

In this edition

Tribute to Steve Pearce

Trainee Voices

Events and notices



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Editor's Welcome

Pamela Peters

Cambridge and Peterborough Foundation Trust



Welcome to the Spring edition of the newsletter. It is wonderful to see and feel the warm sunshine, and the burst of new life around us, although around us life continues to be disrupted, this time by war and its fallout, as well as the lingering effects of the pandemic – a psychological “long Covid”. Climate change also continues to impact the world, and there are increasing uncertainties associated with the rising cost of living and potential food shortages. All of which contribute to a general sense of unease and increasing acuity of mental ill health.

Saddest of all for the Faculty, being close to our professional hearts, the passing of Steve Pearce our Faculty Chair has left a gap that will be hard to fill. My personal memories of Steve are from my SHO and early SpR days in Southampton, where he was a Senior registrar in the Psychotherapy Department. His wry sense of humour, intelligence and mischief brought much fun into department meetings. He continued to be available and interested to discuss clinical and service issues long afterwards and was generous with his time and thinking. Our condolences and thoughts are with his family at this sad time. Thank you so much to Rex Haigh for sharing his moving eulogy and to Peter Tyrer for his lovely poem.

We are thrilled to publish the winning entry in the Medical students Essay competition, written by Josephine Akoro – well done Josephine!

A theme pervading this edition is around teaching and training doctors at all levels, including medical students, and the huge importance of relational approaches and understanding in doctor-patient interactions, and of using the self as an instrument of healing. There is also some reflection on how clinical practice continues to be impacted by external events – especially Covid and its aftermath.

I would like to congratulate Jo O'Reilly who will be stepping into the role of Faculty Chair – very well done Jo and all the best in your new role!

Many thanks for all your contributions! Please keep them coming!

Message from the Acting Chair

Jessica Yakeley

Tavistock and Portman NHS Foundation Trust



It is with great sadness that I am letting you know that Steve Pearce, our former Chair of the Medical Psychotherapy Faculty, died on 19th March 2022. He passed away peacefully in the presence of his family, and our condolences go out to them.

Steve excelled in many areas in his career as a Consultant Medical Psychotherapist – clinical, research, service development and much more. He worked tirelessly for the Medical Psychotherapy Faculty as Vice Chair from 2014 and then as Chair since 2018. His leadership was incisive, inclusive and inspiring, and under his direction the influence of the faculty has grown in many key areas. He was instrumental in developing the faculty's current strategy in ensuring parity of esteem for the 'psychological' within the bio-psycho-social model, which we are taking forward with the College. Steve believed that psychotherapy and psychiatry were inextricably entwined rather than separate, and this was evident in his work.

As well as his professional achievements, Steve was warm, compassionate, and supportive, with a wicked sense of humour and not afraid to speak his mind when needed. He will be hugely missed by many. The Medical Psychotherapy Faculty will be thinking about how to commemorate his life and work, but for now, our thoughts are with his family, and friends.

A Professional Tribute to Steve Pearce: 24.03.1966 – 19.03.2022

Rex Haigh
Oxford Health NHS Foundation Trust

Peter Tyrer
Emeritus Professor in Community Psychiatry

As a close friend and colleague of Steve for the last twenty years, I want to explain how, from a professional point of view, we have all lost somebody who was very special and very dear to us. This is to honour his memory, celebrate what he has done and convey the sort of person he was - the Steve we all knew, respected and loved. He was a great colleague, a great person, and a force to be reckoned with in our field. We didn't always agree about things, but that is an aspect of the strength and breadth of open-mindedness he brought to the work. The qualities of kindness, humour, humility as well as inspiring and helping others have been much mentioned by colleagues in the messages received since he has been ill.

When he asked me to do this eulogy, I was hoping to write it with him – we have written plenty of other things together – but sadly the ending came too soon to allow that to be possible. But I have discussed it with him, and know the sort of things he wanted me to convey - so I hope you will hear his voice coming through as well as mine.

Steve was a high-flyer from early days. He trained in medicine first at St Andrews, a very ancient and venerable medical school in Scotland, where he had an enviable reputation of only needing to revise just before exams: he was known as 'the professor' by his fellow-students, and he received a philosophy distinction and gold medal on graduating in 1987. Then he went to Manchester, one of the country's leading centres of clinical training, and qualified as a doctor in 1990. Soon afterwards he took the specialist physician examinations (which only the brightest tend to do) and went on to train in psychiatry at the country's foremost academic centre – the Institute of Psychiatry and the Maudsley Hospital, in London; before leaving there, he also took a higher degree, an MSc in research methodology. He went on to do his specialist higher training in psychotherapy, one of the rarest of psychiatric specialisms, based in Southampton. Although the rarest of specialisms, I think we would both agree it is one of the most interesting and rich - and ripe for new in-depth approaches.

It was when he was based at Southampton, and living in Winchester, that I first met him, in 1998: he came for a placement in the unit where I was consultant – a *therapeutic community* – or TC - in Reading. He was always busy, and so was also doing some time in London: finishing his MSc degree as well as being a locum consultant in a therapeutic community at Guys Hospital. A therapeutic community is a fairly radical, democratic and progressive form of mental health treatment that relies on group therapy ideas, and living

together in a way such that everything that happens becomes part of the therapy. In the old days – before our time – it was usually full time, 24/7, sealed off from the world, for a year, two years, or more. Our work together over the next twenty years, and with the wonderful teams we have worked with, was to try and show that it could be just as good – or even better – when you did it in condensed form alongside people’s real lives, so they could continue to be in their homes, usually in their families, and sometimes even working, while having an intensive form of therapy.

I have already said that we often saw priorities differently, and that the mixture of our personalities was a creative force. I think to characterise it, I was the rather unfocussed dreamer while Steve was the driving energy that actually got things done. I would talk about things like ‘the golden thread of relational practice’ and all the woolly stuff, while Steve was rigorous, sharp and precise about what we were up to. That double track bound us through all the work we did together – from his early days in Oxford through the training programmes we set up and ran together, to the therapeutic community textbook we wrote and had published more recently. I think what we both experienced was the most professionally exciting time of our lives – they were great days – exciting, creative, playful and fun; as well as being deeply serious and professional. I certainly couldn’t have done it without him.

So let me explain a few of those things and try to convey some of the passion he had for the work, and the difference he made – not just to patients, but to colleagues, and indeed the whole system of care.

It all started in a pub, as many of the best ideas do, I suspect. He was living in Winchester and a place called Dummer was halfway between us, so we met every couple of weeks or so to cook up mischief together and do some serious scheming. We called it the ‘Dummer discussions’ – and it led to him applying for, and getting, the consultant post in Oxford, and moving here to Eynsham a little later. In the Dummer discussions, I remember him saying ‘if I come to Oxford and haven’t got a therapeutic community in five years, I will leave’. But, as it all panned out, he never needed to even *think* about leaving.

An early success – and the one that set the scene for years to come – was by designing and bidding for funding for the ‘Thames Valley Initiative’ in 2003. It was the largest of eleven government-funded pilot projects for the National Institute for Mental Health in England (NIMHE), and it was based on a profound modification of therapeutic community practice. It took a great deal of work to put together, much of it in chasing senior people from across three counties (and Milton Keynes) - to get them to agree to it and sign the bid documents. When we finally submitted it, on the day of the deadline (of course), we went for a weekend celebration with both our families – to a rented Georgian house in Bath. Happy days of anticipation, with family time together – a lovely memory, although I seem to remember there was something tricky about the different aged children and the Sunday lunch.

Soon after, we heard that our bid was successful – it had to be trimmed a bit – but had scored well from the first line of judges for the bids (who were actually service users and people with lived experience of personality disorder), and then it passed the rest of the

administrative hurdles it needed to. So we started recruiting and building the team – I think we shortlisted about 40 people for 24 jobs across Berks, Bucks and Oxon – and had a whole day in Friends Meeting House in St Giles - making them listen to our plans, have lunch together, play games – and have formal interviews in the midst of it all. The 'lucky' winners then were invited for four days to one of the highlights of our adventure – the Sicilian team-building event.

We all met at Stansted, and Steve led a number of his newly recruited staff onto a Ryanair flight to Trapani, which is a port in the northwest of Sicily. There I think about 14 of us embarked on a boat run by a couple of Italian psychiatrists – they had it as a training base for psychodrama therapy; but never had it seen a crew like us from UK. It was clean and ship-shape, and newly painted, but very basic – but I don't think I should trouble you with details of the plumbing. Suffice to say we had four days of extreme team-building, plus a lot of work designing the details of the new service and building the community culture that influenced the clinical service thereafter. One abiding memory is of Jan Lees – one of the external facilitators – with recent hip replacements – being helped down to a remote beach, hand in hand, by Steve. She always thought of Steve as the Mick Jagger of therapeutic communities, and she was worried that his kind actions would destroy his street cred!

That was all about setting up the clinical service he ran, but I now want to mention a few other of the extraordinary things that Steve did, above and beyond the call of duty. The treatment method that we were both specialists in is the non-residential democratic therapeutic community. Steve spent 2010 to 2013 as chair of a Royal College of Psychiatrists project called Community of Communities, which was a network of nearly a hundred different TCs, across the country with a few abroad. He gave it an authority and psychiatric gravitas that I don't think anybody else could do – and it survives and thrives to this day.

