that 'postgraduate training needs to adapt to prepare medical graduates to deliver safe and effective general care in broad specialties.' Alongside this the GMC developed the 'Generic Professional Capabilities framework'. The framework sets out 'the essential generic capabilities needed for safe, effective and high quality medical care in the UK'. At its heart are 'the principles and professional responsibilities of doctors', which the GMC have translated into educational outcomes which can be incorporated into curricula.

I hope this sets the scene for the work that the SAC has started to undertake. We last met in January and we have started working on 'Higher Learning Outcomes' (HLOs), for the higher medial psychotherapy specialty curricular rewrite.

Alongside our Faculty SAC, I have been attending the Curriculum Revision Group meetings at the College. The group is made up of SAC chairs, trainee representatives, and a lay representative and chaired by John Russell, the associate dean for the curriculum and facilitated by Tony Roche, RCPsych Curricula and Quality Manager. The initial work is to write a 'purpose statement' for core psychiatry training and to agree to HLOs for core training. The purpose statement is a section at the start of the curriculum that explains its objective. 'It should describe the patient and service needs of the specialty and the scope of practice required. It should also set out the high-level outcomes that a doctor who has completed the training programme should meet' (GMC).

Other specialty SACs have also been involved in writing their specialty specific HLOs. Currently we have taken a step back to look at commonalities that might be shared for certain HLOs across subspecialties. Once the core psychiatry curriculum purpose statement and HLOs have been through submission to the GMC's Curriculum Oversight Group (COG); the Medical psychotherapy SAC can use this as a guide to developing the purpose statement for our curriculum.

Training was also the focus of the Faculty strategy day in January and how we can use this opportunity to develop the structure of the higher medical psychotherapy curriculum to ensure that it is flexible enough to reflect and include contemporary developments in therapeutic modalities while at the same time providing a secure foundation in a major modality of therapy. It is only through having the depth of immersion into a major therapeutic modality that can allow for the development of a secure professional therapeutic identity, our internal therapeutic model, and base to explore from. This is gradually built up through incorporation and identification with the modality through supervised practice, enabling the development of our reflective capacity; the capacity to occupy a 'third space' in our minds; and the 'capability' to work with complexity, manage uncertainty, in a range of clinical contexts. Experience of minor modalities, working with families and in groups, together with experience of organisational dynamics all contribute to establishing this secure foundation.

In our discussions there was a consensus that central to this development is engaging in our own personal therapy or psychoanalysis, and the need to support trainees in this endeavor. It was through the work initiated by my predecessor James Johnston that we were able to ensure the GMC mandated the funding on one session/ week through deaneries. Some training schemes are able to fund more than this, which is to their credit. We need to ensure that this is retained in the new curriculum.

If you would like to get in touch and share your thoughts about developing the medical psychotherapy curriculum, please do so through Stella Galea.

**William Burbridge-James**
**SAC Chair**
**Contact William c/o** stella.galea@rcpsych.ac.uk

## EXECUTIVE COMMITTEE TASK GROUPS

### The Talking Therapies Task Force

**Sue Mizen**

I have said quite a lot about the talking therapies task-force over the last few years and so may be at risk of becoming a bore on the subject. So as not to repeat myself those who want to know more will find a briefing on this link: Talking Therapies Task Force Briefing

I will provide a quick update as I think there is the potential for our first piece of work to be published later this year. By now you may know we are developing the case for investment in psychological therapies for people with severe and enduring mental illness, particularly those whose difficulties are relational in origin. The first step is to make clear how much public money is being spent on this patient group. The strongest case is to be made for those most severely relationally disturbed patients who are very difficult to manage outside inpatient settings whether these are in physical or mental health services. The health economic study the Task Force is undertaking with the Centre for Mental Health is now well underway and seems to be well supported by the participating organisations. This is a two centre study looking at the cost of high cost outliers with relational disturbance. We anticipate the report of this study will be published over the autumn / winter of 2019 alongside a report summarising the evidence for effectiveness of therapeutic intervention for this patient group. There is on-going work amongst the Clinical Working Groups to think about how we can train ourselves as specialists in working with the high levels of complexity of this patient group. There also discussions on-going with commissioners re pathway design. In short, the work is gathering momentum, it is as ever difficult to keep up!

**Susan Mizen**
**Talking Therapies Task Force co-chair**
Contact c/o stella.galea@rcpsych.ac.uk

## The Neuroscience Interest Group

**Sue Mizen**

Cynthia Fu, Marcella Fok, Michael Moutoussis, Sarah Srieh and I, later joined by John Hook, set up the Faculty neuroscience interest group in 2015 following the London Conference at which Jaak Panksepp and Mark Solms spoke about affective and relational neuroscience and neuro-psychoanalysis. We wanted to provide a forum for interested members, to find out more about neuroscience and its relevance to psychiatry and psychotherapy; to discuss research ideas and to influence the content of the new Gatsby Welcome neuroscience curriculum. This is the funded project to update the neuroscience curriculum for psychiatrists. We feel it is important that this includes affective and relational neuroscience.

We held a neuroscience interest day at the annual conference each year between 2015 and 2018 with 20 to 35 attendees. We held interest group meetings twice a term and joined forces with the London Neuro-psychoanalysis group for a weekend conference in September each year. We have been part of the neuroscience curriculum advisory group and have submitted questions for incorporation into the MRCPsych exam.

Over the past six months or so we have developed closer links with the London Neuro-psychoanalysis group who have established networks and expertise in neuroscience. We have formed an umbrella organisation with them called The Bloomsbury Neuroscience Group. Our aims are to:

1. Influence the training of psychiatrists and psychotherapists in relational and affective neuroscience through direct teaching and the development of online teaching materials.
2. Funding research grants for original research in relational and affective neuroscience.
3. Providing regular open seminars and courses on relational and affective neuroscience and their applications to psychotherapy and psychiatry.

We hope to organise regular events at the College through CALC and at other venues. The neuroscience interest day could not be held at the conference this year because the date unfortunately fell in the Easter holidays, so we will organise a stand-alone one-day event at the College later in the year. The Bloomsbury Neuroscience Group will be running a conference at the Tavistock Clinic over the first or second weekend in October. Mark Solms will be offering training and supervision to psychotherapists integrating neuroscientific and clinical perspectives.

Look out for advertisements for the future programme of neuroscience events advertised through CALC before the end of the year.

