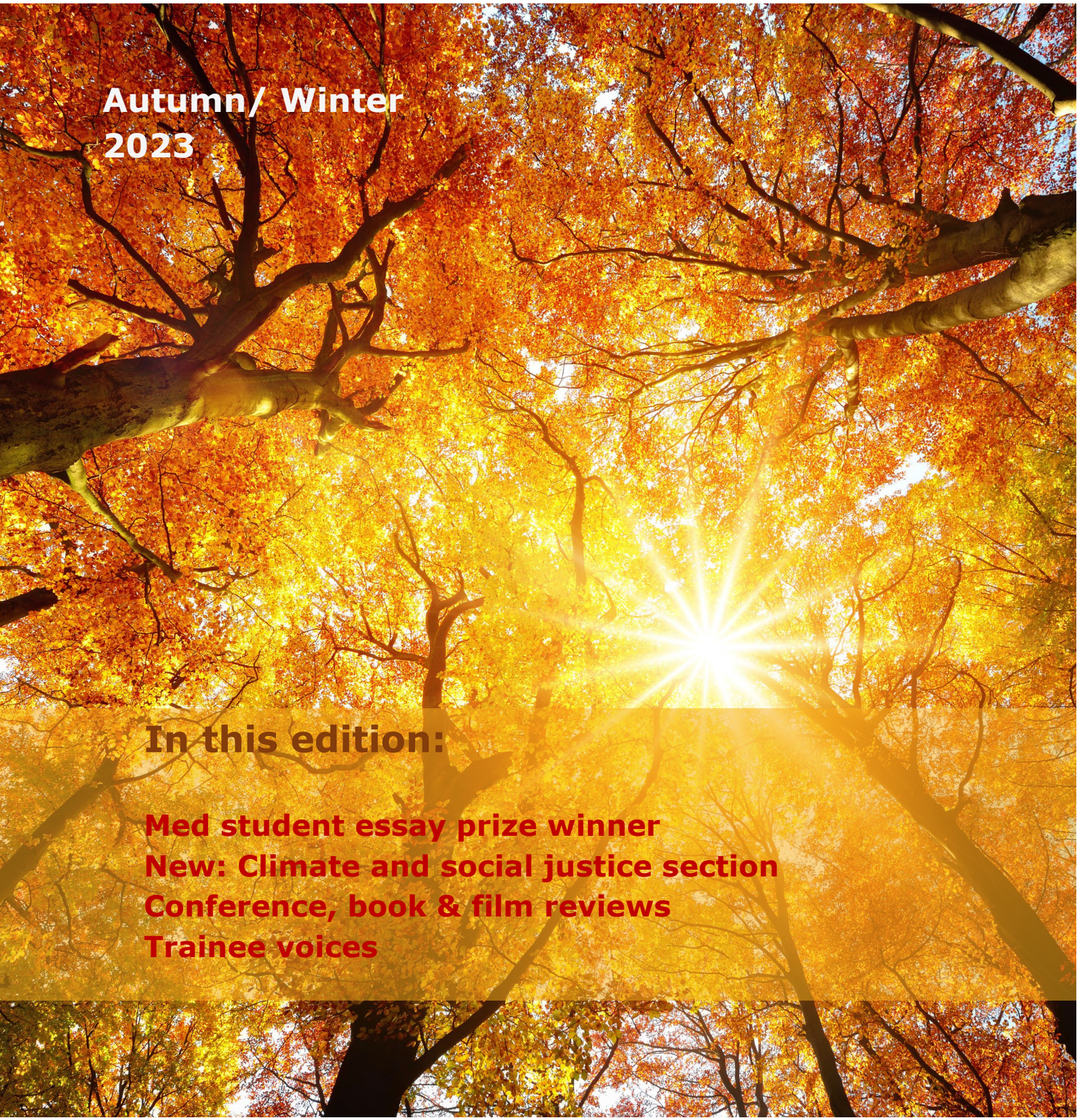
RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NEWSLETTER

FACULTY OF MEDICAL PSYCHOTHERAPY



Autumn/ Winter 2023

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Med student essay prize winner
New: Climate and social justice section
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Editor's Welcome

Pamela Peters
Consultant Psychiatrist in Medical Psychotherapy, Cambridge and Peterborough Foundation Trust

The clocks have gone back, the nights are drawing in, and we are in the season where we usually seek out cosy evenings and comforting food, perhaps become a bit more introspective and count down to Christmas. This year, however, the world is in turmoil, and whichever way we turn there is difficult news. Many of our authors have commented on the crises of our times – war, humanitarian catastrophe, disease, famine and the constant backdrop of the climate emergency which is becoming ever more urgent, and its effects more devastating.