In most psychotherapies, part of the training involves being in the therapy yourself. So several of us developed what we call Living-Learning Experiences – which are weekend courses where staff members have an immersive experience of doing almost exactly what they would if they were members of an actual TC (by being in a patient role rather than a staff role). Steve was chair of the organising committee for several years – and he saw the courses continue and develop into regular events. Three times per year in the UK, with the training model also being taken up in Italy, India and Portugal – with others in line to start running them in different countries. Because a homelessness group in Vancouver used our TC textbook, they have asked us to set it up over there, later this year.

The other area that defines Steve's practice is *Personality Disorder*. This is the diagnosis most of the people in our TC treatment programmes would attract, with all its complexities and controversies. The leading research organisation for it in this country is called BIGSPD – which stands for the British and Irish Group for the Study of Personality Disorder. Steve was elected to be chair of it from 2011 to 2015, and he helped to develop it as an organisation that genuinely listened to the voice of service users – so the research and work being done was organised democratically. This meant that the people being researched – those with the diagnosis of personality disorder - didn't feel like things were

being done to them as if they were guinea pigs in a laboratory. That movement is continuing and gathering strength as a truly radical and progressive strand of modern mental health care.

For research into therapeutic communities themselves, Steve is definitely the Mick Jagger of the field – he edited the TC Journal for several years, and helped to usher it into the digital age, so it now has an online presence alongside all other peer-reviewed science. With his own service he ran the first ever modern randomised controlled trial of democratic TC treatment, published in the British Journal of Psychiatry in 2017. It's hard to overstate how important this sort of evidence is in medicine today – although it is extremely difficult to do for treatments as complex and nuanced as therapeutic communities are. But he managed it, with the loyal and excellent team in Oxfordshire – and that paper will stand proud as a beacon of good science for others to follow and hopefully emulate in the future. Without it, many of us feel that the whole humane treatment approach that characterises therapeutic communities would be much more likely to wither and fade away.

As well as clinical work, training and research, Steve was involved in psychiatric politics and the corridors of power. Between 2013 and 2019 he was chair of a personality disorder clinical reference group for specialised mental health with NHS England and has been an energetic reforming leader of the Psychotherapy Faculty at the Royal College of Psychiatrists since 2018. Speaking from my own experience, committees at the Royal College can seem tied up in their own procedural knots, rather stuck, and impossible to have much passion or energy about; I have never lasted very long. But Steve has much more stamina and his determination to make positive progressive change has opened matters up in ways that I think will continue to have benefits for the future of mental health care.

As if all this is not enough, there is also the small social enterprise that three of us are directors of, and of which Steve has been chair for the last few years. It is called Growing Better Lives CIC and is the proud owner of a therapy yurt in which we have been practicing 'greencare' (a type of ecotherapy) since 2007. As well as the therapy, we do some training and consultation. Because we're an ecologically-based organisation (and won the Royal College of Psychiatrists' first ever sustainability award) it means we can add another feather to Steve's cap - as a part-time eco-warrior.

There are so many stories to tell and activities to mention that I can't do full justice to all Steve has contributed, so the last one I will mention is the textbook we wrote together and published four years ago – *The Theory and Practice of Democratic Therapeutic Community Treatment*. Over the course of a couple of years we toiled away at it and included a couple of retreats away for a few days to deeply immerse ourselves in the writing. It emerged as something we are both very proud of – a crystallisation of the work in the field pulled together in a way that had not been done for about forty years. Steve's name is first on it, because he did more of the work – and it proudly bears his name as a marker of what he has contributed and will do so into the future. Since its publication we have also started an international 'practitioner training', with Gill Attwood and the Oxford team, which has had students from Japan, India and Italy as well as UK. It was interrupted by covid, but we're

hoping to recruit the next batch of participants later this year – Steve will be very much in our minds for it all, and in the spirit of the course.

This is all a matter of record – with publications in the scientific literature, and many devoted colleagues to confirm and remember it. But it doesn't convey the passion and excitement of working with and being friends with Steve, and what a truly extraordinary person he was. A phrase we would sometimes use is 'quality of relationships', and it epitomises what has been different about therapeutic communities. It is not about something that can be weighed or measured – but only felt between people. And it is also the bedrock on which all therapeutic practice – as well as most human relations – depend. And Steve wanted me to convey how these relationships include *all* the people that he came across in the work, and how much he valued them.

So to finish by talking directly to you, Steve:


You have already given so much to us all - the quality of relationship with its energy and spark that gives us that kindness, humour and humility. For all of us, for all your patients, and for so many more, it will never be lost or forgotten.

We had a horrible foretaste of things to come when you had your subarachnoid haemorrhage, shortly before the pandemic, and we all feared losing you then. But what a cruel twist of fate, that almost as soon as you recovered from that, that this very aggressive and incurable cancer struck you down.

It is just such a tragedy that it has ended so shockingly early, with so much more you could have given. When we spoke for the last time, a few days before you died, you said "what could we all have done together if we had another twenty years". It is so sad that is not to be.

You have left such an unusual legacy for a professional leader – as much in the ripples that spread out as in your many concrete achievements. The field will be so much poorer without you – but those around you will carry the flame – I am very sure that it is going to burn brightly and never go out.

In a way, I like to see it that you have gone on ahead of us. So we don't so much need to feel sorry that you have gone, but be truly grateful for the time we had with you when you were here with us. That will never be lost or forgotten. Each one of us takes the path we do through an amazing collection of coincidences – how grateful I am that one of my coincidences was that our paths crossed, twenty-odd years ago. Thank you, Steve, thank you for everything.



**Looking back, you know
You've achieved so much
Visited that forgotten field
Marked out its boundaries
Added fresh loam, tilled the soil
Harnessed helpers, including those in need
To create a concord of easy harmony
So now it grows
Pleasing on the eye
And the soft wind caressing each golden ear
Tells of the harvest
Yet to come**

Peter Tyrer

Essay Prize: Winning Entry

Q: Tell us about a patient you have seen, showing how your reflections on psychological issues deepened your understanding of the case and contributed to your personal learning

Miss Josephine Akoro
Imperial College School of Medicine

Introduction

Historically, Emotionally unstable personality disorder (EUPD) and Medically unexplained symptoms (MUS) have both raised questions such as 'Are you genuinely sick?', 'Are you just making this all up for attention?' and 'Is this just bad behaviour?'¹. Research has even shown that when a patient is labelled EUPD, staff respond less empathetically². Our scientific world asserts that every effect has a cause, which makes it hard to be compassionate when there is no hard proof. Hence these diagnostic labels frequently lead to the withdrawal of sympathy². These patients are often treated as untreatable, as their sick role credibility is doubted, and associated benefits are revoked³.

This essay will explore what can happen when EUPD and MUS intertwine by discussing a patient I saw during my Liaison Psychiatry rotation. To deepen my understanding of her health-seeking behaviour, I will reflect on the impact of adverse childhood events on her physical and mental development. I will then explore how her early experiences formed a template through which she related to herself and her clinicians. Although it is easier said than done, I will conclude that it is necessary to develop an open attitude devoid of preconceptions when working with 'difficult patients' to improve patient and doctor satisfaction.

Case Report

On the first day of my psychiatry placement, I overheard my team nurses discussing a patient who was threatening to "jump out of the window". This statement immediately caught my attention, so I eagerly asked the nurse if I could accompany her to carry out a risk assessment. When we arrived on the ward, I met a 28-year-old woman named Hannah* who looked shocked to see that staff from Liaison psychiatry had come to visit her. She claimed that the comment was just a joke. However, Hannah has EUPD and so the nurse explained that this diagnostic label often makes staff more cautious.

Hannah was admitted to the ward following a Botulinum toxin injection administered to treat her laryngospasm. The procedure went well with no recorded complications. However, Hannah began to complain that she could not swallow food and drink without violently coughing. Various investigations including a Fiberoptic endoscopic evaluation of swallowing (FEES) were carried out to assess her swallow. No physiological abnormalities were found, yet Hannah remained distressed and insisted that the dysphagia was preventing her from

eating and drinking. Despite this, Hannah's observations and examinations remained stable, and she would leave the ward several times a day for long periods. This pattern prompted her multidisciplinary team (MDT) to believe that she was lying or exaggerating her dysphagia and secretly eating and drinking. The belief was further reinforced by Hannah's continuous demands for a nasogastric (NG) tube. This marked the beginning of a complicated case, as the MDT tried to figure out how best to manage a patient who insisted on a procedure, they deemed unnecessary.

Each day Hannah was gently encouraged to try to swallow small amounts of food and drink. Yet each day Hannah said she could not and asked for an NG tube. She remained in hospital for a while as the MDT struggled to figure out how best to move forward. Several MDT meetings were held both with and without her. She expressed that she wanted to get better and to go home. But when asked what she wanted us to do she either said "I don't know" or continued to be adamant that she needed an NG tube fitted.

