

Faculty of Medical Psychotherapy Executive Committee

Chair: Steve Pearce, Oxford

Vice Chair: Jessica Yakeley, London

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Editors' Welcome

Alison Jenaway



This Newsletter is a strange Hybrid creature, as it was prepared and almost ready to go before the announcement of the “Lockdown” due to Covid 19. As a mostly retired clinician, I have been working completely from home, like many others, and was leaving the Newsletter in the hope that things would soon be back to normal. It is now clear that there is a new normal and we will all be having to cope with new ways of working for some time. I have therefore invited some of the Faculty executive to update, or add to their original reports to members, but the other sections remain as they were. I am sure that the next issue will be full of virus related

reflections and experiences but I hope that you may enjoy the other articles in this issue as a glimpse into the past before any of us had even heard of Coronavirus or R numbers! Do send in any comments about the articles in this newsletter, new thoughts about your own work in the online age, Virtual CPD and conference reflections or book reviews for the next issue by the deadline of 14th October 2020. Above all, stay safe and look after yourselves.

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Message from the Chair of the Faculty of Medical Psychotherapy

Steve Pearce



Dear Faculty members

Times are difficult for many of our members, and our patients. This has necessitated new ways of working for most of us, and an increase in busyness for many.

The Executive of the Faculty has been meeting weekly via video-calling since late March. This has been a productive time, during which members have been involved in various Covid initiatives at

the College.

Initial shutdown of services has mostly been reversed, and although some staff have been redeployed, our impression has been that many Faculty members have seen their departments adopting innovative ways of carrying on their work. Increasingly Trusts have recognised that not continuing psychological work will provoke crises in the short term and store up problems in the long term, as well as impacting waiting lists.

Members of the Faculty have produced and collaborated in several sets of guidelines and statements for working during the Coronavirus outbreak. These include Faculty guidance sent to all Faculty members on 16th April, and the document *Organisational Wellbeing During the Covid-19 Pandemic; A Guidance Document*, available on the College website. Members of Faculty executive are currently working on a document on good practice in online therapy, which should be available imminently. You will receive separate notification of this.

Several faculty members have become involved in staff support for those working in acute Trusts as well as mental health Trusts. Questions have been raised about whether the requirements for training, such as Balint groups, should be relaxed – with the answer that, if anything, these kind of groups are more important now, and a relaxation of requirements would not be appropriate. Guidance about training during the outbreak can be found here: [COVID-19 and Psychiatric Training](#)

After a long period of inactivity the Faculty email list sprang into life in early April, as the only practical way for large numbers of Faculty members to keep in touch. This is

particularly focussed on those working at least part of their contract in a medical psychotherapy role. The list has now been taken 'in house' and will be moderated by the vice chair, currently Jessica Yakeley. It provides an easy way of keeping up to date with developments in online therapy, online assessments, staff support, trainee issues, and other developments during this time when conferences and face to face meetings are not possible. If you would like to be added to the list email Jessica at jyakeley@gmail.com

The 2020 conference has been cancelled, as have all RCPsych conferences until the end of 2020. The Faculty took the decision not to roll over the Oxford conference, but to hold the 2021 conference in London as planned. This has left us with costs, but we are in a financially secure position and are confident we can absorb this. In the meantime our academic secretary Maria Eyres and her team are looking at producing some webinars to attempt to at least partially compensate for the loss of the conference.

The first small project grants have been approved. Congratulations to:

Dr Dimitrios Chartonas, 'Time to think' – psychoanalytically-informed reflective practice group for GPs in the London Borough of Islington (Camden & Islington NHS Foundation Trust, Islington Practice Based Mental Health Service)

Dr Frederico Magalhaes, Provision of psychotherapy to psychiatry core trainees (Oxford Health NHS Foundation Trust/Thames Valley Deanery)

Dr Giovanni Polizzi, Developing a short psychoeducational intervention for patients presenting to short term support services with self-harm and emotional instability (Lambeth Integrated Psychological Therapy Team (IPTT), South London and Maudsley NHS Trust)

Finally, my very best wishes to all Faculty members during these trying times.



Steve

Dr Steve Pearce

Faculty Chair

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Message from Vice Chair of the Faculty of Medical Psychotherapy

Jessica Yakeley



I was pleased to contribute to this issue of the Newsletter, in February 2020, as acting Chair of the Medical Psychotherapy Faculty, whilst the Faculty Chair, Steve Pearce, was on leave.

There have been several important developments relevant to the Faculty since the Autumn newsletter.

The College Personality Disorder Position Statement has now been published following its successful launch in January at a meeting chaired by myself, Oliver Dale, Rex Haigh and Julia Blazdell. This meeting was attended by key figures within the personality disorder field, including College members who had contributed to the document, as well as psychologists, service users and commissioners. The statement is the result of a cross-faculty working group convened by the Medical Psychotherapy Faculty in 2017 and sets out the Royal College of Psychiatrists' views on how high-quality personality disorder services and care should be developed and implemented. Its recommendations include training all psychiatrists throughout their core and specialist training in the assessment and diagnosis of personality disorder, evidenced theories of aetiology, and treatment approaches, including optimisation of the therapeutic setting, relational practice, the appropriate use of medication, and specific psychotherapies; the College playing a leading role in developing suitable training for other professional groups; the appointment of a Personality Disorder Lead in every NHS Trust; ensuring that patients with personality disorder are not denied access to mainstream services; ensuring that where clinically indicated, all patients should have access to local tier 3 provision, and that each tier 3 service has access to a specialist residential tier 4 service; 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. This is the first time that the College has formally stated its position on personality disorder, marking an important juncture in which beliefs that personality disorder is untreatable and not the business of psychiatrists are dispelled.

Another recently published College Position Statement, which the Medical Psychotherapy Faculty contributed to, is on cannabis use. This is the outcome of a College Expert Reference Group convened to examine the evidence and review its position on cannabis, following the

Advisory Council for the Misuse of Drugs' recommendation to change the scheduling of Cannabis-based medicinal products to allow them to be prescribed by clinicians. Recognising the substantial evidence of the risks involved with frequent cannabis use and its association with psychosis, the College had serious concerns regarding any change in legislation or drift towards decriminalisation which might lead to an increase in the use of cannabis. To prevent this there would need to be adequately funded multiagency services to treat cannabis addiction and other co-existing disorders and the introduction of an evidence-based public education programme that tackles the causes of use and awareness of the harms of drugs, particularly to young people. Following a rigorous debate in Council, the College's final position was that it would support an approach that limits the number of people diverted to the criminal justice system and instead divert those whose use is problematic into support and treatment services, however, it opposes the legalisation of cannabis due to the risk that this could increase the harms caused by cannabis and the levels of mental illness in the UK.

A further College stance on an important issue relevant to medical psychotherapists is its response, which included the views of the Medical Psychotherapy Faculty, to the proposal by the British Psychological Society (BPS) that psychologists should, under certain circumstances, be able to prescribe and 'de-prescribe' medication for patients. The College raised concerns that the BPS's emphasis on de-prescribing would likely put the role of a prescribing psychologist in conflict with that of a prescribing medical doctor who has clinical responsibility for considering whether prescribing is indicated. Moreover, de-prescribing among patients with very complex issues requires a significant amount of skill and judgement, and psychologists would therefore need substantive training to meet the standards of patient safety and quality of care. The College would support supplementary prescribing – being able to prescribe medicines in accordance with a pre-agreed care plan that has been drawn up between a medical doctor and the service user already - but not independent prescribing psychologists who would be able to prescribe medicines under their own initiative.

Finally, the Medical Psychotherapy Faculty Executive Committee held its annual strategy day on 29th January 2020 to discuss the Faculty's strategic objectives. It was agreed that the remit of the Faculty was to promote the value of psychological therapies and psychotherapeutic approaches nationally, both within and external to the NHS, and championing the psycho-bio-social, as opposed to the bio-psycho-social model. It should be clear about its role in psychiatry education and keep psychotherapy alive among all psychiatrists. Medical psychotherapists should be encouraged to engage in research, education and leadership, and the Faculty should support trainees and consultants within the specialty, with a long-term vision to ensure medical psychotherapists had the tools to do their jobs and a context to work in. At the same time, the Faculty should avoid being

defensive and recognise that it is in a unique position to break down unhelpful boundaries between professionals, based on its members' multi-modal training.

The second half of the strategy day was focussed on the challenges of outcome monitoring and data gathering in local psychological therapies and medical psychotherapy services. Professor Mike Crawford, Director, College Centre of Quality Improvement (CCQI) presented on *The National Clinical Audit of Anxiety and Depression (NCAAD)* which had published a new report following an audit of psychological therapies provided in secondary mental health care settings, carried out by the College in partnership with the BPS between 2018 and 2019. Fifty NHS Trusts participated and registered a total of 232 services. 4,462 service users' case notes, 662 service user surveys and 1453 therapist questionnaires were analysed. The audit evaluated access and waiting times, the appropriateness of therapy, service user involvement, outcome measurement and therapist training and supervision. The audit found that most adults who received psychological therapy rated their therapists highly and felt helped by the treatment they received. However, access was poor, with almost half of adults waiting over 18 weeks from referral to the start of treatment. Many service users also reported a lack of choice in key aspects of their therapy. It was found that outcome measures were not routinely used to assess change, despite some evidence that outcome collection was supported by patients as it increased the frequency of patient discussions about progress. More details about the audit are presented later in this Newsletter in the update on the Talking Therapies Taskforce by Sue Mizen.

This talk was followed by a presentation by Jeremy Clarke, Senior Adviser, Healthy London Partnerships, Research Associate, who has been involved with IAPT services since their inception in 2007. He highlighted how funding for NHS talking therapies over the past decade had gone mostly into IAPT and CBT, and that IAPT had failed in its objective to pay for itself in reduced invalidity benefits and increased subjective wellbeing. IAPT was driven by clear performance targets relating to access rates, waiting times and recovery targets. Specialist psychotherapy services were now under pressure to agree to similar targets, however, outcomes focusing on efficiency gains risked degrading complex 'harder to reach' clinical work. Clarity was needed regarding the purpose of outcomes and it was necessary to differentiate 'routine' from 'hard' outcomes. Routine outcomes were the benchmark standard of care, a means to measure performance. Hard outcomes were different, in showing sustained recovery and cost-effectiveness. Mr Clarke argued that strategically, it was important to get local commissioners to engage with hard outcomes. It was also important to measure the wellbeing of staff, as there is evidence that in some IAPT services, the burden of targets was causing stress and unhappiness.