Faced with all this, it can be hard to maintain our equilibrium and continue with normal life, let alone galvanise our energies to fight for what we believe in. It is inspiring therefore to read the submissions in this newsletter, from doctors of all grades around the UK, who are working hard to maintain a thoughtful and reflective stance in the face of these difficulties, and to remind us of actions we can take, as individuals or as part of organisations, to make things better.

It is helpful to be reminded of the fundamentals – the centrality of the mind/ brain in medicine, as well as the importance of the therapeutic alliance, kindness and a compassion focussed approach. As always, we have a diverse range of submissions from trainees: book, film and conference reviews, articles and lots of wonderful poetry and art. A new and important addition to the newsletter is the Climate and Social justice section, with an introductory message from the College working group and links to organisations and websites to guide those that are interested in learning more or joining a movement. Please consider writing something for this important section if you are already involved.

The Faculty Exec is very active and there have been a number of successful events in this year's calendar: the Faculty conference, Trainer/ trainee conference, memorial event for Steve Pearce, the recent Faculty training day focussing on relational aspects of prescribing and the International Congress. This edition publishes the winner of the essay competition for medical students – well done to Carly McCullough for her excellent and moving essay on birth trauma.

The Patient Safety Group, chaired by the Exec Vice Chair, Rachel Gibbons, petitioned the College to produce a statement regarding moving away from risk assessment tools and towards psychosocial assessment. This important work resulted in the College's press release in early September: Inaccurate suicide risk assessments could be putting lives at risk says RCPsych. Additionally, the National Government Suicide Prevention Plan for England includes postvention support for clinicians following the suicide of a patient or colleague, as recommended by the document that the PSG produced for the

college CR234 which included reflective practice, suicide groups and Family Liaison Officers Suicide prevention in England: 5-year cross-sector strategy - GOV.UK (www.gov.uk).

I am always delighted and grateful for the overwhelming response to requests for submissions – please keep writing and sending in your articles, poems and art for the spring/ summer edition! The deadline for this is 31st January 2024.

Message from the Faculty Chair

Jo O'Reilly
Consultant Psychiatrist in Medical Psychotherapy, Camden & Islington NHS Foundation Trust

Hello and a warm welcome to the autumn/ winter 2023 newsletter. I hope you have all had a chance to relax over the summer.

Since the last Newsletter the Medical Psychotherapy Faculty has continued to campaign for the importance of psychological thinking within the heart of psychiatry, and to promote training, educational and clinical activities in keeping with this. Our annual conference in April 2023 was held in person for the first time in 4 years and addressed key global issues, including the climate crisis, disaster management, the experiences and psychological needs of refugees, as well as the challenges we face working within psychiatry. Despite the serious nature of these concerns the importance of our connections with each other and how our individual creativity flourishes when we work as groups was evident throughout the conference.

We continue to mourn the loss of Steve Pearce and the memorial event organised by Gerti Stegen was strongly appreciated and supported. At the International Congress our work was represented in a number of powerful presentations addressing issues of urgent importance, such as the impact of human activity upon our environment, why it's so difficult to talk about race and cultural difference, scapegoating within the NHS (with a powerful conversation between Rachel Gibbons and Hadiza Bawa-Garba) and the impact of suicide and homicide upon clinicians. Events like these highlight the central importance of fully facing both our potential to behave in deeply harmful ways and how an understanding of human psychology can shed light on how to both understand extreme behaviours and find ways forward from this basis. All these talks attracted large and highly engaged audiences and there were many very moving discussions.