It was not clear if Hannah consciously produced her dysphagia in which case, it would signify factitious disorder. Alternatively, if the symptom was unconsciously produced then this would represent conversion disorder ¹. Either way, it was agreed that Hannah's dysphagia was an example of somatisation. Given her EUPD, the Psychiatric consultant theorised that Hannah wanted the NG tube inserted so that the team could risk harming her. This was an example of self-harm by proxy. I watched the consultant try to reassure Hannah that she could physically swallow and that her dysphagia was anxiety induced. However, Hannah firmly disagreed, and the MDT remained stuck for a while.

Eventually, I discovered that plans for Hannah's discharge were being made. This surprised me so I decided to speak to her to learn more about her hospital experience. When I arrived on the ward, I was shocked to see that the MDT had ultimately given Hannah what she wanted – an NG tube. I was even more shocked when Hannah told me that she "did not want the NG tube anymore".

During our conversation, I learnt both about her personal life history as well as her opinions of her treatment. Hannah felt that once health care professionals heard that she had EUPD, she was immediately treated differently. She also complained that there was a lack of communication as the reason for the MDT's change of heart was not clear to her. She believed that there were 'many people talking about her but not to her'.

How did Hannah make me feel?

Hannah is the first person I have met with EUPD (that I know of). I felt both excited and hesitant before meeting her. I was curious to see if she would make me feel uncomfortable in any way, due to the stereotypes such as 'manipulative' and 'attention seeking' that I had heard. Interestingly, I felt at ease in her presence during our first encounter and pity for what she was going through. Hannah radiated an innocent, somewhat helpless vibe that made me want to sympathise with her. I found myself looking for common ground and searching for parts of myself in her, to relate and build rapport.

Throughout the various MDT meetings, I got the impression that staff were walking on eggshells around her. Nobody wanted to upset her or trigger a confrontation by disagreeing

with her demands. I recognised that listening to other people's perspectives of Hannah's behaviour would help me gain a broader understanding of who she was. However, I was aware that patients with EUPD are judged more negatively than others ¹, so I did not want my view of her to be influenced by other people. I wanted my opinions to be based on the behaviour that I saw. Yet, I soon realised that I was starting to feel ambivalent towards Hannah. I struggled to pinpoint how Hannah made me feel as I could not identify where my emotions began and the MDT's ended.

When Hannah told me that she did not want the NG tube anymore, I felt astonished. Perhaps members of the MDT were right after all, and I was wrong to take everything she said at face value. I felt somewhat betrayed for trusting her. I also felt a sense of powerlessness because the team eventually gave her what she had been begging for, just for her to take it back and behave as if she had never wanted it. My feelings towards her were complicated further when I discovered that she had threatened to overdose if they discharged her. Perhaps it is because I desire to try to see the best in people, but I struggled to envision a hostile side of her. I was very confused; she was the sweetest person to me, and I had not met this other version of her. I had started by wanting to remain passionate and hold faith in Hannah but by the end of my time knowing her I became more concerned about being naïve.

What was good and bad about the experience?

I admired the way my consultant sensitively asked Hannah if her dysphagia could be anxiety-induced. Her gentle and non-patronising tone assured Hannah that we were all on the same team. We were all here to help her recover. Even though Hannah did not believe the problem was psychological, she still responded positively to the consultant's compassionate approach. Watching this highlighted the importance of avoiding a paternalistic 'I know best' tone when dealing with MUS. Making the patient feel like their concerns are valid is important, as it encourages them to further open up to us ¹. This is important for strengthening rapport in the patient-doctor relationship.

Nevertheless, the assumption that Hannah was eating and drinking when she left the ward did not sit well with me as I did not hold the same scepticism. She said that she could not eat and drink, and so I believed her despite her stable observations. This made me wonder – how can I find a balance between gullibility and cynicism? Perhaps with experience of working with EUPD patients, I will come to realise when people are lying. Either this or her EUPD made people assume the worst of her.

As one of the features of EUPD is a history of intense and unstable relationships ⁴, knowing this likely made staff anticipate a tumultuous patient experience. There is a strong impression that people with EUPD are manipulative ³. This was demonstrated by the assumption that Hannah was feigning her dysphagia to gain medical attention. However, intentional manipulation requires a lot of planning and calculation, which sits in contrast to the helpless, childlike Hannah that I saw. Whether or not it was deliberate, her behaviour was normal in her world but difficult and contrary in our own ³. Instead of viewing manipulation as part of her illness behaviour, it was considered immoral. This view reduces sympathy and breeds distrust as the behaviour is a direct threat to the traditional hierarchy within medicine ³. Patients are to look up to doctors, not the other way around.

When I discovered Hannah had been given the NG tube, I wondered about the ethical implications of this decision. I did not think it was in her best interests to receive the NG tube because the health risks of inserting the tube outweighed the benefits to her ⁵. However, as time passed the team realised that Hannah was not going to budge and so they gave in. They hoped that this would lead to her quick discharge, yet she still wanted more attention. In the end, both the patient and her clinicians were dissatisfied with the outcome. On reflection, taking the time to explore Hannah's history in further detail could have helped us get closer to figuring out why she could not swallow. If we had explored what had happened to her during her life, rather than what was wrong with her, we may have picked up on her psychosocial cues ⁶. Understandably, the main priority was finding a solution so that she could be discharged. Hospital beds are a precious resource and there was not enough time to delve into her past in such a way that would quickly lead to a resolution. However, a deeper understanding of her might have helped us remain compassionate towards her and alleviate the intolerance for her behaviour.

Why did Hannah somatise?

Somatisation, the unconscious psychological expression of physical symptoms, is the process that led to Hannah's dysphagia ⁷. This concept is incompatible with modern Western medicine's tendency to treat the mind and body as separate entities under Cartesian dualism ⁶. Treating physical and mental illness so distinctly negates the idea that the body and mind are one system. This is reflected in the separation of Psychiatry from other medical specialities, as Medical professionals handle physical disease and Mental health professionals look after the mind ⁶. Even Liaison Psychiatry, a speciality that focuses on the interface of physical and mental health, still implies that they are 2 separate systems that occasionally interact.

The biopsychosocial model challenges mind-body dualism by demonstrating how biological, psychological, and social factors interact and overlap with each other to produce disease ⁸. However, the tendency to separate mind and body still exists. The philosophy reduces the body to a machine that has broken parts to be fixed ⁹. This led to treating Hannah's subjective illness experience as secondary to discovering an organic cause for her dysphagia ⁶. Under this culture, an organic cause gives meaning to her symptoms and legitimises her suffering. However, her negative investigations provided no meaning. So, the reality of her suffering was questioned as Hannah was told to keep trying to swallow despite her pleas that she could not. Her experience was then attributed to a psychological cause whilst still doubting that her symptoms were real. This black and white view of suffering implies that it is either physical or mental, but not both. This led to her feeling like her experience was not taken seriously and further increased her distress.

To increase satisfaction for both parties, it is the responsibility of the MDT to try to understand Hannah's health-seeking behaviour from her point of view ¹⁰. Therefore, I used my conversation with Hannah* to produce a case formulation to help me understand why she was experiencing medically unexplained dysphagia.

	Biological	Psychological	Social
Predisposing	Family history of Bipolar disorder, Depression and Anxiety	Family history of Bipolar disorder, Depression and Anxiety. Insecure attachment style	History of sexual abuse
Precipitating (trigger)	Laryngospasm	Emotionally unstable personality disorder Multiple drug overdoses Stress	Father recently diagnosed with cancer
Perpetuating (maintaining)	Poor sleep	Emotionally unstable personality disorder Poor coping mechanisms	Isolation EUPD Stigma Low self-esteem

Figure 1: Hannah's Case formulation

Hannah had a history of multiple overdoses, with her most recent one resulting in her detention under the Mental Health Act. Soon after she was discharged, her father was diagnosed with cancer. Hannah took on the caretaker role alone as she does not have a strong support network. Not long after this, her laryngospasm began, and she was admitted to the ward. Applying Parson's sick role theory, the MDT have no right to blame Hannah for her EUPD or somatisation, but Hannah must make recovery her priority¹¹. Yet it was difficult to believe that she wanted to get better given her threats to overdose if they discharged her. Going home meant facing a stressful reality – her isolation and her father's illness. Thus, it is easy to see why she would prefer to be in the hospital. There she was given attention and absolved of responsibility as she switched positions to take on the sick role¹¹. It could be argued that Hannah's preoccupation with an NG tube would further consolidate her image of what being sick looks like especially because the procedure would lengthen her stay in hospital.

Emotions are considered a mental process, even though they are experienced within the body - for example, feeling palpitations when scared. The ability to know that physical sensations arise from within you and not outside of your body requires the development of a sense of self⁶. This allows one to know who they are, where they end and where others begin. This requires us to combine our mental and physical experiences, which we learn to do during our early interpersonal relationships⁶. Therefore, our childhood experiences

directly impact the development of our sense of self. Sadly, as is the case in many people with EUPD, Hannah had a history of sexual abuse which disrupted this process.

Hannah's adverse childhood event directly influenced how she perceived and responded to herself and others in her life¹². Trauma reduced her mind's sense of connectedness to her own body as she tried to escape the painful emotions and protect herself from extreme suffering. This led to her frequently dissociating and reduced her bodily awareness^{12,13}. This made her less likely to notice and trust her body's expressions of her own emotions^{6,14,15}. The abuse also affected her ability to identify and regulate her emotions^{4,12}. Struggling to recognise her emotions, and how they were expressed through physical sensations, increased Hannah's tendency to relate to her physical self as a 'thing rather than me'^{6,16}.