**Susan Mizen**

Contact c/o stella.galea@rcpsych.ac.uk

## CONTEMPORARY PRACTICE IN MEDICAL PSYCHOTHERAPY

# Role Play in the Teaching of Psychotherapy

**Harold Behr**

“You have ideas which are both good and new”, said the apocryphal professor to the student. “Unfortunately, those ideas which are new are not good, while those ideas which are good are not new”. Encouraged by this admonition, I would like to recount one way of teaching trainees about psychotherapy, which, while far from new, has nevertheless aged well over time. I am referring to the experiential technique known as role play, which came out of the psychodrama toolkit in the nineteen thirties and which has since served to inculcate in trainees a spirit of empathy and identification with patients and their families.

Basically, role play teaches trainees to imagine what it must be like to be a patient by fostering a dialogue in which the trainee is invited to speak in the voice of the patient and act as if he or she were the patient in a given scenario.  An exchange which sometimes starts off hesitantly and self-consciously soon takes on a life of its own and bears an uncanny resemblance to actual therapeutic exchanges with all their concomitant emotional colourings.

The tutor has responsibility, not only for structuring the role play in ways which will maximise the learning experience, but for safeguarding the mental wellbeing of the trainee in the process. Embarrassment, unexpected rushes of emotion, inadvertent disclosures of personal issues and feelings of distress which linger after the event are some of the hazards attendant on an emotionally engaging role play exercise. The tutor has to be alert to such possibilities and manage them sensitively if and when they arise.

Forty years ago, I began using role play with small groups of medical students to simulate families in trouble (Behr, 1977). I soon realised that the students, who were steeped in the rigours of a scientific training, were not always receptive to a brand of psychiatry which located disturbance, not only in the individual mind, but in the relationship between people. The notion of intervening in order to influence interpersonal relationships was often alien to these students. In addition, some students frowned on an exercise which seemed to rely on ‘pretence’ or ‘play-acting’ and preferred to be given hard facts which could then be crystallized as knowledge about illness and exchanged for examination credits when the time came. To counter these reservations, I built in a prelude to the role play, consisting of a so-called ‘warm up’, and an aftermath, colloquially referred to as ‘de-roling’ or ‘debriefing’.

There are many techniques for 'warming up' a group in preparation for role-play. The one I settled on was to ask the students to pair up, retire to a private corner of the room and spend a few minutes exchanging anecdotes about an incident which they could recall from their childhood involving an encounter, pleasant or unpleasant, with a health professional. I would then re-convene the group and ask each student in turn to recount for the benefit of the whole group the remembered experience of their partner.

Interesting scenarios would emerge, providing, for example, recalled glimpses of parents being ushered away from the bedside of the child being prepared for the operating theatre, memories of other distressed children in adjacent beds, impressions of soothing but incomprehensible words being uttered by kindly anaesthetists and a range of remembered sights, smells and sounds calling to mind passages from Marcel Proust's '*A la recherché du temps perdu'*. The student narrator would be ably assisted by his or her partner, who was often keen to amplify, amend or clarify the account. This exercise tuned the students in to the world of the child as patient and prepared them to try their dramatic skills for the role play.

For the role play itself I would invite between three and five students to compose a family in which one student was cast as a child who was giving rise to concern and considered to be in need of professional help. To avoid confusion, I suggested that the students should use their own actual first names in the role play but that otherwise they should be as free-ranging and imaginative as they wished in choosing the nature of the problem, the family predicament and the identities of the family members.

In order to model techniques of engagement and so as not to muddy the waters by having to step in and rescue an inept student 'therapist' who might be at a loss on how to proceed, I volunteered to play the part of the interviewing therapist myself. To simplify matters further I would explain that we would be enacting the family's initial visit to the clinic. The students comprising 'the family' were then given enough time (usually around ten to fifteen minutes) to get into role, construct a skeleton identity for each family member, sketch out a brief history of the problems leading up to the referral and decide more or less how they were going to present themselves on arrival at the clinic. The interview would last for about half an hour, allowing enough time for a vivid family dynamic to emerge and for some sort of resolution to take place.

When the students returned to the room, this time in role as the family, they would find the stage set as for a family interview, with play materials and drawing materials set out in anticipation of younger children and the appropriate number of chairs arranged in an inner circle. Taking their cue from me (I would rise and greet them as one would when meeting a family for the first time) the students would immediately enter into the role play with gusto,

revealing a multitude of interactions which would later furnish talking points for the theoretical discussion.

The purpose of the de-roling exercise which followed hard on the heels of the role play was to release the students from roles which could easily linger on beyond the exercise and possibly leave some students uncomfortably close to a situation faced by the simulated family. My technique for this would be to ask each student in turn to think for a few moments about ways in which they were *unlike* the character whom they had just been playing. This often occasioned mirth and visible relief. Even so, I frequently had to correct a drift towards the students stating similarities between themselves and the role-played characters, instead of differences.

One aspect of role play which is sometimes neglected is the involvement of the 'audience', the handful of students who have self-selected to watch rather than to act and whose contribution to the discussion invariably proves enlightening. One way of including them would be to invite them to select a member of the family with whom they could particularly identify, and then offer reasons for their choice. This would typically generate interesting discussions on the family dynamic.

Another way to link the exercise to theory would be to invite comments on my own interventions in role as 'therapist'. How successful had I been in engaging the family? Would the family be likely to return for a follow-up interview? If not, why not? Would another family interview even be an appropriate way forward? I listened with interest to the students' intuitive observations, inwardly acknowledging some of my own blind spots but also looking for opportunities to use the role play as a springboard for discussion on the main avenues of psychotherapy available for children and their families.

Role play can be tailored to the training of professionals from any discipline and in any field of health care. As a teacher and supervisor of trainee psychiatrists and trainees on multidisciplinary advanced courses in family therapy and group psychotherapy I was able to build on the template which I had used for medical students. With these advanced groups, already committed to the practice of psychotherapy, I could pitch the discussion at a more sophisticated level and introduce certain modifications in technique to take into account the knowledge and interview skills of the trainees in their chosen field.

For one thing, advanced trainees were prepared to lay their own skills on the line by stepping into the shoes of the therapist in the role play and opening themselves up to reflections from their colleagues on their interviewing styles and methods of engagement. For another, there would be scope for focusing on specific clinical entities and teasing out their interpersonal ramifications both within the family and the professional network. This would call for some preparation in advance by way of a brief script outlining the issues to be

dealt with. For instance, a trainee might be issued with a basic profile of the 'patient' or the nature of the presenting problem. The trainee would be given the script ahead of the role play to use as a framework, on the understanding that flexibility and imaginativeness should be brought into play and could, if preferred, trump adherence to the script.

As an example, a script might read, 'You are a 55 year old man who manages a supermarket and has recently been made redundant. You have begun to drink excessively and you have been having dark thoughts about ending your life. Make up any other details about your background as you think fit. Your GP has referred you to a psychiatric clinic and this is your first appointment'.