The difficulties in collecting outcomes in psychological and psychotherapy services were discussed – anxieties about how outcome monitoring might interfere with the therapeutic relationship and clinical frame; lack of financial, IT and administrative support; and how

when outcomes were collected, they were often not used in any meaningful way. However, it was acknowledged that there was an imperative to demonstrate that psychological treatments were effective, particularly where there was a perceived lack of evidence.

Dr Jessica Yakeley

Faculty vice chair

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Message from the Academic Secretary

Maria Eyres



I started writing this in February which meant that things around our annual residential conference, our Faculty's flagship event, were really heating up and we were working very hard to iron out any remaining glitches in the programme. We had a new conference committee this year, with Parveen Bains, Andrew Williams and P.J. Saju working with me to bring you a thought provoking and hopefully enjoyable event. We wanted you to leave with a lighter and warmer heart, as well as being intellectually stimulated.

The title of our Oxford event, which was to be held on 22-25th of April was *Survival and Development; Exploring our Internal and External Landscapes*. The event was to be held in a beautiful hotel on the Thames and we hoped that you would find the setting a bit of an oasis in itself.

Our work can still be heavily influenced by the Cartesian duality of body and mind. While the body has become more visible in the consulting room in recent years, thinking about our patients' spirituality and the external reality outside the consulting room, including the physical environment, might be less present. The conference was to explore the links between those aspects of our patients and ourselves, and how they impact on each other.

The opening talk on Wednesday would have returned to the topic of social dreaming which gathered much interest at our 2019 conference. This was to be followed by two early morning events on the Thursday and Friday for those who wanted to explore this further in the experiential sessions. This part of the conference would have only been available to 20 participants and would have been on a first come, first served basis. Our second speaker on

the Wednesday was to speak on loneliness and lovability, concepts very much still present in our 21st century hearts and minds and really emphasised by the recent 'Lockdown'. Thursday was to be, again, a more conceptual day, with talks on climate change, the presence of the body and the relationship between therapy and spirituality and three parallel workshops linked to the conference title. Friday was to focus on clinical work, looking at those themes in more detail and thinking about what we needed ourselves to feel supported enough to develop and even thrive in our work. There would have been an experiential aspect of group work through a large group on the Thursday and Friday, with the focus on ourselves, followed by the end of the conference plenary. The confirmed speakers included Julian Y Manley, Richard Gipps, Sally Weintrobe, Rosine Pelerberg, Deborah Lee, Sue Stuart Smith, Jo Stubbley, Jonathan Ross and Sushila Dall. We were to have large groups on Thursday and Friday facilitated by Diana Menzies and Chris Holm and social dreaming events early in the mornings for those interested. Finally, on Saturday 25th of April, there was to be a Neuroscience Special Interest Day, organised by Sue Mizen, featuring Oliver Turnbull as a main speaker.

Unfortunately, having worked so hard on the programme, we had to cancel the conference, and one of the consequences of that decision was that, in addition to missing thoughtful presentations, we have also missed the opportunity to come together. This was something that came out in last year's feedback as the highest ranked reason for attending. To remedy this, I have invited the conference large group facilitators, Chris Holman and Diana Menzies to consider running a virtual large group. They have very kindly agreed to run this independently of the College but with the support of the exec. The facilitators initially committed to running the group for the jobbing consultant medical psychotherapists and for senior trainees in medical psychotherapy. The proposal is for a session once a month for 6 months to support attendees in their daily work managing the impact of the epidemic. I am very grateful to Chris and Diana for their generous offer.

The College events team is currently working on choosing the platform to manage large events virtually as actual conference gatherings have been cancelled till the end of 2020. I have indicated we are interested in putting in a virtual event later in the year gathering at least some of our speakers who were to speak in Oxford. I will keep you informed of any further developments.

I have also submitted a proposal for a medical psychotherapy COVID19 seminar and I am waiting to hear from our events team about potential dates. Many thanks to the colleagues that agreed to contribute to it; Jo O'Reilly who will present the essence of the paper we prepared jointly on organisational wellbeing, Jo Stubbley who will talk on the impact of the pandemic on patients with complex PTSD, and, Sue Stuart-Smith who will speak on the mental health benefits of connecting to nature through gardening.

On another matter, before 'Lockdown' the faculty have been thinking hard about ways of promoting the inclusion of psychotherapeutic topics in the Royal College of Psychiatry's main conference and the Congress, and so I have been in discussions with Katie Newton, Congress Coordinator. While I received some helpful responses from her, I felt that it would be useful to bring the subject to the Faculty Exec for further exploration. Following our strategy meeting in January, the Exec recommendation was that Jessica Yakeley (acting Chair) write to the Congress Committee. It feels as if having a psychotherapist on the organising committee may be the best way to increase presentations and workshops concerning psychotherapeutic and psychological topics. We are awaiting their response.

I am looking forward to seeing as many of you as possible you in the virtual world in the coming months.

Maria Eyres
Academic Secretary
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Message from the Chair of the Specialty Advisory Committee (SAC)

William Burbridge-James

Training in a Time of Covid 19



As everyone is experiencing, these are difficult times for our patients which we as their clinicians are having to cope with and adapt to. So I am grateful to have this space to communicate with trainer and trainee colleagues. Work has shifted online or via the telephone for Consultant Medical Psychotherapists, while our trainees remain engaged in face to face work on the wards and in acute assessments of patients, and are therefore having to cope with the full force of the pandemic. Alongside this, as the effect of the Covid pandemic and continued lockdown impacts on the wider community's mental health, facing bereavement and losses, there is a burgeoning need for psychiatric and psychotherapeutic help. This represents a challenge for all of us. [UK Lockdown Causing Serious Mental Illness in First-Time Patients](#)

The Dean of the College, Dr Kate Lovett, and the Psychiatric Trainees Committee (PTC) have produced guidance with the collaboration of the medical psychotherapy SAC about psychotherapy training competencies during the current lockdown. [Covid-19 and Psychiatric Training](#)

Balint groups are continuing using online platforms, as is psychotherapy with patients who were already engaged in their psychotherapy with trainees where trainees have moved to distance working. My personal experience is that the Balint group has been a vital forum where trainees have been able to bring their current experiences, coming together as a group, sharing their feelings and gaining mutual support and understanding. In addition, the trainees I supervise have been coping well with the adaption to distance working but it is bringing up challenges when thinking about endings with patients if this is not going to be possible face to face.

At the time the guidance was shaped, the SAC thought that it would be too complex a process for core trainees to initiate a psychotherapy via on line video platforms or telephone with a patient that they have never met, especially if it's their first experience of taking a patient into a psychotherapy. This remains the position of the SAC at the time of writing.

So much of the experience that we are hoping that trainees will benefit from is the experience of 'being with' their patient consistently over a period of time within the frame they have established to create the secure setting for a psychotherapy to take shape. Two people present in a room together where the physicality of the face to face experience for both trainee and patient convey important somatosensory information which transmits affective states through projective processes that bring alive the transference and countertransference. This needs trainees to feel contained by their trainers though supervision to be in a position to feel ready to initiate the psychotherapy, and patients need to have been assessed and matched with trainees. This is to ensure a good clinical outcome for the patient and a generative training experience for the trainee.

This is nothing new but is brought into focus when thinking about the possibility of trying to adjust to an online experience if the current situation were to continue for a longer-than-expected period of time. It also continues to highlight how essential it is to have a Consultant Psychiatrist in Medical Psychotherapy as the Psychotherapy tutor leading the training of core psychotherapy training.

In the Faculty I know that consultant medical psychotherapy trainers have been considering starting some trainees with patients working remotely and that some forms of psychotherapy may be more adaptable to this way of working, for example CBT. It also depends on a number of variables including the level of experience of the trainee.

Alessandra Lemma writes about the use of digital media and Skype sessions in her book, *The Digital Age on the Couch: Psychoanalytic Practice and New Media* (Routledge, London, 2017) and chapter 4 is particularly relevant to trainers when thinking about the potential for working with digitally mediated psychoanalytic psychotherapy with particular patients and the importance of having met with patients before embarking on Skype sessions so as to address the limitations of working this way. She writes about how it may not be suitable for patients *‘who have body image disturbances, those who are borderline and/or perverse, those with limited capacity to represent experience, those who experience difficulty with differentiating from the other and whose grasp on reality is tenuous...’* (P113). The Faculty have established a working group to look at guidance for working with digitally mediated psychotherapy and this will also feed into the work of the SAC and future guidance on psychotherapy training.

Away from Covid; the work of the SAC has continued in rewriting our higher training speciality curriculum and I want to express my gratitude to members of the committee who have been painstakingly working on this line by line. The broad HLOs (higher learning outcomes) and our curriculum ‘purpose statement’ achieved their first hurdle – approval by the GMC curriculum oversight group (COG) back in early December 2019. The time line for submissions to second stage of the GMC approval which is the Curriculum Advisory Group (CAG) was pushed back by the pandemic from April to June (apologies for my error in the last newsletter when I said it was August) which is allowing us more time to complete this work. The Core curriculum has been through this second stage of GMC CAG approval and the College is addressing GMC feedback, which has overall been positive to the new structure of the curriculum.

Lastly, Ben Robinson has almost finished his UK map of medical psychotherapy higher trainings, that will go live on the College website but is in need of information from some TPDs. Ben has just achieved his appointment to a consultant post; warm congratulations. He can still be reached c/o stella.galea.rcpsych.ac.uk, so if you have not sent Ben details of your higher training scheme please do.

Looking forward to seeing everyone again.

William Burbridge-James

SAC Chair

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Update from the Talking Therapies Task Force

Sue Mizen

Introduction

IAPT was the first national development programme for psychological therapies, and it set a precedent in attracting funding and continuing to make the case for expansion on the basis of reporting outcomes on a session by session basis. Whilst IAPT has extended its remit towards services for people with severe and enduring mental illness (SEMI) there is still no national strategy to improve access to psychotherapy for people with more severe mental disorders particularly those arising from attachment disorders and adverse childhood experiences. The Talking Therapies Task Force (TTF) was set up to make the case for investment in a national psychological therapies programme for people with severe psychological disorders to include the development of a national data collection system so that access and outcomes can be monitored and the need for, and benefits of, psychotherapeutic help for this patient group can be identified as a strategic priority. In order to make this case, data is needed, and therefore a working group within the TTF have undertaken a scoping exercise to address the following questions about how such a national data collection system could be developed.