It was difficult to determine if Hannah's somatic dysphagia was a conscious process or not. If she was intentionally feigning her dysphagia, then it was because she unconsciously enjoyed playing the sick role. By putting herself in a helpless position she could rely on her clinicians to look after her¹¹. However, Briere's research supports the idea that she was not pretending, as he demonstrated that a history of abuse makes patients appear to exaggerate their symptoms even though they are genuinely struggling with the psychological outcomes of the trauma¹³. This is further supported by French psychologist, Pierre Janet's argument that somatic symptoms are expressions of traumatic memories¹⁴. Hannah remained silent about her sexual abuse for many years. Since her emotional dysregulation manifested as a swallowing problem, her demands for an NG tube can be thought of as self-harming behaviour. It could also be argued that Hannah's dysphagia was a metaphor for her inability to speak about her trauma because she feared not being believed. This lack of belief is mirrored in her experience with the MDT who doubted the reality of her dysphagia.

Both EUPD patients and patients with MUS are commonly labelled difficult¹. Hannah's traumatic experiences influenced the development of an insecure attachment style which is a common link between these two conditions¹⁷. The caregiving role of the MDT triggered Hannah's underlying attachment style which she communicated through her verbal and non-verbal language¹⁷. The team inevitably responded and both parties communicated unconsciously through transference and countertransference¹⁰. Staff generated fearful and defensive body language, to which Hannah responded with distrust and hostility. Hannah also projected her unconscious need for dependence and attention onto the staff, which manifested in her demands for an NG tube. The staff responded to this by rejecting her requests and thus rejecting her needs. The relationship became a self-fulfilling prophecy as Hannah's frantic attempt to avoid abandonment were met with the team's frantic attempts to do anything to discharge her^{3,17}.

What I have learnt

On reflection, I understand the value of improving my own body-mind relationship by increasing my bodily awareness and recognising my unconscious biases¹⁷. If my body and mind are disintegrated, I will struggle to connect and feel present with my patients. Therefore, developing mindfulness and self-awareness will enhance my ability to look deeper at the unconscious motives driving my behaviour. This in turn will strengthen my

ability to do the same with my patients, as I become more aware of the unconscious roles that we play in the patient-doctor relationship.

My experience emphasised the need to uncover my patient's story by taking a comprehensive history. Becoming more mindful of how trauma can restrict a patient's ability to have insight into their behaviour will help me become more tolerant^{18,19}. Mindfulness leads to changes in attitudes and builds empathy and rapport, strengthening the patient-doctor relationship. This would not necessarily prevent the frustration that is felt when navigating challenging patient cases. But it would encourage an open mind, such as the need to consider a patient's attachment style, allowing the patient to feel understood and the clinician to feel more prepared¹⁷.

Unfortunately, taking an extensive history requires a lot of time that is not always available on busy hospital wards. If the history taking is brief, it will not be in the patient's best interests to immediately delve into their past, as reliving unresolved traumas without sufficient follow up brings no therapeutic gain. Therefore, learning about a patient may take multiple encounters. Given there are many other patients and paperwork to attend to, figuring out the unconscious drivers behind a patient's behaviour may be asking too much of psychiatrists who do not have psychotherapy training. In an ideal world, there would have been a team psychotherapist who would take the time to work out each patient's case formulation and provide advice. However, one person cannot do it all. An MDT is still necessary, especially for staff to support each other's wellbeing as they navigate complex patient cases. Furthermore, being able to lean on each other reduces feelings of frustration by providing a professional space for us to offload feelings such as anger. This would prevent me from responding to my patient's projections in a harmful way.

If I enter my clinical encounters believing that the patient will be difficult, then the patient will be difficult³. It would be a useful exercise to look at my negative reactions and consider if they reflect how the patient feels²⁰. For example, when I felt frustrated with Hannah, it could mean that Hannah subconsciously felt frustrated with herself. Furthermore, Hannah's need for attention could be driven by her low self-esteem and loneliness. Hence, I will try to reframe my view of behaviour such as neediness and hostility, from a disruption to treatment to a part of the whole disease process³.

Developing this 'what can I learn from you' attitude and recognising that there is always something deeper beneath the surface will help me respond with more grace and understanding. This will allow me to hold more space for my patients as they navigate their experiences. I appreciate that this will be a difficult and demanding process, requiring much patience, something that is challenging in a fast-paced hospital environment. Many of my patients will have insecure attachment styles that manifest during our encounters, so making effective use of this has the potential to bring about healing¹⁷.

We learn about ourselves through our relationships, so as I take on the caretaker, authority figure role, they become the defenceless child they once were. Hannah's demand for an NG tube and her overdose threats can be thought of as a form of acting out for attention – like a child throwing a tantrum. Patients like Hannah want to have their hands held but I have the responsibility to empower them by giving them choices and

encouraging them to work with me as a team. Building a trusting relationship, checking in with patients and asking for feedback about how they feel about me will encourage growth. However, it is important to maintain boundaries as destructive tendencies can still undermine the treatment¹⁷. Therefore, responding to patient tantrums in an unemotional measured tone will diffuse the intensity and can be thought of as 'reparenting' the patient¹⁷. Establishing solid boundaries will also help me manage negative interactions, maintain my wellbeing and enthusiasm, and prevent emotional distancing¹⁷.

Seeking to heal unstable attachments through the patient-doctor relationship seems to be something that only psychotherapists should do. However, every healthcare professional has a role to play. As a medical student, I will try to be more mindful of the language and tone I use^{6,17}. Using empathetic instead of controlling or dismissive language will help patients feel like I truly believe and care for them. This in turn will help patients be open to different thoughts about their symptoms.

The importance of continuity to maximize the therapeutic potential of the patient-doctor relationship was highlighted to me during my experience. Hannah saw several psychiatrists whilst under our care and had to repeat her history to different people. Patients will not heal if they are repeating their story to different people, many of whom are not involved in their ongoing care⁶. Gaining a collateral history and maintaining good communication with other services that the patient has accessed will help me gain a deeper understanding of my patients.

Long-term treatment for patients with EUPD and MUS could help them integrate their mind and body¹⁸. Lack of agency over emotions and mentalisation is a core part of EUPD^{4,18}. Being unaware of how much of your behaviour is driven by unconscious beliefs and desires makes you a victim to your unconscious²⁰. Experiencing feelings and behaviours that you do not understand makes you feel helpless. This was demonstrated by Hannah's frequent 'I don't know' response when asked what she wanted us to do. She felt that there was nothing she could do to improve her situation. Therefore, helping her to increase her range of consciousness and her ability to process her bodily signals would increase her self-agency. The intention is not to invalidate the reality of the symptoms or to blame patients for their suffering. This can be achieved by practising mindfulness meditation, a feature of Dialectical behaviour therapy (DBT) which is recommended for EUPD⁴. However, this all depends on the patient having a desire to change.

Conclusion

A lot of time was spent discussing whether Hannah was exaggerating her symptoms, yet this is irrelevant in the grand scheme of things. As there is no way to determine the truth, doubting her only serves to build resentment, mistrust, and intolerance. She, without a doubt, perceived this through our body language and tone. Therefore, it is important to assume that a patient's medically unexplained symptom is a real and disturbing experience⁶. At the same time, it is critical to acknowledge that these symptoms are often metaphors for emotions that the patient has not yet consciously understood. My job is to help these patients on their journey to discover the underlying problem. Managing patient expectations without giving them unnecessary investigations and procedures will be challenging. However, if I adopt a beginner's mind approach in which I attend to my

patients with non-judgmental curiosity this will help me to enter their world and decode their symptoms ²¹. Ultimately, getting to the root of the problem, whilst ensuring the patient feels heard, will bring about optimum satisfaction.

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Making the psychodynamic approach clinically relevant for trainees and students

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Making psychodynamic theory relevant in teaching the clinical practice of psychiatry is a challenge. Sometimes it is hard to know where to start. I imagine that many consultant psychiatrists would struggle to explain psychodynamic theory to trainees. Perhaps starting with investment in trainers would lead to better teaching of trainees and medical students. Such an approach was tried in Wales. Health Education and Improvement Wales (HEIW) funded a yearly psychotherapy CPD pilot programme for consultants involved in teaching and training. Dr Kate Dufton organised a support programme of monthly discussions based on Confer online module lectures on personality disorders (Fragile Selves: Working with Narcissistic and Borderline States of Mind) and a separate one on trauma. I would like to reflect on some teaching opportunities discussed in the CPD group.

Power of communication through affect and empathy

Communication through words and establishing connection with the patient forms the basis of teaching communication skills. Trainees would receive feedback on their use of language, for example their use of closed and open questions. Trainee and student placements in psychiatry or general practice offer a good opportunity to observe and reflect on deeper relationships formed over the years. Psychiatrists in CMHTs and Forensic teams, although not engaged in psychodynamic therapy, yet form deep relationships over the years of admissions, home visits and family meetings.