The interviewer might be invited to go in blind, or might alternatively be given a corresponding script reading: 'You are conducting a busy outpatient clinic. This 55 year old man presents with a problem of excessive drinking and suicidal thoughts. Interview him choosing a line of questioning which would point him towards a particular treatment approach to which you have access and which you would recommend.'

Such loosely structured guidelines would lead to lively discussions on the prioritising of different models of therapy, not to mention different techniques of interviewing.

Role play has its place not only in the investigation of diagnostic and therapeutic interview situations but in the wider field of cultural and inter-professional issues. A typical example might be the role play of a hospital case conference surrounding a case of suspected child abuse. The dramatis personae might for instance be the mother of the child, a paediatrician, a child psychiatrist, a police officer, a social worker and a health visitor. A scenario could be prepared outlining a situation in which the child (say three years old) has been admitted to hospital with unexplained bruising which the mother, a sole parent, strenuously denies inflicting. Tension might pivot around the mother's denials of responsibility and her insistence that the child should be allowed home. The role play might include a conflict between the professionals on the wisdom of approving such action. For the role play to work, each of the trainees involved should be assigned a professional identity different to their own, the justification for this being an opportunity to empathise with the professional identity of the 'other'.

Here is an example taken from a course for trainee supervisors of group analytic psychotherapy which hints at both the potential and the complexity of role play.

One of the trainee supervisors is invited to peruse, in advance of the group discussion, a vignette adapted from an actual therapeutic session. The trainee then presents this material to the seminar *as if* the exchanges had occurred in his/her own patient group.

The vignette reads as follows: 'A woman, Lorna, in a group of which you are the therapist, starts a therapeutic session in a state of agitation. She tells you that her seven year old son was mugged on the way home from school by two older boys (of a different ethnic group to herself – make up any details you like about this). She turns to the only man in the group of the same ethnic background as the youngsters who were doing the mugging and says, "No offence meant". The man politely informs her that he was not offended. After a tense silence, there is some general talk about the rising crime rate, how unsafe the streets have become and the need for a stronger police presence. The group then moves to another subject and you are left feeling that you missed an important opportunity.'

By presenting such material at one remove, the trainee is spared some awkwardness and discomfort resulting from peer group scrutiny. Stumbling in sensitive areas of psychotherapy such as ethnic prejudice can be humiliating and not conducive to a learning experience whereas the distance allowed by the role play provides a better opportunity for reflecting on different ways of intervening therapeutically.

I have found over the years, that role playing exercises have invariably added emotional seasoning to what might otherwise have been an intellectually dry teaching experience and that, short of encounters with real-life patients, lessons learnt in this way are more likely to imprint themselves on the memory than the mere delivery of facts and figures, however palatably dressed up they might be.

Reference:
Behr, H.L. Introducing medical students to family therapy using simulated family interviews
Medical Education, 1977, **11,** 32 – 38

**Dr Harold Behr**
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***Editor's comment**:*
*Reading this made me reflect on the current popularity of using actors to play the part of patients in exams and in the recent enthusiasm for teaching through simulation of clinical encounters. Actors playing patients makes the task of the clinician easier in a way, it feels like interviewing a real patient and it means that the task can be standardised, with the actor repeating the same presentation for each candidate. However, as Harold Behr points out, a huge amount of experiential learning goes on when we, as clinicians, act out the role of patient. This gives us a chance to walk in our patient's shoes a little and experience the process of assessment from the other chair. Part of the process of breaking down the barrier between "us and them". Perhaps we lose this if we only use actors to play the patient for us? What do others think?*

*Alison Jenaway*

## INTERNATIONAL VOICES

**Charles Le Grice**

## Psychotherapy – a necessary component of integrative mental health care in an institution – a case study of Institute of Mental Health, Belgrade, Serbia

**Dusica Lecic-Tosevski**

The field of medicine is starting to prove what psychotherapists and their patients knew for decades. In the last couple of years, clinical research has shown that different psychotherapeutic treatments prove useful in treating the majority of mental disorders among both children and adults [Weisz et al, 1987; March et al, 1994; Lindgren et al, 2010; Ritter et al, 2013; Fansi et al, 2015; Horn et al, 2015]. Meta-analytic findings reveal that psychotherapy and pharmacotherapy have similar post-treatment effects for treating mild to moderate depression [Cuijperset et al, 2009] and that the combination of psychotherapy and pharmacotherapy is more effective than monotherapy (psychotherapy or pharmacotherapy) [Cuijpers and Dekker, 2005; Khan et al, 2012; Cuijpers et al, 2014; Karyotaki et al, 2016]. The combination of psychodynamic psychotherapy and pharmacotherapy, when compared to the provision of pharmacotherapy alone, results in a significantly higher remission of depression [Barber et al, 2013]. Modern neuroscience confirms the idea that biological processes mediate the psychotherapy-induced modification of emotion, behaviour, and cognition. Despite the increasing popularity of neuroimaging studies, which evaluate the changes in brain functioning following both psychotherapy [Goldapple et al, 2004; Schnell and Herpertz, 2007; Fu et al, 2008; Schienle et al, 2009] and pharmacotherapy [Bremner et al, 2007; Chen et al, 2007; Haldane et al, 2008; Jogia et al, 2008], it is still unclear whether these two types of treatment share the same neural mechanisms. When reviewing the literature on the neural substrates of psychotherapy and pharmacotherapy, Barsaglini and colleagues concluded that the two therapeutic approaches produce only partially overlapping neuroplastic changes [Barsaglini et al, 2014]. A recent meta-analysis, which evaluated the treatments of depression, confirmed that the two therapies modify different neural structures, and have distinct neural bases [Boccia et al, 2016]. Stahl [Stahl, 2012], an expert in psychopharmacology wrote that "Psychotherapies can be conceptualized as epigenetic 'drugs', or at least as therapeutic agents that act epigenetically in a manner similar or complementary to drugs.

These findings are leading to a paradigm shift in psychiatry such that psychotherapy is experiencing a comeback as various standardized, brief, goal-directed psychotherapies are being integrated with drug treatment of psychiatric disorders by psychopharmacologists who have traditionally relied on a drugs-only approach.”

The aim of this paper is to present psychotherapy practice at the Institute of Mental Health (IMH), Belgrade, Serbia, a leading mental health care institution in the country and the region [Lecic Tosevski, 2014 ].