Our most recent faculty event was the Psychodynamic Psychiatry Day on Friday 27th October at the RCPsych London. Titled **"The Science of the Art of Psychopharmacology: Practical psychodynamics in pharmacotherapy"**. This event considered the powerful influence of the relationship between the prescriber and the patient in determining the response to medication and was a highly stimulating and

clinically important event, challenging our existing beliefs and paradigms as prescribers. The annual residential conference next year is from **17th - 19th April 2024**; the program is currently being developed and we hope to see many of you there.

We already have an editorial article available online in the BJPsych Bulletin titled **Parity of esteem within the biopsychosocial model: is psychiatry still a psychological profession? | BJPsych Bulletin | Cambridge Core** which describes how psychiatry has moved away from prioritising psychological understanding and holistic case formulation within patient care and the costs of this to services, treatment, training and to our professional identity as psychiatrists. Our work on this subject has met with considerable support from the College as well as colleagues, trainees and patient and carer reps. We are forming strong links with Russell Razzaque, the recently appointed presidential lead for Compassionate and Relational Care, whose ideas have much in common with the work of the Medical Psychotherapy Faculty. We are also working more closely with the other faculties and developing joint workstreams on a number of topics, enabling us to address shared concerns and pool our resources with colleagues across different psychiatric specialisms. Strengthening formulation skills, workforce retention and wellbeing issues and the impact of SUIs upon psychiatrists are examples of these areas of work. We were very pleased to welcome Adrian Whittington, the National Clinical Lead for the Psychological Professions at NHS England to our last executive committee meeting and for the important opportunity to work more closely with our colleagues across different psychological professions. Our work on data collection about the availability of psychological therapy services and waiting times across the four nations will continue in the autumn, with surveys being sent to service providers and service users/ carers; we would be very grateful for your responses should this survey come your way.

There is much work to do, and we are a relatively small faculty with around 160 consultant posts across the UK. At the same time, and with the introduction of dual training, our higher training posts are extremely popular and oversubscribed. We do have almost 4500 members of the faculty across the RCPsych suggesting our work resonates with many psychiatrists and trainees. We will have elections in 2024 for new members of the Medical Psychotherapy Faculty Executive Committee so if you would like to contribute to the work of the faculty, please consider putting yourself forward.

I want to end with heartfelt thanks to Pamela for her work on the newsletter which is always so stimulating and readable and to other members of the Medical Psychotherapy Faculty Executive Committee for their hard work and creativity.

I hope you enjoy the newsletter.

Message from the Academic Secretaries

Parveen Bains
Consultant Psychiatrist in Medical Psychotherapy, Hertfordshire
Sophie Atwood
Consultant Psychiatrist in Medical Psychotherapy, Sussex
Vikram Luthra
Consultant Psychiatrist in Medical Psychotherapy and Psychoanalyst, Leeds
Anne Cooper
Consultant Psychiatrist in Medical Psychotherapy, Leeds

We thoroughly enjoyed hosting the first face-to-face Medical Psychotherapy Conference in April 2023 since returning from the Covid pandemic. We hope you agree that it was undoubtedly a success, with multiple highlights around our central theme "Can the current global crisis bring us together?"

Lucy Easthope gave us insights into the work of a disaster planner - how she very sensitively considers all the practicalities to make the aftermath of life-changing events a little less catastrophic. Gaia Vince gave us a taste of the reality of the climate crisis we are facing, and ways to mitigate this if we work collaboratively across nations. Bob Hinshelwood spoke on social defence systems and how we react to stress, and Waheed Arian gave us a very moving account of his path from refugee to NHS doctor. We discussed the experience of doctors more widely the following day, considering the experience of working as a doctor before, during, and after the Covid pandemic. Most importantly, we had a chance to catch up in person and reflect on the wealth of ideas from our amazing speakers.

For next year's (2024) Annual Medical Psychotherapy conference we are excited to be branching out from our RCPsych London base, holding it in the North at the **Met Hotel,** in the vibrant city of **Leeds** from **Wednesday 17th to Friday 19th April** inclusive. The theme: **"Power, Conflict and Leadership"**.

We promise to showcase the multicultural city of Leeds, as well as providing another dynamic and thought-provoking programme. We will let you know as soon as we have more details, but for now **SAVE THE DATE: 17th-19th April 2024.**

We would also like to remind you to let your trainees know about the **Small Project Grants scheme** run by the faculty and also to encourage those of you who work with medical students to let them know of the **Medical Student Essay Prize**; winners of both will be announced at the conference in April.