One of the lectures in the Confer series by Dr Frank Lachmann, brings attention to the transformative power of communication through affect and empathy. Dr Lachmann is a teacher from the Institute for the Psychoanalytic Study of Subjectivity in New York. He argues that deep, enduring change occurs when patient and therapist are affectively related. His lecture inspired a teaching session focused on relationship and connection through affect. Many of our communications focus on words, perhaps it is equally important to bear in mind that patients pick up on our facial expressions, they recognise that we own what we say through non-verbal communications. This is especially important for patients who have early developmental deficits.

Case Vignette: "I have to rein it in."

A woman with bipolar affective disorder and childhood trauma talked about her relationship with her CMHT consultant to a 4th year medical student. She has a severe bipolar illness and poor insight resulting in non-compliance and repeated long hospital admissions under the MHA.

She explained to the medical student that when she becomes unwell she cannot quite follow what professionals are saying, but remains receptive to facial expressions. She talked about noticing concern and anxiety on her doctor's face as she was relapsing into

another phase of non-compliance. She understood affective and empathic non-verbal communication much more than information on medications or their effectiveness and decided in her own words to "rein it in" and re-start taking her medications.

Reflection on psychodynamic triangle of persecutor-rescuer-victim

One of the most difficult aspects of teaching trainees and students is working relationally with patients with enduring distressed states, for example personality disorders with chronic suicidality, or enduring eating disorders. Often skills learned by psychiatry trainees in recognising and managing acute risk are less useful in situations with no low-risk options. Clinical encounters with chronically suicidal patients with disorganised attachments can lead to deeper exploration from the attachment perspective.

Case Vignette: "Just how bad do you have to get before you are admitted?"

The medical student observed a clinic consultation with a woman with borderline personality disorder, who was grieving the loss of her supportive parent. Loss of parental support was historically linked to a suicide plan, yet experiencing actual loss made the patient positively re-evaluate her existing family relationships. The patient was very distressed, yet her level of suicidality remained unchanged compared to her baseline. At the end of the consultation the patient agreed on the proposed management in community and increase in contact with the team. The medical student reflected on the high level of suicidality and asked how bad you have to be to get admitted. The clinical encounter was used to discuss the role of the professional as rescuer and the patient as victim. The practitioner adopting the role of the rescuer places the patient in the role of the victim in need of rescue and with little agency. The therapeutic stance is engaging with the Adult Self within the patient to support recovery.

Teaching general psychiatry to trainees benefits from approaching it from a relational and psychodynamic perspective. Case based discussions can illustrate wider relational and attachment-based work as well as psychiatric diagnosis and management. Improving skills and engaging trainers translates into better teaching opportunities for trainees and students.

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Confer Online Module Fragile Selves: Working with Narcissistic and Borderline States of Mind.

Reflections on setting up a Med student Balint Scheme

James FitzGerald & Fraser Arends

Higher trainees in Cambridgeshire and Peterborough NHS Foundation Trust
Co-Founders of Cambridge Psychodynamic Psychiatry Research and Innovation Group
Follow on Twitter @CamPsyche

Balint groups are longitudinal case discussions and were established to understand the doctor-patient relationship and hence address the needs of the complex patient in the clinical setting. Initially, these groups were set up by Michael Balint, a psychiatrist and psychoanalyst based in University Hospital London, to develop a method of supporting non-psychiatrists in their clinical work by exploring their countertransference and medical imagination. Although Balint groups are well recognized in psychiatry training and GP training, medical student Balint groups have also been popular for many decades. In fact, the early Balint groups themselves included medical students. Here in Cambridge, a medical student Balint group had been tried many decades before but had run out of steam. In 2019, we decided to set up a Cambridge Medical student Balint group scheme to shake things up here and introduce some much-needed psychodynamic work to a system that had long forgotten its heritage. A way of making waves but also surfing them.

Group dynamics are always at play within complex systems and the University of Cambridge medical school is no exception. The various pieces were being organised and then the pandemic hit. Of course, in the turmoil, new projects could not be given any headspace as the status quo needed to be refortified. Obviously, we disagreed but accepted the situation for the short term. A year later, the system was still caught in the midst of its greatest crisis, and through a certain degree of lobbying on our part, we were supported to establish, grow and maintain a viable scheme that can now provide much-needed in-depth reflective practice and experiential groups.

The role of the medical student in clinical settings has many forms. The medical student is often a dehumanized object into which various clinicians project their unconscious fantasies. Some busy clinicians ignore and reject them. Those clinicians who have taken themselves as their own object relation (narcissism) regale students with the heroic narrative of their own endeavours. For those clinicians working out traumas from their own clinical training, they perpetuate the cycle of abuse through what the Americans call *pimping*, a type of questioning that has the student on the back foot and in a submissive position. In this sense, the medical students prop up the fragile and rigid persona of the clinician. There is within the literature the unvalidated conventional wisdom that medical student Balint groups need to be altered and portions of it dedicated to didactic teaching. This suggests that group facilitators do not have confidence in the ability of medical students to engage with complex material or the often-challenging nature of their own countertransference. We decided to maintain the frame and fidelity of the group and not perpetuate the power-based bedside teaching model.

When we started the groups, we tried to balance our excitement about the project with the sheer horror of the stilted mannerisms and pretensions of fragile middle-class

medical students. A painful reminder of our own experience. Initially, the narratives about patients and the dialogue of the groups were briskly paced, punctuated by brief albeit tortured silences, staccato dialogue, and unimaginative cliches that had been internalized from recent encounters *on the ward*. But as a group began to settle down, the container of the space began to produce something different. The medical imagination of the students could be experienced and with it, the humanity of their heartfelt wrestle with the material and their challenge of the conventional practices of their clinical seniors took centre stage. At the heart of each Balint group narrative was the question 'what is my purpose?', a question that should guide all of us in our lives.

However, the transition from medical student to doctor is both fragile and must take on a numinous archetypal quality. An experience that is infused with the medical imagination. The medical imagination is a much-needed clinical tool and personal tonic to combat the sterility of question banks, artificial OSCEs, and the cynicism of real-world doctors. The feedback from medical students regarding the Balint groups is often overwhelmingly positive, from identifying that there is an inner world of experience that mirrors the external world, to the recognition that to be a great doctor one has to be a human doctor, and dare I say a vulnerable doctor. An openness to the sensitivity and vulnerability that modern medicine demands. For beyond the tedious and often restrictive pressures of the NHS with its superego structure and function is the necessity to engage patients and their families with a degree of humanity and integrity that is therapeutic in and of itself. Balint himself often framed the doctor as the real drug that was therapeutic.

There is of course a potential negative side, when the space and time of the Balint group are not protected, for example, with competing seminars and the stress of pending deadlines, we received some negative feedback. Often seen in the choice of image and metaphor of participants is that of clinical reality being akin to war, battling to treat those who are both friend and foe with an expected level of detachment that is systemically entrenched by universities, regulatory bodies, and likely the doctor's own family narrative that is as consciously idealised as it is despised for being the destructive millstone it is. Balint groups cast off together into these dangerous waters where monsters can be found and surviving the journey requires trust in one's fellow oarsmen and in one's captain who must keep one hand each on oar and tiller. Our journey as leaders in this scheme has been of feeling out the best routes on old and fraying maps, navigating at times by sextant and starlight, plotting a course towards what feels safe enough for leader and group members in a system where demand is relentless. Our negative feedback reflected these pressures and is useful material on how we can bolster Balint groups and learn to develop as group leaders.

We now have several groups running, with leaders having the opportunity to co-lead, get supervision and develop their skills in working with these eager young proto-clinicians. It's a great honour, but also a real privilege to get this work done. Not easy, but always stimulating. Developing and delivering new projects during a crisis is of course the perfect time to do it, a time when the intensity of the crisis can give birth to something new, something needed. Medicine itself is now in a crisis and has been for some time. Balint groups have the ability to tap into something we often forget as we become doctors, the source of our healing gifts. Our own humanity, our own irrationality, our own imagination, and our hope to be good enough.

The opinion piece article published here has been temporarily removed. It will be republished in the autumn edition along with a response from the Eating Disorders Faculty.

Trainee Voices

Editors

Michael Milmore, ST8, Dual Gen Adult/ Med Psychotherapy, South Yorkshire

Dr Eleanor Riley, ST4 Gen Adult Psychiatry, Lancashire and South Cumbria

Dr Hafeesa Sameem, CT2 Gen Psychiatry, South Wales

Introduction

Dr Michael Milmore

ST8 Gen Adult/ Med Psychotherapy, South Yorkshire

Over two years on from the first lockdown it is sort of hard to fathom what's just happened, let alone remembering working during a time when all others in society were only allowed out for an hour's exercise a day. I suppose we can't forget but we can think and reflect as we'll read about in this Trainee Voices.

I would however like to start by taking this opportunity to thank Dr John Gossa. He is stepping down as co-editor having now proudly received his CCT and recently securing a consultant post. Congratulations John! Stepping into his shoes are Dr Eleanor Riley, ST4 and Dr Hafeesa Sameem, CT2. They join from the north of England and Wales respectively giving a good representation but needing a southern colleague for a full complement! Challenge accepted anyone?!