**Psychotherapeutic modalities**

Since its founding the IMH has implemented individual and group therapies at the outpatient department of the Clinic for Adults, as a part of an integrative treatment approach (psychotherapy, sociotherapy, pharmacotherapy). It was the IMH that hosted the School of Psychoanalytic Psychotherapy, which was organised by the Belgrade University School of Medicine. The managers of the School of Psychoanalytic Psychotherapy were the Institute’s most distinguished psychiatrists and psychoanalytic psychotherapists. The Psychotherapy Department was founded as a separate unit in 1983 and, since then, it operates together with the outpatient department of the Clinic for Adults. At present, the Institute has fifteen educated and certified psychotherapists of different orientations, excluding the family systemic therapy: psychoanalysis, psychoanalytic psychotherapy – group and individual, analytic psychology (Jungian analysis), rational-emotive behaviour psychotherapy (REBT), and cognitive behavioural therapy. Seven psychotherapists work at the psychotherapy department, and the rest at the Clinic for Children and Youth. Three psychotherapists are psychiatrists (out of whom two have PhDs), four psychotherapists are psychologists (two with PhDs). As all these psychotherapists are employed at the Clinic for Adults, they are only partially engaged in the psychotherapy department, one day during the working week. To our knowledge, there is no other health institution in the region where psychotherapeutic treatment is organised and implemented as a separate organisational unit.

Apart from the psychotherapy department, the institute, since 1996, also has an outpatient department for Couples and Family, which is staffed by family systems therapists. The multidisciplinary team of that department offers different diagnostic, therapeutic, counselling, and psychoeducational interventions, the goal of which is to protect the families in various aspects, including both therapeutic and preventive ones. The activities include the provision of couple and family therapy, counselling for families, counselling and psychoeducation for parents, and a psychoeducational group for parents of mentally ill children. Since 1996, the institute also provides a four-year education programme on family systems therapy, which is, since 2003, accredited by the European Association for Psychotherapy. The family systems therapy is also implemented at the institute for treating alcoholism and addictive disorders. There is a total of 17 family systems therapists at the

Institute. At the day hospital for adolescents, the institute implements an integrative psychotherapeutic approach for treating adolescents with various emotional disorders (milieu psychotherapy) [Bradic et al, 2016].

**Procedure**

Before the initiation of treatment at the psychotherapy department, a psychiatrist makes an initial evaluation of a patient's suitability for psychotherapy. If the psychiatrist concludes that the patient is suitable and fulfils the necessary preconditions for psychotherapy, the patient is referred to a psychotherapist. There are clearly defined inclusion and exclusion criteria, relating to patients' diagnosis and personal characteristics, which can be found on the institute's official website: https://imh.org.rs. The conditions that are not treated within the Psychotherapy Department include addiction disorders, psychotic disorders, intellectual disabilities, eating disorders in an acute phase, antisocial personality disorder, organic mental disorders, as well as individuals with suicidal tendencies and auto-destructive impulses. The final evaluation of the patient's suitability for psychotherapy, as well as a decision on the appropriate form of psychotherapy, is made by a psychotherapist during the first two sessions. If there is a need for a group-based consideration of a given patient (at the beginning of treatment or during psychotherapy), the team of three psychotherapists is brought together. In order to provide the possibility of psychotherapy to as many patients as possible, all psychotherapeutic modalities are time-limited. The short form of individual, dynamically-oriented psychotherapy (Jungian and psychoanalytic psychotherapy) is provided for 24 sessions, and each session lasts for 45 minutes. Group analysis lasts for two years (the group has 6-8 members), and each session lasts for 90 minutes. The duration of REBT is from 3 to 24 sessions, with each session lasting for 45 minutes. Given the high number of patients who require psychotherapy but do not have sufficient introspection abilities or are not suitable for specific psychotherapeutic treatments, individual psychotherapists additionally provide dynamically-oriented psychotherapy (10 sessions of 30 minutes duration). All therapies take place once per week. Psychotherapy, as a health service, is covered by the Insurance Fund of the Republic of Serbia and is accordingly charged and invoiced by the Institute of Mental Health.

Since 2015, researchers at the institute conduct longitudinal, prospective research (approved by the institute's Ethics Committee) on the effects of psychotherapeutic treatment on psychiatric symptomatology, defence mechanisms, and quality of life. The institute is also planning to initiate research on the effects of psychotherapeutic treatment on various biological correlates of mental disorders.

During four years, between January 2015 and December 2018, there was a total of 6.036 initial psychiatric examinations at the Outpatient Department of the Clinic for Adults, out of which 4470 were patients with nonpsychotic disorders. Within the same time-frame, 461 patients started the psychotherapeutic treatment. There was a total of 189 patients who

underwent short-term psychoanalytic psychotherapy, 31 Jungian psychotherapy, 22 REBT, 47 group analysis, 66 an individual family systems therapy and 116 patients who underwent psychodynamic-oriented supportive psychotherapy.

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## CONFERENCE REFLECTIONS

## Reflections on small groups as part of the Medical Psychotherapy Faculty Conference Programme – Cardiff 2018

**John Hook**

**Practicalities**

Getting the set-up of small groups right can significantly affect the quality of the experience as poor management unnecessarily interferes with the group dynamics which are problematic enough without making them more complicated! There were a number of lessons which we learned from Leeds 2016. We were able to put these into the planning for last year and as a result we were able to provide an improved experience for the majority of attendees. The overall experience was a positive one with good engagement and lively discussions.

Some issues remain to be resolved. The main problem in any venue is finding enough appropriate rooms in which to hold the groups. Here we had two groups taking place in the main auditorium, two in the lunch room and one in the bar. This created difficulties in putting the chairs out and putting them back when other events were taking place immediately before and afterwards. The 'bar' group was in a public space with people walking past. It was difficult to hear each other as the dishwasher was running right behind us! Groups which shared a room and in public spaces were adversely affected by these factors. It did help that the conference venue was in a self-contained area. One room was being used by the venue for its own staff meeting and had we known in advance we might have been able to book this for one of the groups which we did on the second day. It is beneficial when each group has its own space. I appreciate there are financial implications in a conference which needs to break-even but this has to be balanced by providing an adequately contained experience if everyone is to benefit positively from the group component of the conference.

The issue of external speakers was less of a problem this year as a good number of the speakers were Faculty members and therefore attended the whole conference. We specifically asked each speaker if they wished to be in a small group so we didn't have

empty chairs for them. There are particular dynamics around having speakers in the groups but my preference is that they should be encouraged to be full members of the conference.

We changed the timing of the groups so that they occurred immediately after lunch as opposed to last time when one day they were at the end of the day. Unsurprisingly a significant number of people went home early then. Holding them in the middle of the day led to a much-improved attendance. Many more people attended both days so we only needed two groups for one-day attenders. Both were better attended than at Leeds.

The preparatory handout was raised. Some reported they had not read it nor needed the guidance. I wrote it in reaction to the prolonged absence of groups as part of our conference learning experience and my growing impression that groupwork is less in evidence in our practice. I may be wrong. I would be pleased to know what people think.