- What outcome measures are psychotherapy and psychology services using currently, how are they collected and what are the obstacles to using existing systems?
- What platforms are available for data collection, what costs are associated with them and what are their strengths and weaknesses?
- What is the strategic context and how can this be used to optimise the likelihood of implementation of the recommendations of the group?

The current availability of public sector psychological therapies for those with (SEMI) and outcome measures.

Information about the availability and outcomes of psychotherapeutic interventions is hard to come by. One source is the recent National Clinical Audit of Anxiety and Depression (NCAAD) spotlight audit completed by 50 NHS Trusts in 2019 giving an up to date view of current practice in psychotherapy services.

The NCAAD comprised both a “core audit” of provision for inpatients with anxiety and depression and a “spotlight audit” of psychological therapies services. This was the second national audit (the first one was carried out between 2010-2014). It assessed 13 standards representing best practice between 2017-2018. Eligible patients for the “Core audit” had to be over 16, have a primary diagnosis of depression or anxiety, and be admitted to NHS

inpatient services. Overall, data from 3,795 people's case notes were analysed, taken randomly from 54 NHS Mental Health Trusts.

Core audit key findings:

- Key information is not routinely being recorded during assessment, particularly for physical health data, demographic info, comorbidities, history of trauma, response to previous treatment,
- Shared decision making needs to be improved. Service users are not always given a copy of their care plan and key info is not routinely shared with them.
- 26% of service users did not have a crisis plan at the point of discharge and sufficient notice of discharge was not given.
- Psychological therapies were only offered to 36% of service users.
- Outcome measures are not routinely being used to assess change.

Spotlight audit key findings:

The focus of the spotlight audit was on psychological services within secondary care. Their performance was measured against 8 standards (access to therapy, type of therapy provided, service user experience and satisfaction, therapist training and supervision).

50 NHS Mental health Trusts in England took part. Data was collected through case notes, service user survey and a therapist questionnaire.

Eligible patients were over 18 and had to have ended therapy between 01.09.17 and 31.08.18. In total, 232 services took part, 4,477 service user's case notes were randomly selected (30 from each service). In addition, 662 service user surveys and 1,453 therapist questionnaires were collected.

The key finding from the 'Spotlight audit' were:

- That access to therapy was poor with 48% of the individuals having to wait over 18 weeks from referral to the start of treatment.
- Many service users also reported a lack of choice in key aspects of their therapy
- Outcome measures were not being routinely used to assess change.

45% of professionals providing therapies were members of the British Psychological Society. 20% were registrants with TTTF member organisations

Obstacles to uptake of outcome measurement in psychological services

The NCAAD report recommends the use of outcome measures at two points during therapy for all patients. Of those services participating in the audit, 40% of inpatient services in the Core Audit and 50% of outpatient services undertook no outcome measurement at all. If measurement of outcomes is to provide meaningful data that can inform national strategy and improve services the uptake of outcome measurement by psychological therapies services needs to improve.

It is acknowledged that there are significant barriers to routine collection of data, although some services have managed to improve this. The uptake of collecting outcome measures can be improved by:

- Involving clinicians in the choice of measures and method of administration.
- Promoting interest in therapists' by creating time for feedback and discussion of the data collected.
- Ensuring sufficient time in job plans for these activities
- Clinicians having direct discussions with commissioners over the choice of key performance indicators.
- Resources to allow time for data collection and entry as part of routine clinical record keeping and routine reminders to clinicians and administrators.

Review of IT platforms and existing national data collection systems.

The working group has undertaken a review to understand the strategic context and to establish the capabilities required of an effective national data collection system and the availability of platforms to meet these requirements.

Strategic Context

Data collection, integration of clinical records and the use of data for research and service improvement is undergoing a period of rapid change. It is important that during this period of change the therapeutic needs of those with attachment related severe and enduring mental illness are included in national strategy. Data collection platforms are developing towards integrating with electronic clinical record systems and it is likely that future developments will include the development of a working party to agree a means of progressing toward pseudonymised / anonymised data sharing between the major psychotherapy data handling companies.

Learning from the development of the national outcomes framework for CAMHS by CORC and NHSE points to the importance of utilising the existing data flow to NHS digital. Starting with the data which is already being collected is more likely to be productive than trying to develop a single perfect measure. The evidence suggests simpler measures can be as reliable as sophisticated measures and can result in higher rates of reporting. With regard to uptake of outcome measurement by services it is advisable to recruit and work with services who are willing and interested to improve outcome data collection in the first instance. On this basis the priority should be to increase the uptake of existing measures such as CORE and Honos. Once the uptake of existing measures is more established the problems of the existing measures can be improved.

Dr Sue Mizen

Consultant Medical Psychotherapist

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CONTEMPORARY PRACTICE IN MEDICAL PSYCHOTHERAPY

Medical Psychotherapy Consultation: Titrating the Dose of Disillusionment

James Johnston

My paper is about a Medical Psychotherapy Consultation Service I've offered for the past twenty years in Leeds, a medical psychotherapeutic service offering an application of psychoanalysis in psychiatry for in-patient teams, community teams and primary care.

I will first define the terms used in my title, then I'll set out the dynamic field of medical psychotherapy consultation from a psychoanalytic perspective.

Definitions

A **titration** in chemistry is a technique where a solution of known concentration is used to determine the concentration of an unknown solution. Typically, the *titrant* (the known solution) is added from a burette to a known quantity of the *analyte* or *titrand* (this is the unknown solution) until the reaction is complete.

Drug titration in medicine is the process of adjusting the dose of a medication for the maximum benefit without adverse effects. When a drug has a narrow therapeutic

index, titration is especially important, because the range between the dose at which a drug is effective and the dose at which side effects occur is small. The titrating off of a medication instead of stopping abruptly is recommended in some situations.

Drug titration is also used in phase I of clinical trials. The experimental drug is given in increasing dosages until side effects become intolerable.

A clinical trial in which a suitable dose is found is called a dose-ranging study.

Disillusionment is defined as the condition of being disenchanted or disappointed: the condition of being dissatisfied or defeated in expectation or hope.

Disillusionment might also be defined as to be free from illusion.

I think of the pain of experiencing disillusionment as the element of development which involves a process of letting go of a known state to replace it with an unknown state. This involves mental pain since when we let go of the comfort of our illusions this is a loss linked with our phantasies not being realized, our wishes not being fulfilled and life not being quite as we imagined or hoped, so disillusionment is part of facing reality.

Loss is an inherent part of development and liminal times of change whether positive or negative involves grief, the loss of what was known and anxiety in facing the unknown.

In medicine one illusion might be about our reparative potential – our need for and faith in our capacity to cure. I see this unconscious drive to repair, to heal, to help, to lie at the heart of the consultation task – of attempting to create a space in which the drive to cure can be replaced with curiosity. Replacing cure with curiosity may sound as glib or easy as becoming free from illusion; however this process of disillusionment carries a painful price – of mourning what was cherished and letting go of what was loved.

Shakespeare uses disillusionment in this latter sense of being free from illusion not as a dramatic freedom, not as an exhilarating liberation from blissful ignorance but in the painful, sometimes tragic, struggle with being confronted by the truth in such a way that there seems to be no way out of desperation other than death, as shown in his tragedies Hamlet, Othello and King Lear.

Titrating the dose of disillusionment and medical psychotherapy consultation

What relevance do the concepts of titration, dose and disillusionment have to the task of consulting in mental health work with professionals who seek help from a medical psychotherapist to think about the person with whom they will often say they feel stuck? In a thematic analysis of narratives written by consultant psychiatrists about why they referred their patient for medical psychotherapy consultation the word *stuck* was a leitmotif (Medical psychotherapy consultation: psychoanalytic psychiatry for the patient and professional, 2016).

Feeling stuck

The word *stuck* connotes an impasse in the patient and professional relationship. However the patient and professional relationship may have come to feel consciously or unconsciously impatient and unprofessional.

I think of the experience of being stuck in its glue or adhesive sense; the experience of feeling stuck with someone or stuck to someone you struggle to help. One way of thinking about the adhesive is that it glues through identification– the unconscious experiences of projection and introjection – of expelling mental contents and taking in mental contents

acts to bind participants in a shared struggle in which what feeling belongs with whom is lost in a maelstrom of confusion, recrimination and anxiety.

Grievance

The medium of the maelstrom, of the adhesive or the glue which leads to the feeling of being stuck is grievance – mutual recrimination and accusation of failing as a professional and as a patient, of anxiety about shameful exposure and being damaged and confused and uncertain about what to do with the mess.

Grievance is the glue that binds patient and professional together in a relationship which holds shame about failing, guilt about resentment, impotence about treatment and a longing for a solvent that might facilitate separation.

The patient may offer a solvent in death which leaves the professional feeling that their longing for an exit is surpassed by an exit from life which could lead them to be exposed as the failure they fear they are – left narcissistically wounded and ashamed.

To return to titration in the sense of chemistry – the known solution is the stuck situation – the unknown solution is the solvent that might allow separation. The unknown solution is also known as the *analyte* – that which may be discovered by a gradual process of mixing what is unknown with what is known.

Analysis lies in taking what is known – our conscious experience of our truths, and gradually discovering our unknown truths – our unconscious; this could be seen as a titration as incremental doses of what is known are added to what is unknown so that what was unconscious will become conscious or where Id was there shall be Ego.

The echo of *analysis* in the *analyte* will be evident – their shared etymology being in the greek ana (up) and luein (loosen) so analuein is to loosen up. The term analyte is the subject of the chemical analysis – unknown like the analysand in psychoanalysis.

The loosening of the grip of unconscious in the individual could be seen as analogous with loosening the shared grip of the unconscious in a patient and professional matrix – the adhesive identification is like tiny hooks to Velcro – the hooks of the reminder of aspects of ourselves in the other which hook into our soft felt, our felt experience. It is only in the naming and experiencing of the adhesion that loosening up is possible and therein lies a limitation in consultation – of what can and cannot be named.