Our pieces in this edition share the apt theme of moving on. Dr Sameem begins by a personal reflection looking back at her training in the pandemic, the impact of this and a hope for how we can heal, move on, with compassion. Dr Crofts follows wondering about who we are and our abilities in the healing journey through her long psychotherapy case. Moving on there is of course doubt around but it reminded me of Winnicott and about what may be "good enough" in this strange time. Finally, Dr Riley concludes with her reflection on applying to medical psychotherapy during the pandemic and a hope to move on for herself but also for the system. Moving on, will it return to the old normality or will something rise from the ashes...

Finally, as this edition comes out the appropriately named Medical Psychotherapy Trainees & Trainers Conference: "Loss & Regeneration" will have happened. This is quite momentous as it's the first in person of its kind for some time. That is of course not forgetting that it's being held in the Freud Museum! As always, we welcome contributions of all varieties and modalities, so as you read on here, have a think about adding something from yourself. You can send submissions to catherine.langley@rcpsych.ac.uk.

The Covid-19 Pandemic – A Young Psychiatrist's Ponderings

Dr Hafeesa Sameem

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The train was heading on at full speed. It was a state-of-the-art train. Fully loaded with all the trimmings that modernization could boast. It seemed formidable and unstoppable, all glossy and shiny on the outside, carefully concealing flaws (if any) with impeccable camouflage and representing the 21st century man. As a society we have been feeling pretty formidable. And why not? We have come a long way from our caveman ancestors and have evolved to be far superior beings than anyone could have ever imagined in the past. The development has been phenomenal and blinding. The glare so bright and the pace so fast that no one had the time or means to stop and smell the roses. The survival of the fittest was synonymous with our day-to-day existence.

It seems ludicrous that such a superior society was stopped dead in its tracks, by SARS-CoV-2, which is a minute virus not even visible to the naked eye. This virus has single-handedly managed to stop the high-speed ginormous train and forced us as a society to take a step back, to examine and question our lives and growth. Evolutionary medicine experts and ardent Darwin theorists now look forward to years of long-drawn-out discussions on how and why some groups of people perished like flies caught in a heatwave while others emerged almost unscathed. What prompted such a large-scale natural selection process that hit us out of the blue? Was it something that was necessary to slow down the almost scary exponential growth? Or is it just a case of co-evolutionary science with human beings losing the arms race against pathogens as highlighted by Gluckman *et al.* (2016)? I think I will leave that discussion to the bigwig evolutionary medicine experts.

This pandemic has brought about an avalanche of scientific interest with industry experts researching and studying it from just about every possible angle. These studies are making it clearer that we as a society have not evolved in the best way possible. There were loads of cracks which we had chosen to selectively ignore. The Covid-19 pandemic has forced us to stop and face the things we have avoided for so long. Declining physical health due to poor sleep and nutrition, high stress levels due to trying to keep up with the super-speed societal train as well the exhausting mental strain of our constant need to maintain a façade of success and happiness on social media. The complete disregard for the detrimental effects caused by our infrastructure on the environment. The list could potentially be too long for us to face!

Though global in appearance, the pandemic has actually had quite personal and numerous individual effects. From losing loved ones, to social isolation to financial burdens. The effects of the pandemic seem both monumental and intangible. More than anything this pandemic has cast a very deep and personal fear within people. We are now afraid to even greet and be near our closest neighbours. The ominous mask represents a shield that warns fellow beings to stay away. With modern communication, the world had become a global village bringing us closer together but now we are forced to create physical space between us. It might be inevitable that there will eventually be a blurring of lines between consciously creating physical space and unconsciously alienating ourselves mentally.

I recently read a paper by Banerjee & Rai (2020) which I found particularly interesting. They have quite rightly pointed out that the romanticism of digitalisation, social media, social apps, pubs, bars, malls, and movie theatres serve only to keep us distracted from our feelings and create so called "social ties". People have a tendency to live life in a set pattern that is fixed by the societal and cultural norms of the community they belong to. The Covid-19 pandemic has effectively disrupted that pattern and pushed people into a corner with a dire reckoning of how to live with oneself. It seems like the very thought of being forced to spend time with oneself is scarier and more detrimental to one's mental health than the pandemic itself, or even a nuclear fallout for that matter. Some people are finding it even more stressful being locked down and being forced to spend physical time with their families. All in all, "virtual connectedness" provided by social media has made man uncomfortable with actual physical connectivity. Social isolation and loneliness are key factors contributing to depression and anxiety so it will be interesting to see the effect of the pandemic on existing mental health issues.

I am inclined to believe that the challenges posed by this Covid-19 pandemic coupled with the stress created by simply existing in the fast-paced society of today would have introduced a new configuration of defence mechanisms within us. There needs to be more investment of time, effort and money for research to explore the psychological changes this environment has created within us and how this could be manipulated by our internal system to ensure future survival as well the kind of mental health issues we are going to be prone to in the future.

Though this may make the future look and sound bleak, I believe there is light at the end of the tunnel - that looking at how far we have come, is an indication of how we have managed to survive everything that life and nature has thrown at us. We have evolved, the human brain/mind has evolved and managed to come up with adaptation tools to help us survive at every stage along the way. And that is exactly how mankind will survive in the future as well. By studying and understanding the Pandemic and the evolution of mankind as a whole, we can come up with therapies such as Compassion Focussed Therapy (CFT) that may address these issues.

According to Gilbert (2009), evolutionary theory had contributed to Compassion Focused Therapy, an evidence based psychological therapy based on Bowlby's attachment theory and which is a current favourite among some Psychotherapists. As someone who is offering CFT and currently working with my first client, I am convinced of its benefits as it is based

on human emotions, particularly the emotion of compassion which originated within mammals to care for our offspring, and which has evolved to include caring for one and all. After the trauma that the Pandemic has put us through, compassion is going to be a much-needed healing tool, so CFT is definitely a useful part of our armour to fight the next wave.

As portrayed in this essay the pandemic has caused a major ripple in the world and quite a bit of turmoil within me, triggering a rambling train of thoughts. Along with the rest of my confusion, in a corner of my mind I can't help wondering as a budding, junior psychiatrist, what this means for me and my career. After all, selfishness and focused attention to one's own growth is the core of survival.

Industry experts predict that when the turmoil caused by the Covid-19 pandemic dies down, the next one waiting in line to unleash its fury on mankind will be the mental health pandemic. The juvenile, cynical spirit within me is excited, feeling that it's about time mental health and the field of psychiatry will finally have its turn in the spotlight. For years Psychiatry has been side-lined and ignored by mainstream medicine. It has been ridiculed, ostracized and stigmatized as much as those unfortunate enough to suffer from it.

Even within the speciality, divided opinions and different schools of thoughts with an overpowering influence of psychology and philosophy has made it difficult for young psychiatrists to stand tall as representatives of a concrete speciality with a solid scientific foundation. But the Royal College of Psychiatrists along with all its special interest groups are working hard to change that. Coupled with the world's current ongoing interest in Mental health, these attempts to explain the why and how of mental disorders will hopefully allow the credit that Psychiatry and psychiatrists rightfully deserve to be attained.

Given the relatively early age of Psychiatry as a speciality and the unique evolutionary nature of the speciality, it is a given that we are in constant pursuit to eliminate the stigma and find the right balance of medication supplemented by psychological therapies to ensure a holistic approach that is evidence based. Though this might seem like a mammoth task, this approach is more necessary now than ever before given the current unprecedented catastrophe caused by the Pandemic. It almost feels like the Pandemic took an x-ray of our society and showcased the fractures within the structure forcing us to see it and find ways to heal!

The healing process is of course not going to be as simple as offering a tablet and some Psychotherapy support. It is going to be a long-drawn-out process that would need careful study of what has happened and the effects of it, and treatment that is tailored to individual needs. Which is why, as much as I look forward to it, I am also apprehensive of finding the pot of gold at the end of the rainbow. Is it going to be everything we expect it to be, or will it be a Pandora's box waiting to blow up in our faces? As scientists, we are obliged to tread into uncharted waters armed only with what little we already know together with enthusiasm and hunger to research and gain knowledge. We just have to remind ourselves along the way that we need to be kind and compassionate to ourselves while we try to survive this unprecedented global crisis.

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Freud or Fraud? Reflections of delivering psychotherapy as a Core Trainee

Dr C Crofts

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'You know exactly what threads to pull on'. It's hard to hide my surprise as I hear the words. I am three sessions into my first psychotherapy case and, despite never delivering psychotherapy before, the patient feels I know what I am doing. The feeling of being a fraud replayed in my mind until I discussed it at supervision. I had convinced myself I was doing the patient a disservice by offering psychotherapy and that I was less qualified than my peers. However, when I shared my thoughts, I was surprised to find I was not alone. Many trainees shared similar experiences, and this was reflected in the recurrent theme of 'Imposter Syndrome' in our Balint group. This led me to query what imposter syndrome is, and how training could be exacerbating this feeling.

What is Imposter syndrome?