Can we request all faculty members to offer their support for the RCPsych CASC exam? There are very few medical psychotherapists involved in examining and, more importantly, writing CASC stations. When the next invite comes out for examiner training, please do consider applying. It is a very rewarding process to help our trainees navigate the exam. The CASC is also a vital area for us to encourage and promote our speciality.

Finally, we need your help! The Faculty and individual members are often asked to deliver talks on a variety of topics. Given the breadth of expertise and talent within the faculty we thought it would be useful to have a central resource of speakers and topics of interest. If you are willing to deliver a talk or have existing materials you are happy to share at a local or national level, please contact Vikram (vluthra@nhs.net).

Update from the Trainee Reps

Dr Josie Fielding
Specialty Trainee in Medical Psychotherapy and General Psychiatry, West London NHS Trust
Dr Alan Baban
Specialty Trainee in Medical Psychotherapy and General Psychiatry, Camden and Islington NHS Foundation Trust
Dr Sophie Stokes
Specialty Trainee in Medical Psychotherapy and Forensic Psychiatry, Birmingham and Solihull Mental Health NHS Trust

Josie Fielding

Alan Baban

A warm welcome to all those who have started their training this year, we hope you are settling in and enjoying it so far.

The first piece of news to share is that two of us (Josie Fielding and Alan Baban) will be stepping down as trainee reps from October. We have really enjoyed our time in the role, and are pleased to welcome the newly appointed reps, Dr Toby Stevens and Dr Elias Diamantis, who will be joining Dr Sophie Stokes. As reps, we continue to work closely with the Faculty to address issues raised by trainees – if there are issues concerning your training that can't be addressed locally, or you'd like to get more involved, please do get in touch with us at mptraineerep@gmail.com.

The 2023 Trainees and Trainers conference, **Psychotherapy at Play**, took place in Birmingham in May, and for the first time was a collaboration with PsychArt (a trainee-led organisation celebrating the role of the arts within psychiatry). With themes around creativity and the very serious business of play, highlights included talks by Dr Simon Heyland, Dr Haroula Konstantinidou, Dr Sue Mizen, Dr Susie Orbach and Dr Adrian Sutton, as well as workshops on creative writing, avatar therapy and a particularly popular drama therapy workshop. We were lucky to have a beautifully sunny day and an inspiring venue in the form of the Midlands Arts Centre. Despite some challenges with the air conditioning, the day sparked many conversations, connections and ideas, and was rounded off with ice cream on the grass outside.

In another first, the conference featured an art competition, on the theme of the creative potential that inherently 'belongs to being alive'. We were very impressed by the images submitted, and are grateful to everyone who shared their work with us. Congratulations to our winner Dr Komal Patel, whose compelling image 'Self Portrait' is featured here:

'Self Portrait': Dr Komal Patel

As reps, we were joined in organising it by a brilliant conference committee, and all of us would like to thank the speakers and attendees who made it such an enjoyable and lively day. Do watch this space for details of next year's trainee conference – and indeed, get in touch if you'd be interested in contributing to organising it.

Finally, a reminder that we have an active Whatsapp group for trainees to share news and ideas. To be added to this please email us on mptraineerep@gmail.com.

Feature Articles

WINNER OF 2022 MEDICAL STUDENTS ESSAY PRIZE: Mother Nature's Most Successful Lie: How psychotherapy concepts can inform obstetrics in the prevention of birth trauma

Carly McCullough
5th year Medical student, Quenn's University, Belfast, N Ireland

Abstract

In the flurry of an obstetric emergency, such as the one I witnessed and describe here, the distress of a mother can be left to spiral with dire consequences. Birth trauma is an under-recognized consequence of high-risk births that has far-reaching effects for both the mother and her infant. By examining psychotherapy concepts such as Polyvagal theory, the Defence Cascade, the 5-part model, Co-regulation and Mentalisation, the development of trauma can be recognised and addressed quickly. Applying these concepts in this clinical context can identify methods of maintaining engagement of the patient throughout the intrapartum period and mitigate the looming burden of Post-partum PTSD.