The dynamic field

The dynamic field in psychoanalysis and psychotherapy describes the transference – countertransference in a two person field which is populated by multiple characters in an

unconscious movement as some characters move centre stage and others recede for both in the relationship. In the psychoanalytic relationship, the work is with the phantasies or unconscious templates developed since infancy and repeated in the transference. The unconscious templates might be understood as illusions and the process of transference interpretation can be understood as a process of becoming conscious of unconscious illusions - of differentiating between the illusion and reality. This is a process of gradual disillusionment requiring titration of what is known in the conscious realm to discover what is unknown in the unconscious. Disillusionment in psychoanalysis and psychotherapy involves facing the pain of disappointment in the working through of limitation and loss for both analysand and analyst.

Since all development involves loss, the disillusionment of facing what one has to let go of is inherent in life and transference provides a medium to investigate our illusions and to titrate the dose of disillusionment through heightened emotional experience.

How can the dynamic field of psychoanalysis be applied in the work of consultation?

The dynamic field in the work of medical psychotherapy consultation usually includes multiple professionals. Sometimes the professionals don't know one another or don't know of the involvement of the other professionals. It is a dynamic field involving a lot of people and multiple countertransference experiences. For each professional there is a unique influence arising from the patient's character, circumstances and their way of being in the world with resonance for some not others, being reminded for some but not others. These impressions may be articulated or may remain unspoken.

These emotional impacts ripple and reverberate through the minds of the professionals with different echoes and many voices with a potential for a Tower of Babel with many different languages spoken limiting the chances of understanding. It is like a jigsaw in which the pieces are scattered and there is no box lid to be able to see the picture that may be produced and to help the puzzle to be assembled.

Less is more

All development involves loss. The work of development involves grieving and when grievance becomes a familiar groove - the impasse and resistance to change is because it is easier to stay in a familiar groove than grieve. This is the basis of the less is more principle underlying the model of consultation I offer.

The relationship between patient and professional involves understanding the motivation in the patient and the motivation in the professional. Motivation in both the patient and professional involves resistance – for the patient resistance to change, resistance against mourning well-trodden paths which are like habitual grievance grooves: because change

involves loss in order to recover we need to relinquish what was known and turn to the unknown. This is a risky and scary business; it is why people do not give up a familiar way of being, even it feels a bad state because facing the unknown without a bad object as a companion is too threatening.

All development involves loss since in progress we relinquish what held us before which leads to regress as we fear letting go of what holds us.

Resistance in professionals is to facing not being able to change their object – of facing not being able to help, to heal, to repair or to cure. The resistance of the patient to change, motivated by a refusal to 'grieve their groove' might meet the resistance of the professional to not changing and a refusal to 'grieve their groove' as a helper rewarded by the capacity to heal. The capacity to heal and help is a loved object and letting go of this reward in reparation is a challenging task. The thwarting of a wish to repair may lead to heroic or aggressive attempts to cure.

In both patient and professional there is a problem of letting go – for one of letting go of what is known and familiar – a bad object, a hated object and for the other of letting go of an ideal object – a cherished illusion of reparation – a last bastion of cure.

The paradox of less is more is that we help the other more when we try to help less. To achieve this we have to try to be helpless.

In the dynamic of 'better the devil one knows' the devil is in the detail: the detail of what we cling to secretly which may be a grievance or it may be greatness but we stay in a familiar groove rather than grieve. Grievance, whether about deprivation or trauma or the inability to repair damage or fill the void take the place of grieving.

Being damaged, being disturbed

Mourning in the patient and professional relationship cuts both ways. The professional may have the door marked exit from their service in mind as the patient improves and recovers or is evacuated from the service despite, or because of, a lack of improvement. The patient may have the door marked exit from life in mind which locks the door marked exit for the professional.

The experience of being damaged and being disturbed inevitably evokes the experience of damage and disturbance in the professional environment. When loss cannot be felt it must be enacted in order to maintain a relationship in which anxiety surrounding loss can be experience. Separation must be avoided at all costs.

The narcissistic wound of facing limits in the capacity to help and restore well-being leaves professionals feeling resentful and weary - often ashamed of their struggles to help and subject to lacerating judgment, most acutely from their own superego, but also feared in the organisational and professional environment - being exposed and found to have failed in their duty of care.

The narcissistic professional wounds of exposure and shame are an echo of the patient's experience of exposure and shame. The burden of professional responsibility for the patient comes to be the focus of action - of shifting responsibility to the patient or of shifting the responsibility to someone else.

The notion of responsibility is linked with therapeutic risk taking and belies an interest in the possibility of autonomy. However, in the paranoid-schizoid attitude, responsibility will become a weapon as opposed to a therapeutic tool - therapeutic risk-taking becomes risk taking as malignant alienation sets in. The possibility of autonomy when viewed through a depressive attitude is one of recognising limitations in care which may have involved feelings of professional helplessness.

The experience of impotence may herald the breaking down of omnipotence and with it the illusion of cure. The depressive attitude to autonomy lies not in separation or the door marked exit but in separateness - for the professional to find some separateness from their own phantasies of transformation and recovery for their patient. In this process there is a work of mourning for the professional which is the working through, in a unique way with each patient, of their desire to heal. In mourning, their wish to repair a loved object they cherish is damaged and this is profoundly disturbing for the professional.

Tact

My aim is to show that I'm curious about the patient and professional relationship and not about cure, curious about what happens between them which illuminates the illusion.

There is no mandate in consultation to explore one's colleagues' lives but although this analyte will remain unspoken to me it will inform the consultation conversation.

The internal work of each professional in personally working through the painful limits of their work are at the back of my mind in each consultation as I carry what I know from my own work as a psychotherapist and psychiatrist and from work with other mental health professionals into each unique consultation experience. The 'titrate' (what is known) the known element from my work and work with colleagues, is added to what is unknown is the consultation to try to understand this idiosyncratic experience.

My attitude in the relationship with the professionals who seek consultation is one of a collaborative partnership in which I do not have the answers to solve their problem or cure their patient and, maybe strangely, I want to listen in a way which shows I'm not only interested in their patient, but I'm also interested in the professional/s with respect to their patient. The professional's personal experiences usually remain unspoken.

I make it clear that I am interested in hearing about the patient but I'm also interested to explore their emotional experience of their patient listening in a way which is informed by the view that facing limits, facing loss, facing the painful task of not being able to help are likely to be in the back of the minds of my colleagues.

Consultation vignettes

The following vignettes each focus on an emotional theme common in all consultations, more or less.

Feeling frightened

A consultant psychiatrist working in a pre-functional model was responsible in both community and the ward for the patient. She was anxious about the discharge of the patient from the ward as she feared this would lead to the death of the patient.

The patient was not seen in this consultation and part of the dynamic field was to recognise the experience of omnipotence in trying to reflect on someone in danger without seeing them. The risk of death was less immediate for the consulting medical psychotherapist and he was therefore both compromised in not having direct clinical contact (one arm tied behind his countertransference back therapeutically) and liberated by being able to use this relative emotional distance with less anxiety than the referring psychiatrist about responsibility for the death of the patient – a relative freedom which helps to support the transition towards discharge from 'the brick mother' (Rey 1994) with those more acutely emotionally involved.

In this consultation we can see the experience of the threat of patient death (being liberated from the pain of living), discharge (being liberated from the brick mother) and the consultant offering consultation having a space to think (being liberated by virtue of emotional distance and space to think). These experiences of being *liberated* – for the patient, the psychiatrist and the consulting medical psychotherapist are a transition to *separateness* which represents a threat for the patient, a danger for the psychiatrist and a necessity for the psychotherapist in order to secure a space to think beyond the fear.

Feeling bad

A patient was very critical of her care coordinator and in the consultation the consultant psychiatrist seemed to echo an experience of dismissing the care coordinator. In a series of

professionals' meetings it transpired that a psychotherapist in the third sector was seeing the patient who was idealised and the care coordinator was left holding the bad feelings of being impotent and ineffective. The psychiatrist was in the position of holding a privileged position as prescriber and, it emerged, was also anxious to please the patient and not to fall from grace. Medication was the currency of being loved.

The withdrawal of the 'bad' care coordinator and the end of the therapy in the third sector allowed a split to be crystallised in which the psychiatrist was loathe to be a bad object for the patient who would be depriving. As a new care coordinator took on the case, she soon took on the role of attracting the patient's bad feelings on behalf of the psychiatrist who could continue to be the recipient of the patient's positive transference.

In this consultation the pain of being loathed - or being experienced as a bad object - is being 'moved around' – the projective requirement is for a scapegoat for bad feelings so the last bastion of being the good object can be maintained.

Feeling helpless

A care coordinator desperately wanted to secure what she called 'an exit strategy' for what she felt was a hopeless contract with a patient who, like her, was a nurse and who valued her highly. In professionals' meetings she disclosed her struggle with the patient and her desire to rescue the patient in reparation of loss in her personal life.

The patient being seen for an assessment meeting allowed recognition for the consulting therapist of the pain for the patient of mourning his career and painfully facing his limitations in no longer being a nurse.

In subsequent meetings with the care coordinator an exit strategy emerged as the care coordinator began to accept her limitations professionally, not only in relation to the patient, but also for herself as a nurse in and beyond work, the latter only hinted at in the consultation process. It was only in this process of working through the limits of her reparative potential that the professional could let the patient go.

Though she felt he could not leave her, to allow separation she had to be able to leave him and what he represented for her – not being the nurse and having the personal life she wished for - most of the personal aspects of her working through remaining implicit and private.

In this consultation, the challenge of facing one's limitations in the process of mourning the capacity to cure can be seen as a patient - professional last bastion in which the identification between a patient and professional lies in the mutual pain of facing the pain of impotence and disappointment – disillusionment with one's lot (or not) in life.

Feeling ashamed

A psychiatrist was ashamed of her struggles in the face of trying to help a young doctor whose resistance to all her best efforts to help denied the feeling that the doctor reminded her of herself. The young doctor felt ashamed of failing as a doctor.

The consultation process could not be about the problems of the treating psychiatrist but in recognising in the professional an unconscious echo of the patient's dilemma but, putting this to the back of the consulting mind, it was possible to see that the young doctor had got under the older doctor's skin in a tantalising and painful promise which was never fulfilled – of being the ideal doctor she longed to be but fell painfully short of becoming.

The feeling of shame in facing failure to fulfil the medical ego ideal was mutual. Focusing on the ways in which the young doctor patient could not allow herself to be a patient was implicitly informed by the experience of professional resistance to receiving help.