The concept of Imposter Syndrome was first noted in psychotherapeutic sessions with high achieving women in the 1970s (Clance & Imes, 1978). In this paper, they described three defining features of 'impostorism'. The first is a feeling that others have an inflated perception of your abilities. The second is a fear that your true abilities will be found out, and the third is a persistent tendency to attribute successes to external factors, such as luck. Individuals with imposter syndrome are unable to internalise success and conditions such as depression or anxiety often occur co-morbidly. Clance went on to describe an imposter profile further in 1985, suggesting it is composed of six parts: 1. Sufferer engages in self-doubt, 2. The need to be the best and dismiss their talents if they fall short of this, 3. A need to do everything perfectly & with ease, 4. A fear of failure associated with shame & humiliation, 5. Denial of competence and discounting praise, 6. Fear & guilt around success due to fear of the consequences.

The potential impact of imposter syndrome on trainees

Imposter Syndrome can result in trainees feeling isolated, having low self-esteem and developing burnout. In 2020, Gottlieb et al. completed a review of imposter syndrome amongst physicians and trainees in the USA and found that imposter syndrome was positively

associated with burnout. Moreover, Clark et al (2021) surveyed 158 mental health workers in the USA and found that the imposter phenomenon had a statistically significant positive linear relationship ($p < 0.001$) with burnout and compassion fatigue. Although this survey was completed within the USA, it is important to consider whether this could be applied to psychiatry trainees in the UK. It could be suggested that imposter syndrome drives trainees to push themselves to achieve more and ultimately improve patient care. However, Hutchins & Rainbolt (2017) found that unfavourable work outcomes, including avoiding opportunities and procrastination were associated with imposter syndrome. With this in mind, it could be suggested that trainees suffering with imposter syndrome are less likely to perform at a higher level. In addition to this, patient care is at risk of suffering due to imposter syndrome being associated with compassion fatigue. Additionally, there is the issue of retention within Psychiatry. Although the Royal College of Psychiatrists have developed the 'Choose Psychiatry' campaign to recruit doctors, data trends within the NHS suggest there is a retention crisis throughout the UK. Could the feeling of imposter syndrome be adding to burnout amongst trainees and worsening retention rates?

Could training reduce imposter syndrome?

So far, I have concentrated on the potential impact imposter syndrome can have on core trainees in Psychiatry. However, as the medical workforce becomes more aware of imposter syndrome, how could senior clinicians and organisations support trainees with this? Because imposter syndrome is characterised by a fear of being exposed as inadequate, and our local trainees shared a feeling of imposter syndrome whilst delivering psychological therapy, a potential method for targeting this is by increasing the training in psychological therapies. This may help some trainees feel more assured in their skills, although it is unlikely to resolve imposter syndrome. Other strategies could include encouraging trainees to set goals which are specific, measurable and achievable, and to reassure trainees of realistic expectations for their level of experience. Ultimately, organisations should be enabling trainees to speak openly about their fears, particularly around times of transition. This could be achieved with a high standard of supervision alongside the continuity of an Educational Supervisor.

Is this a unique issue?

As alluded to, imposter syndrome isn't an issue unique to trainees in Psychiatry or even healthcare professionals. Are trainees alone in the feeling of fraud or do senior clinicians share similar experiences? The development of imposter syndrome suggests it can exist at all levels of success, with the original cohort identified with imposter syndrome being high achieving women. Despite my initial reservations, speaking to peers about my concerns allowed me to appreciate I am not alone and, in the current NHS climate, perhaps being able to offer psychotherapy to an individual is beneficial regardless of our level of experience.

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My experience of applying to higher training during the COVID-19 pandemic

Dr Eleanor Riley

ST4 Gen Adult Psychiatry, Lancashire and South Cumbria NHS Foundation Trust

In writing this article I hope to share some of my personal experience of applying to higher specialty training (ST) during the Pandemic. In 2020 the application process was changed to its current format as a response to difficulties that arose directly from the spread of the coronavirus to allow recruitment to continue despite social restrictions. There has been no further information from Health Education England as to when these changes to recruitment process will be reviewed.

I hope readers will become aware of why I think it is important that this process is reviewed soon, and I will contrast the current ST application process with that which immediately preceded the Pandemic. I believe that the current application format does not allow sufficient opportunity for potential STs to demonstrate their suitability for specific posts within "general psychiatry" and I hope that a more personal, specialty-specific interview will be incorporated.

For the past eight years during a designated timeframe applicants to ST training input basic details (identity, demographics, qualifications, proof of core training competencies and referee contacts) onto an online portal, "Oriol". Provided eligibility criteria are met the application proceeds and this is the point at which the changes in response to the Pandemic become relevant. Whereas pre-2020 around six interviewers were involved in contributing to an applicant's total score, now there are two interviewers. Whereas pre-2020 the interview would last 45 minutes in total, this is now twelve minutes. Based on their score, preferences and ranking applicants are subsequently assigned to posts on a national level automatically by Oriol.

Pre- 2020

Prior to the Pandemic applicants received a total score which could then be used for national ranking. This score resulted from a 45 minute in person interview comprising of three stations, equally weighted. The stations were 'portfolio', 'audit and leadership development' and a mock 'clinical scenario' which varied according to the subspecialty applied to (i.e. CAMHs, Intellectual Disability, Old Age)

During the portfolio station applicants were expected to illustrate why they should be considered for their chosen subspecialty using examples from their portfolio. The clinical scenario involved a ten-minute interaction with a role player which was observed by the interviewer panel, followed by five minutes of interviewer questioning stemming from the scenario. The following clinical scenario was used for medical psychotherapy interviews in August 2017:

"You are seeing a patient, Sam Smith, in the outpatient department. She/he is expressing dissatisfaction with her CPN, care coordinator, Michelle. Sam has repeatedly presented to A&E with self-harm but is not attending care coordinator reviews. You know her care coordinator and respect her clinically. Your consultant, Dr Green, is not available but has asked that you see the patient.

The clinical background is that Sam is 24 years old and has presented with repeated episodes of self-harm. There is anxiety about Sam's risk. Sam is described as having an idealised relationship with the father and an aggrieved relationship with the mother who left home when the patient was 11. The behavioural aspects of the relationship with the mother in adolescence included resenting and reacting aggressively against the boundaries the mother tried to impose. The rejection of the mother was complete; the patient has nothing to do with mother and remains very angry. You are not expected to take a full history or carry out a risk assessment.

Your two tasks are: 1. To explore the dynamics of the patient's relationship with mental health professionals. 2. To persuade the patient to come to a CPA meeting next week involving consultant and care coordinator.

The station will last 15 minutes. The role play will run for 10 minutes but you can finish earlier if you choose to do so. The interviewers will then ask you questions about it for a further 5 minutes. They will assess your communication skills and your ability to form a successful doctor – patient partnership (Good Psychiatric Practice CR 154)."

2020 - Present

Obviously, face-to-face interviews were not possible and significant changes to the application process were made. The 'abbreviated CASC score' was introduced whereby applicants are awarded a score for the total pass mark achieved during the MRCPsych CASC examination and this forms 50% of applicants' total score. 17.5% of the total score comes from the 'verified self-assessment score' which replaces the portfolio station. Applicants now award themselves a score across each of ten domains and upload electronic evidence to support their self-score, which may be verified by an independent assessor.

The remaining 32.5% of the total score comes from an online interview held via Microsoft Teams. Applicants discuss two pre-set clinical scenarios with a panel of two interviewers who are the same people. One scenario is about working in a stretched system and one about managing complaints. No mock patient or actor is used. The interview scenarios are identical regardless of subspecialty and likewise interviewers come from any branch within Psychiatry and are not matched to applicants. Interview duration is twelve minutes in total (six minutes each) plus/minus two minutes admin time, contrasted with fifteen minutes pre-2020.

Personal

The CASC exam is a major step before obtaining full college membership. I remember how I prepared pre-Pandemic with my study partner, in small groups, doing mock exams and courses, and during lockdown we turned to video groups to practice online in anticipation of a virtual CASC. Back then my primary objective was to pass the exam and achieve full membership. I wanted to graduate with my peers at the college headquarters in London and mark the personal journey to reach that point. Other less pleasant thoughts pervading my mind were the financial pressures of the exam as a 60% less than full time trainee, the fact that there were two diets per year and how this fitted with my Core Training end date. It was simply a binary pass or fail. I failed my first attempt in September 2019, which was to be last sitting of the in-person CASC before the Pandemic struck. I can recall memories of mixing awkwardly with other candidates during the breaks and the buzzer at the sports hall causing me to startle each time it sounded the end of the station! Although this was generally an unpleasant experience in hindsight, I was grateful that I had attempted it and reassured myself I that had tried my best in the circumstances. In some way this failure helped me realise and work through previously unconscious fears of failure. Nevertheless, I was painfully aware of internal pressures to not fail twice for the sake of my confidence and also fearing the disappointment of loved ones and colleagues who wanted me to succeed. The next sitting in January 2020 was the first ever virtual CASC which I from the comfort of my kitchen knowing that both the online format and the setting would help relieve some of the performance anxiety which hindered my first attempt. Back then I had not had the amount of experience of interacting via a computer screen, microphone and camera as I have now and realised that I had found the experience surreal, artificial and unpleasant. On the day I became aware that I was behaving differently virtually; finding my body language, facial expressions and tone more restricted and less spontaneous. However when the results email informed me I had passed I was surprised, relieved and overjoyed.