Introduction

"I will greatly multiply your pain in childbirth, in pain you will bring forth children" (1). In this quote God enacts his punishment upon Eve for her sins. It has informed women for thousands of years that childbirth will be a brutal debt to pay for achieving the coveted goal of bearing children. Despite the generational anecdotes of the realities of childbirth, in 2021 in England and Wales 624,828 live births were recorded (2). Current international statistics reveal that 45% of mothers of live children describe their birth as traumatic and up to 9% of all mothers develop Post Traumatic Stress Disorder (PTSD) directly related to the birthing process. Birth trauma is defined as events that occur in labour that threaten or cause injury or death to the mother or her infant (3). Reflecting on these statistics, I realised there is a possibility that medical students may witness this trauma occurring during their obstetrics and gynaecology attachment. Whilst on placement I followed a patient in labour from the delivery room to theatre for an instrumental trial with the possibility of caesarean section. I came away from this experience having witnessed a trauma take place in a patient's life and have since understood the need to acknowledge the impact birth trauma can have on patients, their families and healthcare staff. By viewing my experience through the lens of psychotherapy I can better understand the emotional and cognitive processes of birth, and how these processes are influenced by birth trauma. From doing so it may be possible to identify and apply the most relevant concepts of psychotherapy to a speciality in much need of addressing the realities of trauma.

Discussion

Women and their reproductive ability have long been associated with psychological trauma. The first studies of trauma stemmed from an attempt to understand the causes of hysteria, which was almost exclusively diagnosed in women in the later part of the ninth century. Jean-Martin Charcot posited that hysteria was psychological in origin and linked to trauma, particularly relating to female sexual and reproductive function [(4)]. His work served as a foundation for further contemporaries to build the psychoanalytic movement. The earliest exploration of the psychological consequences of traumatic birth was published in the 1950s, detailing how pregnancy and childbirth can lead a patient to be susceptible to psychological disturbances such as anxiety, depression, and psychosis. By the 1980s the implications of trauma had been recognised and the term PTSD was circulating in the medical domain. The feminist movement highlighted the experience of PTSD in women through sexual and domestic violence, and how it was akin to the symptoms displayed by those affected by war [(5)]. The study of birth trauma was cultivated in the psychiatric sphere, but such concepts could be applied to Obstetrics where health providers are present when the trauma occurs.

The study of trauma has advanced enough to begin to explain the psychological and biological mechanisms that result from the immediate impact of trauma. The initiation of trauma begins when the perception of threat is first registered in the thalamus. The thalamus relays information to the brain stem which increases the activity of the autonomic nervous system with a preference for sympathetic nervous system activation. Autonomic nervous system arousal can precipitate physical reactions to trauma such as increased heart rate, sweating, blood pressure and respiratory rate. At the same time the thalamus relays information to the amygdala where the emotion of fear is formed in response to the threat. These processes occur in tandem and offer a quick registration of the threat, offering a greater chance of survival. The cerebral cortex also registers signals from the thalamus and can modulate the emotional and physiological responses. This is known as the 'top-down' approach to central nervous system functioning where cognition can modulate thalamic excitation, effectively filtering between true and false threats. [(6)]. In the case of childbirth, the sympathetic nervous system is already primed as the pain of contractions is perceived as a physical threat to the body.

The registration of threat for the patient in this clinical scenario was not immediate. Following two painful vaginal examinations (VE) in quick succession by the attending and senior midwife a decision to artificially rupture the membranes (ARM) was reached. This was explained to the patient, citing it would 'make the baby come quicker'. Once the membranes were ruptured the patient's pain level initially decreased. I was under the impression that this was a promising clinical sign. However, after monitoring the CTG the midwife called the registrar as the fetal heart rate had not recovered. This prompted another VE from the registrar. At this point the patient had begun to perceive that the threat to her or her child was mounting due to the increase in medical interventions. The patient was still fully engaging in her care and could communicate her needs clearly, depending on the medical staff for reassurance and guidance.