**Content**

One of the central themes, as in Leeds, was that of the professional identity and role of the Medical Psychotherapist. There was unsurprisingly ill feeling about the over-involvement of management in clinical decision-making, lack of support felt both by trainees and consultants, lack of proper supervision, lack of resources (e.g. pertinently the paucity of psychotherapy in Wales), hot-desking, poor administrative support, splits in physical and mental health services and the anger, devaluation and demoralisation these brought. There was a sense of threat to identity as doctors, psychiatrists and psychotherapists. Psychotherapists felt themselves to be bottom of the pile. A medical student perceptively asked if we could link these changes to patient outcomes. It’s a good project!

On the other hand, it seems attendees valued and appreciated the chance to share these difficulties. Trainees appreciated the chance to talk with consultants and hear their anxieties, finding this containing in contrast to what some consultants feared. There was humour and warmth and examples of initiative-taking e.g. accessing support through external supervision and how continued thinking about services and research could militate against a sense of helplessness. He felt the College could do more by bringing patients on board. Surely, we need greater emphasis on how we can positively influence the environments we work in.

There was a sense of cohesion in expressing frustrations, anger, fear, sadness in face of cuts and feelings of helplessness. It highlighted the need for resilience, and how continuing dialogue can support us in our roles.

The talks were touched upon in most groups but overall appeared to be secondary to the difficulties of the work environment. There was most interest in the idea that psychedelic

drugs may prove helpful in mental disorders, but it also raised some hackles about pressure to accept compromises with the 'purity' of a psychotherapy model. It's an age-old problem that potential advances cause anxiety to established thinking, to my mind linked to the anxieties about identity. The topic of immigration was little picked up – strange in the current Brexit environment and considering the international nature of staff in the NHS!

My thanks to my fellow group conductors: -

Anthony Ang
Radha Bhat
Chris Holman
Chris McGregor
Diana Menzies
Steve Pearce
Mike Rigby
Jenny Stansfield

**John Hook**
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## Psychodynamic Psychiatry Event for Non-Medical Psychotherapist Colleagues

**Jo O'Reilly**

This event was held at the Royal College of Psychiatrists on 8th November 2018 and was organized by Dr Jo O'Reilly and Dr Rachel Gibbons, with support from Dr Maria Eyres the academic secretary of the Psychotherapy Faculty.

During the day consultant psychiatrists who are also psychoanalytically trained gave a series of talks seeking to understand aspects of how patients present and relate to staff within psychiatric teams from a psychoanalytic perspective. Dr Rachel Gibbons acted as chair for the day and introduced the day by describing the importance of psychiatrists being able to reflect about their work and the impact of working with severe psychological disturbance on teams.

The first talk, entitled *The Maternal Lap and The Mental Health Trust* was given by Dr Jo O'Reilly and was based on a book chapter she had written about maternal function in psychiatric care. The processes of containment as being crucial in psychological

development from early infant life and also to recovery from crises in adult life and in psychiatric breakdown was described. The importance of approaching psychiatric care from a receptive and responsive state of mind able to think and to process our patients' communications, referred to in the talk as a concave state of mind was discussed. Unconscious processes and the risk of countertransference enactments informing care within mental health teams were illustrated with clinical examples.

In the second talk entitled *Historical Childhood Sexual Abuse; it's Effects on the Mind and Body* Dr Maria Eyres spoke about the devastating impact of HCSA at an individual and societal level and gave an update on the impact of trauma on the brain and on mental and physical health. A historical perspective on trauma from Freud to Bessel Van der Kolk was outlined along with the ways in which this topic has always tended to be met with a 'blind eye'. As an area of key importance to psychiatry, Maria talked about working with patients who have been sexually abused who present to mental health services and the kinds of countertransference issues which can arise. The morning ended with a discussion with the audience.

After lunch we had talks from psychoanalysts with experience of working in forensic settings. Dr Carine Minne spoke about her work at Broadmoor Hospital in a talk entitled *Understanding Homicidal and Suicidal Urges; A Psychoanalytic Perspective*. Carine described a clinical case of matricide she had been working with and the limits of psychiatric diagnosis in capturing the highly complex and changing states of mind one is working with in severe disturbance. This was followed by a talk by Dr Rob Hale, *Understanding the Pre-Suicidal State of Mind* based on his extensive work with suicidal patients and staff affected by the suicide of patients in their care.

The day ended with a lively plenary session in which many points were raised for further consideration, particularly around issues of risk, clinical pressures, fragmentation of teams and challenges to offering continuity of care. A theme which emerged during the day was the importance of the relationship between psychiatric team members and their patients and how difficult this can be to preserve and prioritise within the structure of services.

This was the third successive year that we have run a psychodynamic psychiatry event at the Royal College and the event has really grown. This year it was fully booked some weeks in advance with an audience of 130 psychiatrists from across the country and working in a range of psychiatric specialties. We offered a small number of reduced cost places for medical students. Feedback from the day was extremely positive with a number of requests to run the event more frequently. It seems there is a real appetite amongst psychiatrists for the opportunity to think more deeply and from a psychodynamic perspective about their patients and also for space to address the impact of working with psychiatric illness on staff.

We are very grateful to Emma George and the CALC Team at the College for their support of this event- which also contributes to psychiatrists CPD. In addition, the event raises money which the Medical Psychotherapy Faculty is able to put towards a range of projects.

***The next Psychodynamic Psychiatry Day is on Friday 1st November 2019 at the Royal College of Psychiatrists.***

***Jo O'Reilly and Rachel Gibbons will also be presenting a psychodynamic psychiatry workshop entitled From the Nursery to PICU- What went wrong? A Psychodynamic approach to Mental Illness at the International Congress on 4th July 2019.***

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## TRAINEE VOICES: MEDICAL PSYCHOTHERAPY TRAINEES SECTION

**Alasdair Forrest, Michael Milmore**

The trainee voices section this time has a focus on reflective practice in the broadest, but also most essential, sense. John Gossa, who has just started as an ST4 in Medical Psychotherapy in Glasgow, has written about reflective work in an inpatient unit for young people while my colleagues in Aberdeen, Fifi Phang and Ehino Mallum, have written about their reflections on the RCPsych in Scotland Faculty of Medical Psychotherapy annual conference. Rajiv Shah writes in a forceful way about the value of the reflection that comes from personal therapy.

My co-editor for the Trainee Voices section, Michael Milmore, has written about the experience of moving from Scotland to Yorkshire, where he is now in the ST5 year of his dual training in General Adult Psychiatry and Medical Psychotherapy.