(The treating psychiatrist felt terribly exposed in needing to seek the consultation from the medical psychotherapist). In the triangle between a doctor as a patient, a doctor treating her and a doctor consulting with them was a less exposing space which revealed that the treating doctor found it easier to treat the problem of shame in facing failure in the other doctor, but it was much harder to face the need to allow a similar problem to be understood in themselves.

In this consultation the unconscious identification between the patient and the professional leads to impasse – a last bastion connected with the 'no go area' of treating someone who exposes the professional resistance to experiencing shame in the need for help, the young doctor's struggle with becoming a patient finding its echo in the older doctors' exposure in seeking the consultation.

Consultation sandwich

I call the model I offer a 'consultation sandwich' - the first slice of bread is a meeting with the professionals seeking consultation and then, if it is in the interests of the patient, I may meet with the patient, and then a second slice of bread is the meeting with the professionals informed by my meeting with the patient. In the majority of consultations however there is no meeting with the patient; there is no meet in the sandwich - I have to consult without a direct experience of seeing the patient which is harder. This absence of a meet in the consultation sandwich, the vegetarian option, is challenging because I don't have my own emotional sense of the patient and I have to rely on the experience of my colleagues - it's a perspective from the periphery: living on the veg you might say.

Conclusion

The theme of this psychoanalytic application is that coming to tolerate disillusionment as it is bearable in titrated doses of reality rather than an overwhelming experience of loss is the basis of working through our reparative limitations as professionals. This is a work of mourning – not a counsel of despair but acceptance of the limitations of our capacity to cure while remaining curious and receptive when we can.

Perhaps this capacity to bear facing our limits has to be worked through in a different way with each new relationship as we are challenged in unique ways by new people.

As professionals who seek to help, we learn the paradox that we help more when we try to help less or at least try to bear being helpless, at times, in order to become helpful.

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VOICES FROM THE PAST

A Tragic Case

Stephen Wilson

(Taken from *Psycho-Therapy* by A.W. van Renterghem and F. van Eeden, first published in French under the title *Psycho-Thérapie*, © Société d'éditions scientifiques, 1894. Translated from the French by Stephen Wilson © Lamad Vav Press, 2019.
<https://www.amazon.co.uk/dp/1710485949>)

Introduction

In the six years between 1887 and 1893, Van Renterghem and Van Eeden treated more than a thousand patients in their Amsterdam suggestive psychotherapy clinic. This book *Psycho-Therapy* summarises the results of their work. It was addressed to the medical profession and clearly intended to provide an evidential base which would justify the use of the

method. But it also had a larger purpose, to counter prevailing materialistic conceptions of the human mind and to make the case for a reconsideration of vitalism. In demonstrating the influence of suggested ideas over both psychological and somatic processes, they highlighted the inadequacy of mechanistic explanations.

Both authors allied themselves to the therapeutic methods of Ambroise August Liébeault and Hyppolite Bernheim whom they had visited at Nancy, France. But they were at pains to distinguish what they were doing from the dramatic hypnotic séances given by Jean-Martin Charcot in Paris, and the dubious, but undeniably popular, activities of various stage-hypnotists, magnetists and mountebanks. Charcot thought suggestibility was pathognomonic of hysteria. He was more interested in using hypnotism to induce symptoms such as anaesthesia or paralysis, and thus clinch a diagnosis, than in its application for therapeutic purposes; whereas the Nancy school believed that suggestibility was distributed to varying degrees in the general population and could be harnessed for the benefit of patients. For this reason, Van Renterghem and Van Eeden preferred the use of the term psycho-therapy in one of the earliest uses of the word. Below is one of the clinical examples from the book. Today, we would probably think of this case as an example of a patient with Bipolar Affective Disorder.

OBS. (observation) 34.

SEVERE NEURASTHENIA; NOTABLE IMPROVEMENT. RELAPSE

On the 14 August 1890, I received a visit from a retired Royal Nederland's Navy doctor, who asked me if I would treat him for neurasthenic problems.

Family history

His father is a neuropath, his mother had been admitted several times to a nursing home and treated for hysterical mania. One of his sisters is a hysteric who has a range of symptoms.

Personal history

Due to his mother's mental condition, the patient was brought up by his grandparents in a provincial town. He was constantly in the company of older people, he rarely had the occasion to play with children of his own age. This resulted in a precocious knowledge of things and people that it is better for a child to be unaware of. Although he was very much loved, he was not a happy child. He doesn't remember having had any serious childhood illnesses.

He did very well in primary school and then at the lycée and became a medical student at the University of Amsterdam at the age of 19. From his 14th year, he developed the habit of masturbating and became passionately attached to this vice. The beginning of his nervous

trouble dates from that time, manifesting itself in alternate bouts of melancholy and exuberant gaiety.

He applied himself seriously to his studies, but this cost him a lot of effort. He gave up his bad habit and visited a prostitute from time to time. At that time he was already suffering from a nervous inadequacy; ejaculation during the coital act taking place prematurely, before or immediately after the introduction of the virile member.

He took all his examinations on time and acquitted himself well. Among comrades, he was considered to be very knowledgeable and to have a great facility for learning. According to him, nothing could have been further from the truth, he had to struggle and spend sleepless nights in order to succeed.

Appointed doctor at the age of 26, he received his nomination as a military medical officer in the Royal Nederland's Navy.

Life on board, his time in the tropics, the whole new world which unfolded in front of his eyes, left him with happy, pleasant associations. He remembers this period of his life with great pleasure. However, none the less, he was often unhappy, irritable and troubled by a tiredness of his whole being, a fatigue that he just couldn't explain to himself. He slept badly and tried to get some sleep with the help of alcoholic drinks, which incidentally he hated. He didn't exceed certain limits and preferred to be awake all night rather than run the risk of getting drunk. He never had recourse to narcotics, fearing addiction to morphine. He often had bouts of precordial pain and suicidal ideas.

Good and bad phases alternated. He carried out his duties well and was respected as a doctor, well liked by his comrades. Being ambitious, the idea of not being able to read and study at his leisure without having to put up with mental fatigue which forced him to put down his book, distressed him.

After four years service in the Indian archipelago, he served two years at Leyde in navigation school, then returned to the Indies on board a frigate.

During this voyage, in a fit of psychological depression, resolving to end his life, he let himself fall down a flight of twenty stairs. He was left with some bruises but found himself relieved of his melancholy for some time. Several months later in the Bay of Batavia, sad ideas took hold of him again, he was admitted to hospital, provisionally sorted out, and sent back to Europe.

On arrival in Holland, he was granted unlimited leave. He used it to consult several foreign medical authorities, such as Professors Erb and Rosenthal. He spent some time in Vienna

where he underwent electrotherapy then returned to Holland in order to take a ten month hydrotherapy cure. After these cures he was just as sick as before, the Naval Medical Commission definitively reassessed him and he was retired on grounds of nervous ill health following on from brain concussion, arising from an accident on board during service.

Having left the service, my colleague first had a feeling of relaxation. He felt relieved of medical responsibility which had weighed very heavily upon him during his last days in the Navy. However this state of quietude didn't last long. Returning to the paternal home he soon found himself just as unhappy as he was before. He became sad, morose, stopped sleeping, refused the narcotics that his father (a pharmacist) urged him to take. He accused himself of having cheated the authorities by hiding the fact that he had deliberately let himself fall down the stairs, so that the retirement pension he had been given was actually a theft he had committed from the state etc.

A suicide attempt by hanging was noticed in time and prevented. A passing calm followed this period of excitement. Several days afterwards, at the recommendation of the Naval Inspector of Healthcare who had been to see him, he came to consult me and asked me to look after him.

Present state 14 August 1890

Nervous man, agitated, average constitution, complaining of precordial anxiety, worries, aboulia¹, incessant doubt. He is particularly preoccupied by and ruminates over this question: did I have an accidental fall on board or did I intentionally let myself fall meaning to kill myself. If the latter is correct, I am a thief and haven't the right to touch one centime of the retirement pension given to me.

He complains of heart palpitations and insomnia. He often used to drink beer and cognac in the evenings in order to sleep. However he has ceased drinking for fear of becoming drunk. Occasionally he has taken bromides never for a long time and always in small doses. He has often made use of chloral hydrate and sulfonyl, never morphine for fear of becoming addicted.

He is tired all the time, however it doesn't stop him shopping for several hours; in the evenings he feels most at ease. He talks a lot, never stops moving, couldn't remain seated for a quarter of an hour.

He can't seriously concentrate on anything. He can't read, that is to say when he tries to read his thoughts are elsewhere, furthermore reading tires him out and gives him headaches.

¹ *Lack of motivation.

Appetite excellent. He eats a lot. Always feels a bit better after a good meal. No digestive troubles. Bowels normal. On examination no organic lesion.

He asks me to take him on as patient having put all his hope in a cure by suggestion.

From 14 August 1890 till 12 April 1891, I looked after the patient in my house as a member of the family. During this time he abstained completely from all medication and, with the exception of a glass of beer at table, from all alcoholic drink. My treatment had been simple suggestion. I was never able to obtain the least degree of sleep. He presented himself every day at the same time in my clinic, lay down on a chaise long, closed his eyes and stayed like that for one or two hours. During that time I placed myself near to him 3 or 4 times and made various suggestions according to his current symptoms. At first the effort required to remain calm and lying down cost him a great deal, however gradually he got used to it, then the habit became pleasant and agreeable. Soon he arrived early and greedily drank up, so to speak, my suggestions of calm and repose. He often got me to make very special ones for him or to repeat particular ones.

After some weeks, the irregular sleep began to get better, the anxiety calmed down, the patient took part in various family games (tric-trac, draughts, dominoes), got involved in making cardboard cut-outs. From the beginning of December his folie de doute, anxiety and melancholy disappeared and his sleep left nothing to be desired. He took up his favourite theoretical studies, skin diseases, at first studying for one hour per day, then little by little I pressured him into visiting the dermatological polyclinic. Soon he was attending it every day between 2 and 3 o'clock and playing an important role in treating the patients. From then on his morale went from strength to strength, he felt reborn, began to have faith in his abilities once again and recovered his identity as a doctor.

His irritable mood softened noticeably, he became agreeable, chatted and felt more and more at his ease.

During January, February and March, he made some visits to the paternal home, sometimes spending one or two nights there. In the end everything went well.