Following the VE, the Registrar made the decision to move to theatres for a trial of assisted delivery with the possibility of a caesarean section. There ensued a flurry of activity to bring the patient to theatres that signalled to me that this was an emergency. The tension of the situation was steadily growing, and I felt my role of participation in the delivery shift to strictly observation. Although this was an unexpected turn of events, I readily accepted the decision made by senior medical staff as I had limited experience of the birthing process. However, the patient had three previous children, all of which had been induced and delivered vaginally with no other complications. Therefore, the patient had a preconceived idea of how the events of this labour ought to unfold based on her experience. For this patient there would have been an element of rehearsal of events with the previous births, solidifying her expectations of the current labour process. This decision to move to theatres could have been perceived as a loss of control during the birth, as control was then transferred to the medical team to achieve birth. Ayers and Ford [7] identified factors that, if present during the intrapartum period, could leave a woman vulnerable to developing Post-natal PTSD, even without a history of trauma. These factors included lack/loss of control, fear for the baby's life/ health and high intensity of pain. This patient experienced each of these during her labour. While being wheeled to theatres, various members of staff offered fragmented explanations as to what was happening, primarily that there was a concern over the baby's wellbeing. All three factors hit in quick succession for the patient, setting her up for the development of birth trauma.

From this point I witnessed a rapid deterioration in the ability of the patient to be receptive to incoming information, recall the information and engage with the team. This deterioration could be explained by Stephen Porges' Polyvagal theory. The theory identifies a relationship between the autonomic nervous system and social behaviour. Environmental cues can activate the parasympathetic nervous system producing socially engaging behaviour in patients or activate the sympathetic nervous system which produces socially defensive behaviour. This system has developed as a compromise between the need to respond to threats and the need to socially engage as humans depending on the environment. Porges' theory has been used to describe the resistance that a client may display in psychotherapy towards their therapist. Resistance may be displayed by the client if they perceive the therapy environment as unsafe.

Porges' theory includes 3 levels of autonomic arousal that underpin the behavioural responses of patients in stressful situations. The first is the Ventral Vagal pathway, mostly directed by the parasympathetic nervous system. This is activated when the environment is safe. It allows for decision making, problem solving and social engagement. In the clinical context of labour this state may be diminished due to pain, lack of sleep and social factors.

The next state is dictated by the sympathetic nervous system. This occurs when the patient detects a threat, triggering a fight or flight response. This type of response is evolutionarily helpful as it is necessary for survival. During this state resistance might be presented by patients and their decision making and communication may diminish.

Once a safe environment has been restored, through fight or flight, the individual can begin to move back into the Ventral Vagal pathway with the threat effectively resolved. The aim of this response is to restore homeostasis to the nervous system and discharge any emotional impact the threat has caused. Although this was an imminent response for this patient, the mechanisms of fleeing or fighting were not available as she was physically incapacitated by the labour and socially incapacitated by the number of staff moving her to theatres.

During the journey between initial threat recognition and move to theatres the patient could have entered the third state of Polyvagal theory called the Dorsal Vagal pathway, colloquially known as 'freeze'. Without the possibility of escape from the threat, the patient becomes so overwhelmed that physical and mental changes occur. Observations of humans in this state note a transient bradycardia and reductions in resting body movements in favour of muscle rigidity. Mentally there is an enhancement of vigilance and attention which heightens the awareness of threatening cues. In this state parasympathetic and sympathetic activation co-exist [(8)]. This can be a transient pre-traumatic response that lasts seconds. I didn't observe a dorsal vagal response in this patient. However, if this state had occurred, the patient would have registered the full gravity of the threat facing her and her baby as her perception for threat would have been heightened. Polyvagal theory may be helpful in obstetrics to explain a patient's observable physical reactions to obstetric complications. It can also help staff recognise the onset of birth related trauma. By employing this concept from psychotherapy, obstetric staff could be afforded a unique opportunity to intervene while the trauma is occurring to offset long term sequelae.

However Polyvagal theory holds the assumption that each state occurs in a stepwise sequence as the patient's fear of the threat increases. It also assumes that patients begin in a Ventral Vagal state and descend into a Dorsal Vagal pathway. It maintains a stepwise progression through the assumption that, as fear increases, the newly evolved ways of tackling a threat (such as social engagement) fail, and older mechanisms are then relied upon. While the overarching themes of the theory held true for this patient, it does not explain the full range of reactions she displayed and lacks in-depth analysis of the mental processes occurring during trauma.