There is, because of this, a bit of a Scottish theme in the Trainee Voices section this time. Of course, we welcome contributions from any part of the country. As the northernmost Psychotherapy registrar, though, I am not immune to some parochialism, so here it is. I think the most imaginative living Scottish writer is Alasdair Gray. He is not a psychotherapist but like a lot of writers he thinks like one. The epigraph on one of his books quotes Alan Jackson: "Truly the remedy's inside the disease and the meaning of being ill is to bring the eye to the heart".

I think it is easy in a pressurised system to focus only on the painful aspects of our reflective work. I am not sure that our training is really about that, though. Maybe at times, by reflecting on the problems in our work and with our patients, we can reveal something about what matters.

Symptoms are, after all, communications. All our authors this edition remind us of the value of that special kind of listening that we need to develop to understand these inarticulate communications and turn them into something useful: something that is in service of the patient and of healthy ways of being and relating.

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## Multidisciplinary reflective groups in a Low Secure CAMHS setting

**John Gossa**

Following Core Training, I was interested to spend some time out of programme to see how psychotherapy practices from my training thus far might be applied to other clinical environments. I undertook an Associate Specialist post at a Low Secure (Tier 4) inpatient adolescent hospital, with a particular curiosity about the ways in which psychotherapy might be brought to bear in a CAMHS setting. The unit was a female-only service, with the predominating clinical presentation being risk to self.

A particular, though by no means unfamiliar, clinical culture had developed in response to risk. Frequently attempted self-harm or fatal self-injury reinforced the primary task of patient safety and longitudinal reduction of risk over time. However, risk management had a generally reactive air. Unrippable 'safety suits' were used in response to attempts to fashion ligatures from clothing or, at times, when such was deemed likely though not immediate. Psychological interventions focused on risk and were primarily implemented at the behavioural level. Positive Behavioural Support was the primary model in service, with the suggestion that other therapies should similarly adopt a more behavioural approach, including family therapy, despite its systemic orientation. Mood stabilisers and antipsychotics, including Clozapine, were frequently used for impulsivity and anxiety associated with self-harm and suicidal features.

During supervision, I was advised that inurement to patient distress, self-harm and reliving of traumatic events was inevitable and, to some degree, a welcome part of making the job easier. I felt encouraged to avoid reflecting on my clinical encounters, and the case-based discussion groups from Core Training felt like a distant pocket of indulgence against the immediacy of the ward environment. Yet there was a dissonant incongruity emerging in how we, as a team, were thinking about these young people. Severity of risk mandated interventions at the level of the pharmacological, behavioural and sometimes cognitive. Yet when we formulated the difficulties of these individual patients at clinical reports and meetings, we did so in a way that was largely psychodynamic - though a psychodynamic therapeutic approach was very rarely instituted, let alone formally. Where was there room for such an approach, where the prevailing culture reflected an understandable 'not on my watch' attitude?

In the Winter/Spring 2018 Newsletter, Dr Burbridge-James emphasised the 'powerful reflective space' within the Balint group particularly in situations that carry clinical risk and risk of blame. I observed a similar need on the wards but learnt that, while there were monthly nursing meetings and informal case presentations, there had never been an attempt to open a reflective group. I suggested to the clinical psychologist that we organise a staff Balint group. We felt confident that opening a forum for psychodynamically-informed

reflection would allow for insight into symptomatology or transferential exchanges, but we also hoped that it might benefit staff working in a clinical context that can often feel demotivating or disheartening.

The Balint group started as an open group with a standard weekly format. However, in beginning to organise this, it became clear that some flexibility would be needed. All clinical staff were invited to attend as and when they able, and this invitation was extended to all staff working regularly with the young people at the hospital and included teaching staff from the on-site school.

The date for the first meeting approached. We were excited and optimistic, but how did others feel? I put together a brief questionnaire for members to complete before attending their first group.

Questionnaires were kept anonymous, but members were able to indicate their role if they chose to. All did so: 6 nursing staff (nurse or support worker), 4 therapists (art therapist, assistant psychologist, occupational therapist or assistant occupational therapist), 1 social worker and 1 teacher completed initial questionnaires.

The questionnaire put forward the following statements, with responses on a seven-point Likert scale (1=strongly disagree, 7=strong agree). Twelve questionnaires were collected. Results are included below as a range value:

1. In order to work effectively with patients, I need to keep my emotions to myself **(Range 3-7, Average 5.1)**
2. Talking about work with peers is only useful if it improves my practice **(Range 1-6, Average 2.5)**
3. Reflective activity, such as groups, are only for people who struggle at work **(Range 1-6, Average 1.5)**
4. How a professional interacts with patients depends on the kind of person they are **(Range 1-7, Average 3.9)**
5. Sometimes I feel angry when I think about the patients I work with **(Range 1-5, Average 3.0)**
6. How I feel on a particular day can affect the way I interact with patients **(Range 1-5, Average 3.3)**
7. Sometimes I feel upset when I think about the patients I work with **(Range 1-5, Average 3.3)**
8. Understanding how I feel in response to the patients I work with is important **(Range 4-7, Average 5.4)**
9. Processing difficult emotions is all about letting off steam **(Range 1-6, Average 2.9)**
10. Sometimes a patient's relationship with staff can resemble a different relationship from their personal life **(Range 2-7, Average 5.4)**
11. I feel like I have space to discuss difficult feelings that arise from my clinical work **(Range 1-7, Average 4.2)**
12. Thinking about my experiences working with these patients can help me to learn more about myself **(Range 4-7, Average 5.5)**

There is perhaps much to be made of bias here, not least because only those attending were given questionnaires. Nonetheless, we took responses to show a general appreciation of the value in reflective practice.

As might be imagined for a busy inpatient unit, the group constitution varied significantly. Attendance was usually 3-6 participants, though work patterns meant that participants were often unable to commit to weekly attendance. It was very difficult to plan individual presentations in advance and most felt uncomfortable presenting in this way. We afforded the groups more flexibility and, if no clinical encounters were offered, discussion was allowed to begin spontaneously and evolve. It was tempting to interpret this as digressive and lacking focus, however we noticed that keeping to a single presentation required significant direction which limited member interaction and risked bringing an overly didactic feel to the group. The purpose of the reflective group was nonetheless maintained, particularly as distinct from a forum for problem-solving. Without a presenter, one member of the group would instead suggest a recent incident, interaction or outcome to talk about. Initial discussion from several members would then furnish this focus with additional details.

Some groups maintained this focus. Others opened into broader themes with limited recourse to the initial starting point. On one occasion, a participant raised the subject of a formal complaint recently received from the parents of a patient. Many were disappointed with the complaint and how this was being dealt with, but rather than enter into discussion about clinical management, the group brought related experiences of complaints from parents. Soon we were presented with an image of the ‘trying child’ hidden behind the ‘difficult parent’. With this collection of clinical experiences before us, we discussed how a child’s admission might leave parents feeling not ‘good enough’, having been stripped of their capacity to contain, and how seemingly unfair complaints might be understood in terms of guilt or transference. We considered the child who recognises that they cannot be cared for at home and the depressive guilt that may follow. Despite the position of inpatient services to offer help at times of crisis, we reflected on our own feelings of helplessness in looking after many of these young people - those same feelings that perhaps we shared with many of their parents.