The cure was so well established that he thought seriously of setting up a specialist dermatological practice in Amsterdam.

However before establishing himself, which he proposed to do in Autumn 1891, he wanted to spend the summer in Paris in order to profit from the teaching of French experts. It was with this in mind that he left me for Paris on 12 April.

On that date he was perfectly well balanced. He left me a beautiful painting as a souvenir which he accompanied with these words:

“As witness to my gratitude and recognition of my cure and at the same time as a souvenir of my friendship.”

My patient stayed in Paris from the 13 April to the 27 May 1891.

His early news dating from the 14 April was excellent. Then I heard nothing from him until the 9th of the following May. He wrote to me thus: “After scarcely more than a few days in the hell-fire of this great Paris, insomnia took hold of me, soon the precordial anxiety was added to it followed immediately by my preoccupations, my doubts, my melancholy.”

On the 26th of the same month I went to Paris and found him in a state of over excitation such that I prevailed on him to return with me immediately to Amsterdam.

The contrast between the family life which he had led for several months — a regular life backed up by moderate exercise of body and mind, recreation according to his mood — with the chaotic life in the chasm of Paris where he found himself isolated, lacking moral support, where nobody gave a damn about him, proved to be too great. It is true that during the last month of his stay with me he was unaccustomed to have his suggestive sessions, but nevertheless he felt that I was there, that he only had to say something in order to get advice or an encouraging word.

The relapse was one of the most severe.

My suggestions no longer had the effect they used to have. The patient no longer completely opened himself up to me as before. After only three weeks of his renewed sojourn under my roof, he confessed to me the new cause of his obsessional preoccupations: he had become enamoured of one of the maids and although nothing serious had happened between himself and the girl before his departure for Paris, on arriving there he felt overcome by remorse, firstly with regard to the maid whom he had promised to take as a housewife as soon as he was set up as a specialist, then vis à vis myself because he had been the cause of impropriety under the roof of a friend and benefactor. Now he could no longer dream of getting set up, nor could he ever fulfil his promise to the maid etc. etc.

He asked me to sort out this business, to give presents. Far from being relieved after his confession, he was tormented by doubt: did I do something improper in my relations with the maid, yes or no? Sleep irregular. Anxiety. Thoughts of suicide. I seriously thought of transferring him into a nursing home, when after dinner on the 29th June while I was out,

he was able to get hold of (being a doctor) an aqueous solution of 1 gramme chlorhydrate of morphine from a local pharmacist. It seemed that he immediately withdrew into his bedroom and swallowed the contents of the phial in one go.

Five hours later, on returning, I found him in a deep state of narcosis. All my efforts to save him came to nothing, he died on the 1st July at 7 o'clock in the morning.

REFLECTIONS FROM CONFERENCES AND EDUCATIONAL EVENTS

Psychodynamic Psychiatry Day November 2019

Jo O'Reilly and Rachel Gibbons

The Medical Psychotherapy Faculty hosted the fourth, very successful, Psychodynamic Psychiatry Day on 1st November 2019 to a growing audience of engaged and interested attendees. The event is held at the Royal College of Psychiatrists in London and organised by Jo O'Reilly and Rachel Gibbons. The theme of the day is the importance of psychoanalytic ideas to everyday psychiatric work. The talks this year included;

1. The 'Truth' about suicide and the Effect the Death of a Patient by Suicide has on Clinicians-Dr Rachel Gibbons
2. Paranoia in the Clinic and in Everyday Life- Dr David Bell
3. Psychodynamic Psychiatry and Relational neuroscience- Dr Sue Mizen
4. Managing Risk and Persecutory anxiety- An organisational Response- Drs Jo O'Reilly and Lucinda Donaldson

Each talk was followed by a lively discussion with the audience and plenary sessions at the end of the morning and afternoon sessions.

Each year there is a varied program addressing different aspects of psychiatry from a psychodynamic perspective. We have invited experienced psychoanalytically trained clinicians working in mental health services to present clinically based talks illustrating key psychoanalytic ideas as applied to a range of mental disorders. Talks have also explicitly addressed the emotional impact of frontline psychiatric work on staff.

We are delighted with how this event has grown by around 75% each year, from 50 attendees four years ago, to 200 people this year. It attracts psychiatrists from across the UK, working in a range of specialisms, from trainee to consultant level, many with little or no dynamic or therapeutic training. In addition, medical students and non-medical mental health staff are increasingly attending.

Feedback has been extremely positive, 70% rating the day as excellent and the rest good. Comments included;

"A great day. Felt really invigorated regarding my clinical work "

"Wonderful conference full of interesting ideas"

"Very helpful"

"It had a mind exploring and reflective effect to it and I look forward to attending more such conferences"

"One of the best one day conferences I have attended. Very stimulating"

"It helped me to think about carers and patients in a different way"

Our own experience from running this event is that there is a real appetite amongst our psychiatrist colleagues for thinking about the emotional and psychological factors underlying psychiatric disorder. They express relief at having the space to think about unconscious processes and the impact upon them of working with disturbed states of mind. This is particularly evident in the audience discussions where they voice their distress about working with high levels of suffering, risk and suicide in the current pressured mental health environment. The impossibility of offering consistent containment to patients as services become fragmented and resources are cut is painfully articulated, as is the lack of opportunities they have to reflect about their work. Talks with a clinical focus showing how a psychodynamic approach contributes to clinical understanding and management, are very well received, as are approaches which link psychoanalytic ideas about the mind with developments in neuroscience. We have learnt to structure the program with time to discuss and to process some of the issues the talks raise.

This event raises significant funds for the Medical Psychotherapy Faculty to invest in other projects. However, more importantly, we feel it demonstrates the central contribution the Faculty has to make to psychiatry, making it evident that psychodynamic thinking is not

limited to the confines of psychotherapy services but has a key role to play in addressing the psychological aspects of a comprehensive bio-psycho-social approach.

We were planning a further event on **Friday 13th November 2020** at the RCPsych in London and will advertise this in due course, once more is known about future effects of Covid 19 on College meetings. We would welcome suggestions about future topics and speakers and contributions from the Faculty about this. We are very grateful to Maria Eyres, the Faculty academic secretary for her support for this event and also to the CALC team.

Dr Jo O'Reilly and Dr Rachel Gibbons

Faculty executive committee members

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TRAINEE VOICES: MEDICAL PSYCHOTHERAPY TRAINEES SECTION

Edited by Alasdair Forrest and Michael Milmore

Editors: Dr Alasdair Forrest, ST7 in Forensic Psychiatry & Medical Psychotherapy, Aberdeen & Perth & Dr Michael Milmore, ST6 in General Adult Psychiatry & Medical Psychotherapy, Yorkshire

I am a trainee in Forensic Psychiatry and Medical Psychotherapy. My interests are not always that elevated. My favourite film is the pretty decent Hollywood action number *Crimson Tide* (1995), which is about a mutiny on a nuclear submarine. Denzel Washington and Gene Hackman lead opposing sides as they fight to do their own versions of the right thing, in a situation where the stakes could not be higher. It is an interesting conflict. To me, relatively late on in my training as a Group Analyst, this line of Hackman's from the film is often in my mind: *we are here to preserve democracy, not to practice it.*

I was reminded of it recently in my analytic group (as I often am), when there was a strong wish to let me give a patient a long leave of absence. If I were a democrat, I would have acceded to the will of the majority—far more than 52%—and allowed myself to be outvoted. But in being first servant of the group, I thought I needed to pay attention to my special role. The democratic elements have to be in service of the therapy, not the other way round. That is the organising principle I need to embody.

At least my reading habits are a little more elevated than my viewing habits. My favourite paper is an underappreciated one by Tom Main (1968), *Psychoanalysis as a Cross-Bearing*. He talks about how we need to balance a discriminative, cognitive awareness of the patient with a feeling-based one. Too far one way and we are affectless and blunt; too far the other and we provide no thinking to the patient. To parallel what Hackman's character says, we are not there just to feel or just to think for their own sake, but to balance both in service of the patient.

I think the papers in the trainee voices section this time address that same tension: How far into *it* to do we go? How far is too far, and how far is not far enough? How do we engage with our patients without losing our thinking sense, or think about them without losing our feeling sense? And, crucially, how do we do that in the service of therapy?

I think the *it* is some kind of empathic, human-to-human engagement with the hurt of our patients, as psychotherapists. Rauf essentially asks: do we go into it at all? Can we think about the needs of minds under strain? Or do we ignore it because sportsmen are the paragon of health? He doesn't ask much about our role as psychotherapists, so perhaps others will think about this on reading it.

Hazan and Congdon talk about going "all in" at a Group Relations experience. There, for sure, Hackman's character would feel at home—in the heat of the group experience, where chaotic feelings and group movements need to be borne to be understood, and cannot be grasped intellectually alone. In the other paper, Chu talks more personally about his own journey towards thinking about personal therapy, perhaps asking the question: can I be in this if I don't know what I'm in? Can I be a psychotherapist without pausing to try to understand myself?

I should confess I prefer Hackman's character, who would have launched the nuclear weapons. When he is about to do so, though, Denzel Washington's character probably has it right: *Sir, I think you need time to think this over*. Surely those are the words of a true psychotherapist.

Crimson Tide., (1995). Directed by Tony Scott. Los Angeles: Hollywood Pictures.

Main, T. (1968) Psychoanalysis as a Cross-Bearing. *British Journal of Psychiatry* 114(509): 501-507.

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The Sporting Mind

Adeel Rauf

In February 1989, Frank Bruno and Mike Tyson fought in Tokyo, in what was billed then as the biggest fight of the planet. Both were champions in their own respect. Tyson was the youngest boxing champion at that time and the most brutal athlete the world has ever known in the ring. Bruno who had 32-2 record till that bout went on to take WBC heavyweight title in 1995. Sadly for both, drugs and psychosocial stressors became an issue and their careers ended in controversy, both fighters were diagnosed with Bipolar Affective Disorder, a mental health disorder with episodes of depression and mania requiring a holistic management approach.

Sports and psychiatric issues stem deep. The pressure of performances in front of huge attendances, pre-match anxiety, glory in success and agonising defeats are all part and parcel of the game. However, the expectations of excellence can take their toll not only physically but mentally on sporting athletes. Mental health issues, as in the general public, are undiagnosed and hence undertreated both in developed and especially in the developing world. In addition to Bruno and Tyson, many have suffered from mental health disorders Johnny Wilkinson suffered from OCD, Michael Phelps from ADHD, Marcus Trescothick and Jonathan Trott from depression. The famous cricketer Robin Smith had alcohol related problems as well as Victoria Pendleton the cyclist had suffered from severe depression. Both contemplated suicide.