The Defence Cascade could give more insight to states seen in this patient. The Defence Cascade includes five instinctual responses to threat that can be displayed by a patient who is confronted by current or past trauma. These include arousal, fight or flight and freeze responses of the Polyvagal theory. However, there are 2 further states which may help to explain this patient's deterioration of engagement during labour. The fourth state of arousal is Tonic Immobility. In this state a physical detachment from the body occurs, resulting in paralysis. This state is believed to occur when the sympathetic nervous system has reached its capacity. When this occurs, there is no further activity in the amygdala which is responsible for controlling the HPA axis in stress responses [(9)]. This state can also be conceptualised as a subset of dissociation that occurs in trauma, often reported by patients as derealisation and depersonalisation. In dissociative states the amygdala activity decreases and patients describe a feeling of emotional numbness. This is a particularly useful state in this patient's case as a last-resort protective

mechanism from overwhelming fear. However, when amygdala activity decreases, processing of emotion cannot occur. Some studies have posited this may be due to cerebral hypoxia caused by bradycardia.

At the same time, the neurotransmitters that had been produced by the amygdala up until this point have flooded the hippocampus, rendering the retrieval of declarative memory (facts and evets) incapacitated. In the hippocampus short term memories are processed into long term memories. If the patient had entered a state of Tonic Immobility this could explain her inability to move, requiring staff to manually move and position her onto the theatre bed. It might also help to explain her inability to retain information about the situation being relayed by staff. This was demonstrated by the patient repeatedly asking for information that had recently been given, asking another question during the previous question's explanation, and speaking in short fragmentary sentences. Entering this state during trauma can increase the risk of developing PTSD after the traumatic event as dysfunction continues in the amygdala and hippocampus after the trauma event.

The fifth state included in the Defence Cascade is Collapsed Immobility. Due to overwhelming cerebral hypoxia the patient experiences a vasovagal response. This is more prominent in animal studies as a response to overwhelming threat, often associated with physical restraint. A common example of this response in humans is fainting due to the sight of blood [(10)]. This state was not observed in this patient.

The Defence Cascade is a useful concept when applied to obstetrics. It can give staff an awareness of why communication with a patient may begin to break down and her recall diminish. This may mitigate the feelings of frustration and difficulty felt by staff when trying to communicate with a patient during a crisis. By having this foundation of understanding as to why this state occurs it may allow for greater discussion and learning on how to move forward in maintaining good communication with patients in such distress, thus acting as a protective factor for women giving birth.

The studies recognise the importance of labour pain in the development of birth trauma. In this case the patient had had 3 previous experiences of labour pains accompanying vaginal deliveries. I observed a fluctuation in the patient's level of pain, with the pain of contraction increasing as her distressed increased. This observation may have a physical explanation. The patient had an IV infusion of Remifentanil, a strong opioid analgesia with a half-life of 3 to 10 minutes. This method of pain relief was administered via a Patient Controlled Analgesia (PCA) system, complete with base-line infusion and bolus dosing at the patient's request. However, a study by Van de Velde [(11)] highlighted the possibility of decreased fetal heart rate variability on CTG due to Remifentanil which can be misunderstood as fetal distress. The initial decrease in variability was what prompted the rupture of membranes in order to speed up labour because the CTG had indicated fetal distress. After the artificial rupture of membranes, the fetal heart rate did not recover, prompting the need for a trial. From the moment fetal distress was picked up on CTG, the patient was discouraged from using the PCA to administer bolus doses during contractions. As her distress began to increase, her need for analgesia also increased. The PCA was physically removed from the patient's reach to avoid use.

From this point onwards, despite a continuous infusion of analgesia, her pain level hugely increased as evidenced through screaming, moaning, crying and begging for analgesia. PCA attributes its high patient preference to the subjective feeling of control that it affords a patient in pain [12]. It is possible that the increase in pain for this patient was cognitively influenced as she may have interpretated the manual removal of her access to PCA as a removal of her control in labour.

Along with this physical contribution to pain there is a well-recognised psychological component to pain. The physiological sensation of painful stimuli is carried via nociceptors to the anterior cingulate cortex (ACC) and the anterior insula (aINS). The ACC is part of the limbic system, responsible for emotional regulation and mood, but also direction of a patient's attention. The anterior insula is a core area for the integration of bodily sensation and the emotional and cognitive interpretation of these sensations. Studies have found that emotional states, either positive or negative, influence the descending inhibitory pathways that can modulate the nociceptive signals to the brain [13]. However, the process of sensation interpretation and emotional reactions to sensation are dynamic and influenced by wider factors.