While it usually happened that this sort of discursive movement reached a relevant theme with emotional reflection, we acknowledged that the group sometimes used a sense of free association to reach it. However, this meant that the group often touched upon tensions not only within their own roles, but embedded within the theoretical and systemic structures in which we worked. What motivation was there to understand patient difficulties when primacy must always be given to risk? And what need was there to understand disturbed object relations if doing so did not alter treatments and outcomes? What about the moral language that often crept into risk-related behaviour, equating ‘good’ with ‘safe’? Would clinical restrictions be perceived as punishments? Were we using that depressive guilt to manipulate patients into safe behaviour?

Discussions varied significantly both in terms of their form and content, and it was clear to us that the group had different functions depending on its constitution on a given week. Groups comprised of colleagues who more frequently worked together highlighted the use of reflective practice in positively impacting motivation and wellbeing. The initial survey responses generally anticipated the potential for this, and feedback from participants' initial group was positive:

| 1. Would you recommend this group to a colleague? Yes (9)/No (0)/Maybe (2) |
|---|
| 2. Was this your first time to attend a reflective group? Yes (10)/No (1) |

**Using a Likert scale (1=strongly disagree, 7=strong agree):**

| |
|---|
| 3. Discussing our experiences in reflective groups can make work more enjoyable (Range 4-7, Average 6.3) |
| 4. Discussing personal experiences in reflective groups has the potential to improve my motivation at work (Range 2-7, Average 6.2) |
| 5. Reflective groups can help me understand some of the difficult feelings I experience at work (Range 5-7, Average 6.0) |

Further feedback was available through additional comments:

- 'I like the fact it is not solution-focused but the coming together of staff to reflect and share their views and knowledge'
- 'Brings staff together'
- 'It's interesting to hear other people's perspectives and makes you think widely'
- 'Joined up thinking, venting frustrations'
- 'Honesty'
- 'Giving people the chance to say their minds'
- 'That the medical team are with us'
- 'The whole group being able to discuss issues'

This additional feedback suggests that some of Yalom's therapeutic factors were at play, particularly *catharsis*, *cohesiveness*, *imparting information*, and *universality* through parity between the experiences and perspective of different members of the team. Anecdotally, I would be tempted to say that the groups allowed for easier subsequent clinical discussions even during pressing clinical situations.

On leaving the post, I discussed the groups with the new family therapist, trained in psychoanalytical group work. She was enthusiastic to continue the groups, although at once favoured the more traditional Balint model against our flexible, inclusive approach. Thus, the tension between the two remained.

In light of the benefits of reflective practice, we must ask whether reflective practice should be given grounds directly within the clinical setting rather than limited to a component of clinical training. However, what form this takes remains a point of discussion. Flexibility and

inclusivity needn't be at odds with a more standard model, but this gives us more to consider. If the group aims primarily to boost team cohesiveness and wellbeing, might compassion-focused groups such as Schwartz Round be better positioned to achieve these aims? Is clinical awareness of psychodynamic theory suited to all members of a hospital team, even where roles differ greatly? Can we assume that this contributes to a Coordinated Management of Meaning, systemically understood, or might this lead to confusion for some members?

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## Games and Thrones: The Systems in which we Live
## RCPsych in Scotland Faculty of Medical Psychotherapy Annual Conference

**Ehino Mallum, Tze Hui Fifi Phang**

**Games and Thrones: The Systems in Which We Live**
**RCPsych in Scotland Faculty of Medical Psychotherapy Annual Conference**
*My colleagues, Ehino Mallum and Fifi Phang, attended the annual Scottish conference. It has run for many years, and a highlight they describe this year was the Systems-Centred Approach demonstrated by Rowena Davis. This approach, developed by Yvonne Agazarian, helps us to think about patterns of communication in the group as a whole, and how we are constituted by being in subgroups and by their relationship to the whole. This year's Scottish conference, in September, will be held jointly with the Faculty of Perinatal Psychiatry —Alasdair Forrest*

Pitlochry – one of Scotland's most beautiful and restful places - once again provided the stunning setting and background to this year's RCPsych in Scotland Medical Psychotherapy conference. This year, the magnificent Victorian Atholl Palace, once popular as a holiday and health destination, opened its doors to delegates and speakers from around Scotland and beyond.

For many, this is a yearly opportunity for connecting with colleagues around Scotland and it also serves to provide an experience that many have found to be useful and educational.

This year's conference was entitled "Games and Thrones: The systems in which we live." The conference kicked off on Thursday 15th of November following the Faculty Annual General Meeting in the morning. Marcus Evans, author of "Making Room for Madness in Mental Health" presented two talks that generated much discussion on current psychiatric systems in the NHS – clinicians' relationships with patients and clinician's relationships with one another and the usefulness of reflective practice for clinical work and organisational dynamics. By using three detailed case examples from his experience as a senior clinician of the Fitzjohn's Unit, he demonstrated the importance of tuning into psychotic communications. This provided an opportunity for a better understanding of our patients' psychotic defences and how these may provide insight into patients' internal worlds. This was a valuable lesson on how psychoanalytic thinking can be usefully applied in the delivery of good psychiatric care!

Marcus spoke of psychoanalytic processes in relationships between senior management and front-line staff and his talk resonated with many delegates working in various hospitals around the country. In light of the financial cuts experienced by the NHS, it is evermore essential that reflective practice and supervision is not lost. We recognise that good management and leadership continue to be the main ingredients to build morale at work as well as maintain quality clinical care provided to our patients.

The evening ended on a high note with a lovely dinner after which delegates were able to explore the beautiful grounds of the hotel and its surroundings.

The second day started with a talk presented by guest speaker Molly Ludlam entitled Open systems – Open sesame? The challenge of freeing psychoanalytic thinking to help unlock impasse in intimate relationships. This was a very stimulating lecture that presented the use of the psychoanalytic approach and principles in dealing with problems faced by couples in relationships. The lecture also opened up the discussion about the role of the psychoanalyst in maintaining free thinking in situations of impasse. This lecture was very well received and led to a lively discussion at the end, with questions and comments from the audience.