The prevalence of mental health disorders is greatest in younger people with 25% of young people between 16-34 meeting the clinical criteria for one or more disorders. UK studies on the mental health of athletes reports a prevalence of 47.8% for anxiety and depression. In NCAA, the collegiate association of athletes in USA, a survey of athletes found that 30% reported feeling depressed over the course of a year. In female athletes, such as gymnasts, long distance runners and figure skaters, as many as 60% are affected by eating disorders.

Overtraining, injury, performance failure, Major life events, retirement, performance expectations, low social support as well as, more recently, social media criticism are some of the many factors that affect the mental health of the athletes. There is also an element of stigma which affects athletes' access to help whether it will involve assessment or treatment. In many rugby clubs for instance it was a taboo a few years ago to even talk

about personal feelings as a sign of weakness in a sport which thrives on so much physicality.

On one hand it is the wellbeing and resilience of the athletes that is on display during the competition but where does the buck stop? The ever-growing tennis calendar makes players prone to injury which is unhelpful mentally and there is cause for concern that prolonging the Formula One season would cause more divorces to occur. High profile rivalries such as the Ashes and the never-ending cricket seasons in recent years have caused many cricketers to take limited and in some cases indefinite breaks at various points due to mental health difficulties, as was the case with many Australian cricketers.

Sports psychiatry focuses on diagnosis and treatment of psychiatric illness in athletes. It started in USA in the 90s and it is an evolving speciality. In the UK, there is a RCPSYCH special interest group that has been formed in the last few years that has highlighted issues and work done in this field.

There are many mental health disorders that athletes suffer from which would be expected in any general adult psychiatry clinic. The prevalence of depression, generalised anxiety, Bipolar disorder, OCD, PTSD, eating disorders, alcoholism, drug and gambling addiction are common issues of note. Alcohol is the most abused substance followed by cannabis and smokeless tobacco.

These disorders would need specialist input but there is a deficiency in having services in place to assess and treat. To treat the disorders, this would require a psychiatrist's input which would be different role to that of a psychologist where talking therapies would benefit athletes. There are various factors to take into consideration in prescribing such as weight gain, sedation, sexual side effects that would affect performance of the players. It also takes into factor external factors such as heat, dehydration, performance enhancing drugs.

Sport provides us entertainment and healthy competition. Physical wellbeing has always been looked after and invested in by sporting bodies responsible for athletes. It is now high time that those sporting bodies look closely at athletes much overlooked mental health and wellbeing as well. As many a time one has heard on television coverage of major events' finals "It's all about maintaining nerves". It is time to look after those nerves.

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Reflections on a Group Relations Conference: the courage to connect, a psychiatry trainee perspective

Dr Jemma Hazan and Dr Lawrence Congdon

“Wisdom or oblivion - take your choice. From that warfare there is no release” - Wilfred Bion

We attended The Group Relations Conference at The Tavistock Centre in North London. It is a conference that has been running since 1965 with the first Conference held in the United States. However, its origins go back to study groups held in the UK in the 1940s.

The conference is steeped in mystery and enigma. Some participants are vague when asked about what went on and what they learnt. They often advise potential attendees not to research or understand the process in great detail before they take part. Having now attended it is unclear why people do not wish to talk about their experience. Two possible explanations are that because it is a very personal and unique experience there is a desire not to influence. It might also be that having been through the conference people believe that part of the potency is due to being in the moment and not intellectualising.

The conference is described as a ‘personal development programme’ with the aim of increasing your personal effectiveness in an organisational role. Development happens via experiential learning with the intention of learning through participation. This conference felt entirely unique in this perspective whereby we were thrust into active participation in a large group setting of 90 other members called ‘the Membership’. Within the first ten minutes of the conference at the opening plenary the reigns were handed over to us and the group were asked to speak. No longer were we passive members of a conference. This felt like an electric shock which rippled through the rest of the week and has had lasting impact. For one of the authors the lasting impact has been an increased awareness at work and in personal life wanting to be actively thinking about what is going on and responding to that.

It felt like we got to see the inner machinations of a group structure in action. There was a heightened focus on the individual, the individual in a group and the group working as a whole. It gave us the opportunity to directly experience one of Bion’s theoretical ideas from *Experiences in Groups Paperback(1998)*: the working group model vs the basic assumption group. The working group functions rationally and in accordance with its task. Whilst in the

basic assumption group the dynamics fundamentally interfere with task orientation and completion. We had the opportunity to experience both types of group workings within the conference.

The participants incorporated: the directorship who were in charge, the consultants who led groups, the membership which included us and other multi-disciplinary professionals and the trainees who occupied a space between the consultants and membership. The roles were often blurred, ambiguous and confusing and this directly led to conflict and a sense of feeling uncontained.

It is important to ask how applicable a conference could be and how transferable the learning could be to our work. Our interpretation of the conference was that it created an organisation which lacked the content of everyday work and thereby revealed the underlying group dynamics that operate within every team in a work environment. These processes occur in our day to day work in the NHS however we do not often have the time to fully reflect or be consciously aware of said processes. By having a content free organisation it provided a thinking and reflective space.

There were a range of conference events including: small & large study groups, inter-group event and the organisational event. This array of events felt confusing and we found it hard to get our bearings. Like a well composed piece of music every aspect of the conference design was carefully considered and orchestrated to provoke a lack of containing environment to increase anxiety and reflection.

In the large group there were animated and fierce discussions surrounding race, religion and sexuality through members' lived experience which was raw and painful for the group.

Another core component of the conference involved tasks which required us to organise ourselves into groups. This invoked some of the first experiences of group dynamics in infancy that created a driver for anxiety which fuelled reflection on our own place within groups. This transported us back to being on the school playground and potentially being picked last for team sports.

The small group event gave us the opportunity to participate in a therapeutic group. As two trainees who are not currently in personal therapy we were thrown in to a group setting where our therapeutic roles were reversed. No longer were we clinicians but members of a therapeutic group. Uncomfortable silences enabled us to focus our gaze on our own inner world and struggle to relate to each other. It was an authentic experience which felt powerful in its ability to draw out some powerful emotions and induce psychic change. Some of our experience in the countertransference was of leaders in the group being persecutory although this could reflect our own object relations. Silent reflection was built

in to the conference which was a new addition to the conference and gave us some breathing space and processing time.

Several tasks revolved around directing the group to take on roles and leadership responsibilities. The inter-group event and organisational event enabled us to examine and withstand the struggle that arises out of a recreation of a bureaucratic authority structure. In our task we were able to directly explore the workings of 'management' and unveil its inner workings. This process highlighted the power struggle that exists within all groups whether they are conscious or unconscious. We learnt that there is a difference between power and authority. It was felt at times that certain members of the group held power without consciously assuming a position of authority. We also learnt that the label of authority does not necessarily imbue power and the willingness of others to follow.

We hope to utilise this experiential conference and continue the reflective space to think about our position in groups, the group dynamics and the impact of a larger organisation on the group and individual. Having written these reflections some months since the conference it still invokes powerful feelings which will stay with us. Bion aptly stated in *Clinical Seminars and Other Works (1994)* 'To dare to be aware of the facts of the universe in which we are existing calls for courage'.

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In Their Shoes: A Journey into Personal Therapy

Kenny Chu

I am a core psychiatry trainee and I am scared. Like many before me, I am about to take on a psychotherapy long case. And perhaps also like many before me, I am scared: scared that I will not know what to do, scared that I will not be a good therapist. After all, it is a plunge into unknown territories.

I had wondered whether our patients would find it baffling (or concerning) that there is a high probability their therapist has never once witnessed a session of therapy, let alone conducted one. Whilst there is the argument that surgeons operate without having been cut open, they have, however, had the opportunity to observe the surgery, to practise the technique, and be supported through their first incision with a senior surgeon overseeing

the procedure. Of course, the psychiatry trainee may observe therapy through video simulations and will have supervision between the psychotherapy sessions, but there is a lack of exposure to how things will feel within the room. We do not have the opportunity to sit into a session of therapy to appreciate the framework, observe how the therapist conducts the session or how the patient brings their material and, perhaps most importantly, to have a feel of the interaction between the patient and therapist. Perhaps the closest we can get to this experience is to be in the patient seat. Whilst evidently it is not a necessity to have had personal therapy prior to taking on our psychotherapy cases, is there something lost in the experience without it?

Prior to my post in psychiatry, I had never considered undergoing psychotherapy. Coming from a cultural background where mental health is much stigmatised and never discussed, therapy itself was not something that I had appreciated existed until I was well into my young adult years. Within my social circle, no one had been through therapy—at least, not to my knowledge. It wasn't until exposure to the psychodynamic way of thinking during a psychotherapy placement did I see undergoing psychotherapy myself as a possibility. Perhaps it was simply ignorance, or perhaps unconscious processes were protecting me from the perceived vulnerability that I would face. As medical professionals, we are accustomed to being in the position of power through asking patients questions in a location we choose; would many of us consider being in the reverse by choice?

I mused about the matter and then discussed this with my colleague in the placement; he had undergone several years of personal therapy prior to entering core training and felt it to be very helpful when he started his long case. Wondering whether our views would be significantly biased, given that we had both opted to have a placement in a psychotherapy service, it seemed interesting to hear from a wider sample size of trainees from other placements. For this, we designed an anonymous survey and I disseminated it to all the core trainees within my deanery. This poster will be on display at the 2020 Medical Psychotherapy Faculty conference.

There was a good response to the survey: twenty-three trainees responded. Four had undergone personal therapy, and of these, three found it helpful whilst one was unsure. The general opinion was that personal therapy improved understanding and application of psychodynamic theories as well as deepened understanding of therapeutic relationships. However, the biggest barriers to therapy cited were the costs involved, followed by time commitment.

There was strong support for personal therapy to be included within the curriculum both from those who have had therapy and those who haven't. The feeling within the cohort is that there is much to be gained personally and professionally while acknowledging the barriers above. Whilst the route into therapy for medical psychotherapy trainees is well

guided via the curriculum, there was the curiosity about whether this support could be extended to all psychiatry trainees? The demand does appear to be present. What would it mean for the psychiatry trainee to be able to access personal therapy more readily?