Neither I nor indeed anyone else could know that the CASC score from that awkward January day would be used to form 50% of marks of my future ST applications for all subsequent years until the current application process changes. All the years of effort I had put in to gathering experience and commitment to specialty for my dual general adult / medical psychotherapy application are now of no value when it comes to applying for highly sought after dual posts. In my dismay I even considered asking the college if I could resit my CASC to get a better score but I resisted and have stayed with my discomfort, yet it has soured the achievement.

I still hope to continue via the ST route. As there were no dual posts available in the North West or Yorkshire deaneries which are local to me, I started working in a single-post general adult ST4 track in February with the Home Treatment Team of East Lancashire, covering a population of former textile mill towns surrounding Pendle. I hope that this experience will help me develop as a psychiatrist and a person and I am still seeking out ways to integrate medical psychiatry into my work such as organising training for junior colleagues, getting involved with Balint groups, attending virtual conferences and seminars, using special interest sessions to attend regional medical psychotherapy teaching, private training courses and personal therapy. Hopefully in the next couple years I may score highly enough to move to a dual post but do not hold much hope if the current application system remains in place unchanged.

It is not an understatement to say I remain uneasy about my prospects of getting into dual training, in particular seeing as I live in an area where single track medical psychotherapy is not offered and dual posts are filled for the foreseeable future. It remains my hope that the application process will be reviewed so future application scores will cease to be so greatly skewed by CASC performance (which assesses performance over a few hours of one day earlier in training); and adopt to a specialty-specific part of the interview that allows an opportunity for each applicant to demonstrate their commitment to specialty and showcase their potential via their portfolio (providing viruses permit). Whilst the changes to recruitment over the Pandemic may have served an essential novel interim measure and perhaps work well for other medical specialties, my experience is that it risks reducing the application to a more generic tick box exercise that misses the reflections, insights, personality, drives and commitment of the individual which are so vital to Psychiatry and medical psychotherapy especially.

Folk Musicians

Dr Elishba Chacko

ST4 Gen Adult Psychiatry, SHSC NHS Foundation Trust

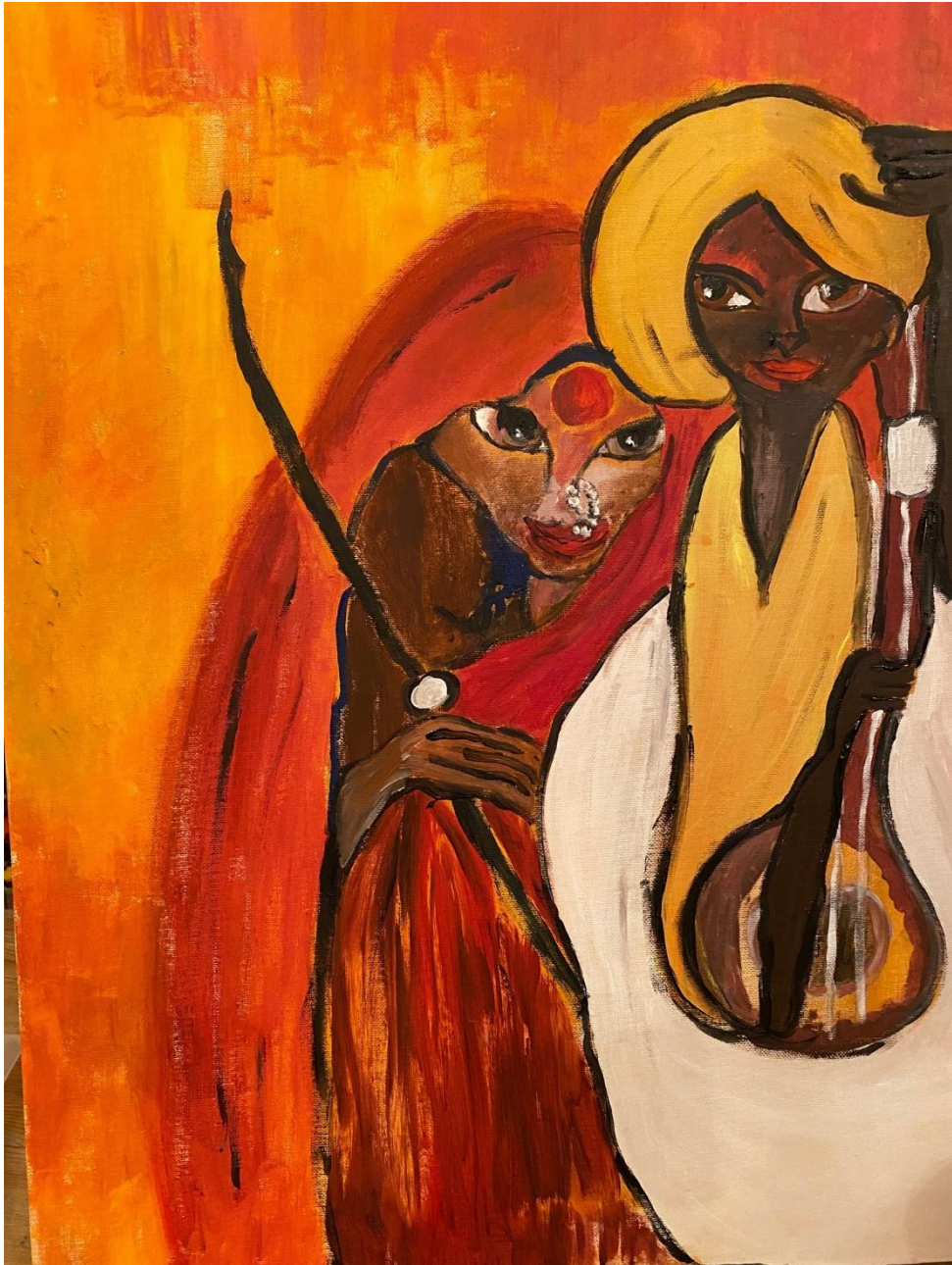


Figure 1: FOLK MUSICIANS

I stumbled upon this painting quite by accident, choosing it over studying languages at my school in India and briefly dabbled in watercolours during my final years.

I remember my mother buying me my first watercolour book with a set of gouache tubes from England during her visit in the 90's. From then on there was no turning back. I experimented with pastels, charcoal, oils and acrylic paints and I enjoyed putting brush to canvas and experimenting with textures and media.

The brush and palette gathered dust over time and only recently came out of hiding during the pandemic and the subsequent lockdowns it brought with it.

I've always had a passion for rural India and have memories of visiting/passing through the villages neighbouring the city I grew up in.

The dirt roads, bullock carts, banyan trees, snake charmers and buffalos lazing in the fields would often be reflected in my artwork.

This piece is entitled 'Folk Musicians' because of their carefree lifestyle and their contentment with simple ways of living. This is juxtaposed with the hustle and bustle of city life and the chaos I find myself in.

I've tried to emphasise and exaggerate the facial features of the folk musicians in this asymmetrical piece and the earthy tones reflect the vibrant rural folk of India.

Psychodynamic Psychiatry Poem

Dr Anna Crozier

ST6 dual trainee in General Adult Psychiatry and Medical Psychotherapy
Essex Partnership University NHS Foundation Trust

Psychodynamic Psychiatry

Inspired by the Psychodynamic Psychiatry Conference 2020

When we see our patients, keep their early life in mind
Guard against the pull to be neurotransmitter blind
For their symptoms will have meaning and a function in their lives
Their treatment resistance is in order to survive



When the mind breaks down its fault-lines and we witness the repressed
The unconscious is revealed in the symptoms so expressed
The projections can provoke in us rejection and alarm
Let our countertransference teach us so we don't repeat the harm



If we prioritise the time for spaces to reflect and share
We'll contain ourselves as well as what our patients cannot bear
So let's instil some curiosity and understanding too
Humanise our patients for they could be me or you



Call for future book reviewers and contributions



We are looking for contributors and fellow bookworms to contribute reviews to the newsletter, as a guide around 800 - 1,000 words but this is flexible.

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

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

Events, Notices and Dates for your Diary

Faculty group: The group for consultants and higher trainees in Medical psychotherapy continues to meet on the last Thursday of the month at 5.30-7pm. If you would like to join, please contact Catherine Langley so that your email address can be passed to Mark Morris.

A trainee representative is needed from the South of England. If you are interested, please contact Dr Michael Milmore c/o Catherine Langley.

College conferences and events can be viewed at [Conferences and training events | Royal College of Psychiatrists \(rcpsych.ac.uk\)](https://www.rcpsych.ac.uk/conferences-and-training-events)

Results of College Elections:

- **Chair:** Dr Jo O'Reilly
- **Vice Chair:** Dr Rachel Gibbons
- **Exec Committee members:** Dr William Burbridge-James; Dr Swapna Kongara; Dr Haroula Konstantinidou; Dr Alice Levinson; Dr Neil MacFarlane

Congratulations to you all! They will take on their new roles at the AGM on 20 June.

Call for submissions

Many thanks to all who have contributed to this newsletter. Please continue to send in contributions over the next few months for the autumn edition. The deadline for submissions is **3rd September 2022**.

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