In the second half of the morning Rowena Davis introduced the delegates to Systems-Centred functional subgrouping, which is based on the Theory of Living Human Systems developed by Yvonne Agazarian. The concept of groups as whole systems with subgroups of different functions was presented and this made for interesting discussion and contemplation. There was a short experiential group session with 10 volunteers facilitated by Rowena, utilizing the principles of systems-centred approach. Participants initially showed mixed reactions to this approach to reflective thinking and group work. However, it was very interesting to observe the evolution of the group and different opinions and emotions about this.

After lunch, Rowena facilitated a second experiential group session with a much larger group of delegates. Following this, there was a whole-group session with delegates reflecting on their experience at the conference, which was primarily positive.

There was a vote of thanks from the Faculty Secretary, Dr Adam Polnay and the Faculty Chair, Dr Marina McLoughlin. We are already looking forward to next year's posters and presentations, and hope to have another exciting conference where like minds come together.

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## Strengthening the Foundations of Psychiatric Training

**Rajiv Shah**

Mental health has been deemed a priority with only words and little action. These conditions are contributing to a shortfall in recruitment and attrition of working colleagues to burnout. Psychiatric training aims to empower us, as future leaders in the NHS, to utilise resources effectively. The financial costs of training doctors are recognised as necessary expenses to nurture the leadership required to provide quality care. Unfortunately, the emotional burden on professionals, as a result of increased expectations of a society waking up to its mental health, may be reflected in our dwindling workforce. Supporting colleagues through the difficulties they encounter in both their clinical and personal lives are essential in maintaining an enthusiastic, engaged and cohesive workforce. Senior support through regular supervision, development of a professional community and protected time for learning and reflection have been cited as important factors in helping trainees feel supported and valued. Unfortunately, these recognised supports are not offered consistently in training programmes throughout the UK. So how can the RCPsych allocate resources to improve access to these valuable assets? Or promote additional opportunities for reflective space that may help support colleagues to avoid burnout? We should be advocating that the profession collect trainees' views of psychiatric training on their health and explore the potential role of personal therapy in supplementing their training.

Supporting trainees to undertake an experience of personal therapy for personal issues or professional development could strengthen self-reflective skills. If the RCPsych supported and valued formalised self-reflection and invested in opportunities for trainees to undertake personal therapy, it would likely promote an environment within which trainees can be open and curious of the difficulties they encounter. It would promote a culture of reflection that could strengthen the foundations of future psychiatrists, potentially improve the well-being of our young professionals and ultimately those they serve.

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## I hear there are people who actually enjoy moving. Sounds like a disease to me…

**Michael Milmore**

***I hear there are people who actually enjoy moving. Sounds like a disease to me …***

I simply couldn't sum it up better myself! It's been something on my mind now for just over a year when the higher training posts were released in the national recruitment programme. I remember waiting for the release of the number of posts, then their locations and later still my national ranking with offers. I had told myself I'd move anywhere for my dream job…I'm not sure if I meant it though!

It has now been close to a year since I made the journey across the border seeking southern skies and I find myself rather reflective. Perhaps it is the ARCP catharsis or even the wistful anniversary; regardless I wonder if there's something in the change? In short, I got my desired dual post and it came with a double edge as a bonus.

Spending my training in a Scottish system, my personal and professional growth was entwined with a sense of community, frankness and also a darker humour. I never appreciated, though, how specific this mix is to this culture. Knowing it from young, I wonder if I was impervious to how it permeated the NHS culture here too. It may not sound it, but this rare alloy brings benefits in abundance with the Scottish NHS having one of the world's best Patient Safety & Quality Improvement (PS&QI) cultures along with an ever-refining efficiency that delivers heartfelt quality to all. So perhaps not all shortbread and Irn Bru then?

*And the danger is that in this move toward new horizons and far directions, that I may lose what I have now, and not find anything except loneliness. — Sylvia Plath*

With high anxieties whilst moving and settling, I fantasised about a desolate disaster; what I found though wasn't that but something rather different. Meeting the border first I immediately met the change and although not as stark or controversial (especially now) as the Irish border was to me growing up it still draws a line in the sand. The people, topography and culture all change from this point. Coming from a smaller more homogenous area the diversity is more easily noted. This said, so too is the disparity. Equally, there are benefits such as the tendency to start and end each communication with a polite declaration.

It's the last point that reminds me of another big change: a shift to a more conservative one. This brings with it at times, a secondary aggressive defence as each fights for their own and not for a whole. This to me is the biggest difference in health systems. A historic move to market forces down south has left its legacy. Bringing a wider awareness of management and resource allocation has its benefits but also its drawbacks. With this other thing more in mind I wonder if what is drawn back is the space for something else at the coalface?

I suppose it's all a question of balances in different senses and perhaps in different ways. I couldn't honestly avow one over the other but what I can declare is that seeing another way has given me something to consider and if nothing else driven home the importance of balance. Whether balancing healthcare systems, interventions or more complexly the time to care, affirms its importance. For me, for now, just balancing countries will have to be enough!

I'll end this piece with a final nod to the literature that inspired it. Although I do accept that *A Caravan of Moroccan Dreams* by Tahir Shah isn't quite as fitting as perhaps Little Britain may be, I do think overall there can be some mileage in a move.

*Settling into a new country is like getting used to a new pair of shoes. At first they pinch a little, but you like the way they look, so you carry on. The longer you have them, the more comfortable they become. Until one day without realizing it you reach a glorious plateau. Wearing those shoes is like wearing no shoes at all. The more scuffed they get, the more you love them and the more you can't imagine life without them.*

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# BOOK REVIEWS

**Dan Beales and Andrew Shepherd**

## Call for book reviewers and contributions

The book review section is a recent addition to the Faculty newsletter. Thus far, the section has been somewhat ad-hoc, but we are hoping it may be possible to grow and develop it further in the future. For this to happen, we need contributors and fellow bookworms. We have a number of ideas on how this section could be developed – two examples of these are review series addressing a theme or debates. We are therefore keen to hear from you - either if you have an idea for a review, 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 and get in touch.

Andrew Shepherd and Dan Beales
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# EVENTS, NOTICES AND DATES FOR YOUR DIARY

**Medical Psychotherapy Faculty Annual Conference**
Creative and Destructive Forces in Groups; Clinical Settings, Organisations and Society
Date: 10 - 12 April 2019
Venue: Royal College of Psychiatrists, 21 Prescot Street, London E1 8BB
Information and registration

**Medical Psychotherapy and Perinatal Faculties Joint Conference**
Date: 11 October 2019
Venue: Royal College of Psychiatrists, 21 Prescot Street, London E1 8BB
Further Information and register your interest

## YOUR CONTRIBUTIONS TO THIS NEWSLETTER ARE WELCOME

We encourage you to contribute to the dialogue. Please send contributions for the next newsletter by the deadline of 30th September 2019 c/o stella.galea@rcpsych.ac.uk

## CONTACTS

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