I had decided that I would undergo my own personal therapy as the next step. Whilst my interest had been sparked by contemplating the long case, I found that my motivation to take action was driven by curiosity about myself which the reflective nature of psychiatry had opened up within me; I had begun to notice *stuckness* that had existed in my life for some time. I began to appreciate that it was not necessary to have a critical issue or problem to benefit from therapy—the curiosity to understand myself would suffice. I also saw that it was likely a part of myself would never allow me to acknowledge any issues or problems as critical anyway... And whilst the worry about what might be unearthed may exist, there was reassurance in knowing that the framework is there to contain this.

Following the decision to undergo therapy, I was then faced by the practicalities associated with this: how to find a therapist. Amongst Google, the options were either having a consultation session offered by the institute of psychoanalysis or asking someone who I know had been through therapy. I chose the latter and spoke to my clinical supervisor whom I knew had psychotherapy experience. He was supportive of the idea and he recommended an analyst who would provide an assessment consultation then refer me to a therapist he felt appropriate for me. I also had to consider when I could consistently have time off, bearing in mind that the six monthly rotations added to this uncertainty. Fortunately, the supervisors of my current and subsequent post were understanding and were flexible to me taking a time slot which bordered into working hours—I could simply make that time up elsewhere. It felt comforting to know that my development was being supported, and that the time in the NHS extends beyond service provision.

I have since made contact with the analyst and have had several sessions. The journey to the beginning of therapy undoubtedly came with worry, anticipation, excitement, curiosity, and uncertainty amongst other emotions—I'm certain a myriad more will follow. I appreciate that the journey will be long but on reflection, I am very glad to have made the first step.

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Core trainee in psychiatry

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Ode to a Long Case

Francesca Hill

70 sessions later: a letter to the GP and a note on Rio. Not quite the pomp and ceremony the occasion deserved. You jokingly asked when you entered the room whether you get a medal to acknowledge your identity as a 'Therapy Survivor'. "I trust your professional judgment that I'm ready for the therapy end" alongside a meaningful look in the final 60 seconds, a glimpse of the desperate anxiety I bore witness to as the trust deepened. Lessened but not quite dead, you wanted me to know that it's still there, that I'm leaving you to deal with it all alone, that I'm deserting you.

But it wasn't all sombre. During the blissful Middle– where your guard has slightly dropped and I have not yet introduced the idea of The Ending – you used wonderful imagery to describe your experiences. The fearsome rat, symbolic of your anxiety, peering over your shoulder, became a squirming gerbil. It was never tamed, but perhaps that would be a step too far. Perhaps a gerbil with attitude is O.K. Your hands are still free to use. An energetic rodent in your pocket is your very own battle scar to be proud of. Maybe we all have hamsters and degu and guinea pigs in our pockets or clamped under our arms, we're just Masters of hiding our anxious daemons.

We did a wondrous job of colluding in the last session, it felt lighthearted and jolly. Bar your throwaway comment as you put on your coat, you never vocalised how difficult it was to end, and neither did I. Perhaps my reason was the guilt of looking forward to this day. Witnessing your Trauma (yes, Trauma with a capital 'T' – big, scary trauma) was sometimes overwhelming. You never knew that I nearly cut short the course of therapy – I had done the required of number of sessions required by the College, you were 'stuck', I was frustrated. Some gentle persuasion from my supervisor (and another explanation of that thing called 'countertransference') and we worked through it.

I eventually got what I wished for: therapy ended. My Wednesday mornings are once more spent in the team office. No more Tuesday evenings spent pondering what mood you'll be in, whether we'll have another session filled with silence because of the break we had had the week before, or whether instead you'll be puffing your chest out, reassuring me that you were better and "the therapy is working".

Outlook pings – it's my psychotherapy supervisor. Time for my short case: facilitating a CBT skills group. A different type of challenge, and one that I do look forward to. But it's not the same.

I wonder how your gerbil is.

(Details have been changed to protect the anonymity of the patient)

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Photo courtesy of Dr A Khan HST4 DHSC NHS Trust

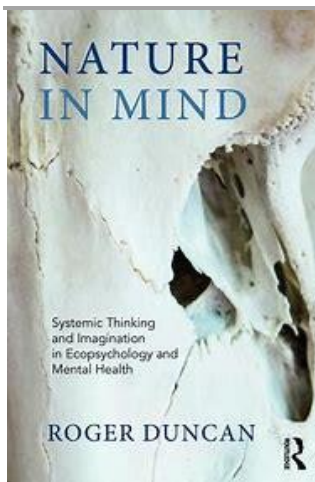
BOOK REVIEWS

Editors: Dan Beales and Andrew Shepherd

Book Title: Nature in Mind: Systemic Thinking and Imagination in Ecopsychology and Mental Health.

Roger Duncan, Routledge 2018, ISBN: 978-1-78220-377-3

Reviewed by: Dr William Burbridge-James



Roger Duncan invites us into the journey that his life has taken him along which inspired him to write this book; from his early life experiences that kindled his passion and study for biology, his travels in the Middle East and across Africa as a young man, then in his working life as a Steiner teacher; and as an educationalist and forester, working with young people with complex needs in the outdoors, and latterly as a systemic family psychotherapist in the NHS.

In the book he weaves his deeply personal experiences with a conceptual framework that has grown out of his curiosity to develop his understanding and establish meaning out of his experience. Duncan builds conceptual links between the 'siloed' disciplines of education, biological science, practical nature based work, and systemic psychotherapy to illustrate how 'approaching nature and human development in a different way can create a 'systemic ecological approach to psychotherapy'. His book captures the zeitgeist as climate change is forcing us to examine our relationship with our planet and that 'the time for talking has run out and action is needed to prevent us living in a destructive relationship with world and with ourselves'.

In the introductory chapter Duncan sets out his thesis that our dislocation from our ancestral relationship with the natural world has led to an emotional disconnection between nature and our instinctual minds, and thus a forgotten un-mourned trauma. This trauma is manifest and enacted in the self-harming, suicidal and addictive behaviours, seen in displaced indigenous peoples linked to their cultural dislocation, which are now endemic in western industrial societies.

He seeks to induct us into an eco-psychological practice that is still in development, making the case that we are 'drawn to and emotionally moved by the aesthetics of the natural world' (p15), therefore incorporating aspects of indigenous experience into education and therapy practice makes good sense. He describes the significant impact that wilderness

experiences can have on the lives of young people struggling with a range of difficulties, including those in contact with the criminal justice system, with a subsequent impact on re-offending rates compared to more costly interventions.

He draws on the work of Gregory Bateson, whose philosophy was inspired by Goethe, and the work of the philosopher Henry Corbin. Bateson was one of the most original thinkers of the twentieth century whose research moved across the boundaries of different fields as an anthropologist, social scientist, and cyberneticist. His publications include 'Steps to an Ecology of Mind' (1972) and 'Mind and Nature' (1979). Bateson was interested in 'patterns that connect' in nature and the interdependencies in the ecological system, which, if we were aware of, we would be less destructive of. 'Break the pattern which connects', he says, and, '-you necessarily destroy all quality'.

It is this experience that Duncan seeks to induct us into; stories that allude to 'something lost' and that there might be another way of experiencing nature and the human mind; a way of approaching Ecopsychology outside of the scientific and even cognitive framework. He introduces us to Corbin's notion of the language of the 'imaginal world'; a forgotten aspect of reality hidden in plain sight, that we can learn to access by the process of 'active imagination';- through learning to recognise the patterns and subtle organising principles not usually experienced by thinking or sensory experience. An area of experience usually left to artists and poets, rather than scientists. Duncan draws on a neuroscientific understanding of trauma and 'the emotional brain' and links this to the American psychologist James Hillman's understanding of the mastery of the 'alchemical language of the material world that is nonverbal and bodily based' (p38); and Corbin's notion that we need to actively inhabit our body and nature. This can be achieved through hands on work and physical encounter with natural materials that is self-healing and therapeutic.

He invites us into the woods with him and illustrates how his work in an educational project set in ancient woodland working with young people, who experienced a heterogeneous mix of complex mental health difficulties, provided an educational and therapeutic environment where through the sensory motor learning in a supportive frame, students experienced embodied engagement with the imaginal world. Duncan provides researched outcome feedback from students who undertook the project as well as giving practical suggestions for therapeutic education woodland activities.

The work is also informed by 'nature based developmental wheels'. A systemic way of conceptualising developmental tasks and stages, that is circular and non-linear, representing both our relationship with nature and the seasons, and cultural context, but also our physical and psychological selves. Duncan introduces us to three developmental wheels, which share an overarching connection, originating in pre-Christian indigenous communities. He elaborates on the specifics of each model and draws on his experience of

Rudolf Steiner's writings and approach to teaching, linking the models to neuroscientific models of development and trauma. A 'bottom up' neurophysiological hypothesis, where working through bodily based activities can help emotional regulation, and which recognises the importance of the 'links between nature and the human mind' (p67).

Essential aspects of development in indigenous cultures are rites of passage at points of transition in development, especially adolescence to adulthood. Duncan trained at 'The School of Lost Borders' in California where the founders Foster and Little had developed Vision Fasts as a contemporary 'pan cultural rite of passage'. Vision fasts involve being out in nature for four days on your own, fasting without shelter but with non-contact oversight of guides. In this process nature is engaged as a sentient 'other' in an intersubjective dialogue with the 'psyche', which creates a potentially transformational experience that needs mindful facilitation. Duncan is clear to differentiate this from psychotherapy, inviting us to share his experience of both undertaking and facilitating vision fasts with testimony from participants.

In the penultimate chapter Duncan expands on his theoretical framework, and describes how systemic thinking and exploration of multiple perspectives promotes a wholistic, as opposed to mechanistic fractured view of nature and the world.

Duncan's book invites and challenges us as practitioners from a biomedical underpinning to open our minds to think systemically across boundaries that have divided us from a lost unarticulated aspect of ourselves and open a dialogue to 'an imaginal narrative' that connects nature and the human soul. I can recommend this book to colleagues wishing to develop their understanding of the emerging practice and epistemology of ecopsychology and its application to mental health.

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Call for book reviewers and contributions

Thus far, the book review 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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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 14th October 2020 c/o stella.galea@rcpsych.ac.uk

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