This can be further conceptualised by the 5-part model used in cognitive behavioural therapy. This theory describes how thoughts, feelings, physical sensation, and behaviour influence each other. However, the situation of the patient influences each of these factors. A study exploring the relationship between labour pain and cognitions of women revealed valuable qualitative evidence supporting the concept of cognitive and emotional influence on pain. The study found that women who were able to focus on the present moment with each contraction were able to mindfully accept the bodily sensation and cope effectively despite the type of pain relief used. This method, using the concept of mindfulness, left women with a positive impression of their birth despite the intensity of their pain. However, this state requires focus. Distractions from the woman's environment can influence it, particularly auditory distractions such as alarms and the reactions of those around them. A preference for vaginal delivery also influenced participant's cognitions. They described their contractions as purposeful and felt better equipped to accept them as physiologically normal. In fact, in the same study, a participant describes a shift in her pain levels following the decision to proceed with a caesarean section, citing that "it felt more painful because I knew I wasn't working towards giving birth" [14]. This correlates to what I witnessed in the clinical scenario. The patient's interpretation of her pain may have shifted to pathological instead of physiological as the reaction from those in her environment and their communication informed her perception.

The recognition that the pain of labour is greatly influenced by the environment of the patient is an important concept for obstetrics that could benefit from use of Co-Regulation to aid patients in distress. Co-regulation is a concept often used in relation to child and adolescent or couple therapy. Co-regulation describes how humans can receive and project subtle social cues that signal our internal state to other humans, with the goal of advertising our lack of threat towards others to achieve social engagement. It encompasses conscious and unconscious aspects of social behaviour from vocal tone and inflection to posture and breathing. It is often used in conjunction

with attachment theory where humans first learn co-regulation from their primary care giver. A child in distress can find the ability to attune to a primary care giver's internal state and signals of safety through the process of co-regulation. Therefore, attachment style can heavily influence the ability of adults to regulate themselves and others [(15)]. This concept could be useful in this clinical scenario as the patient first picked up the signals of danger from the staff around her, through their hasty movements, short and medicalised language, and disregard of her distress. The use of co-regulation could afford staff the awareness that, although there is an emergency, the patient's mental and emotional wellbeing is also a priority. By modifying their approach through calmer and simpler communication, purposeful pacing and self-regulation, staff could avoid overwhelming the patient with signals of danger. However, effective co-regulation requires more than a simple modification of behaviour as patients can pick up on genuine empathy for their situation [(16)].

Therefore, with the assumption that true empathy comes from a relationship that has matured over time, I posit that one midwife should be the channel of communication with the patient. In this case the midwife who had sat with the patient from early labour could have acted as the conduit for the team. This person would be responsible for good self-regulation, clear compassionate communication, and considering maternal mental wellbeing throughout birth. This would allow the patient to hang their need for safety and empathy on one person, and feel accompanied in their emotional challenge. These skills require self-awareness of internal emotional states and cognitive processes and can be honed similarly to a therapist who develops these skills for the benefit of their client, but also themselves.

The next time I saw this patient she was extremely distressed, as indicated by continuous wailing and growling. She was propped up on the theatre bed by 3 staff members who were trying to facilitate the correct position for the anaesthetist to perform a spinal anaesthetic. This was proving difficult as the patient continued to writhe in pain and was not able process the verbal instructions. Conceptualising this using the 5-part model in CBT, the patient was severely cognitively impaired and was perceiving this experience through emotions, physical sensation and thoughts. Polyvagal theory can also explain this patient's behaviour as a reflection of how unsafe she felt, retreating from all social engagement. The patient's only communication during this scenario was refusal for any medical procedure, including spinal anaesthetic, assisted delivery or caesarean section. Medical staff found it challenging to communicate their reasons as to why the intervention was necessary. To understand this withdrawal of consent it is worthwhile investigating the concept of mentalisation.

Mentalisation is the ability to consider and understand the mental state of self and others. It encompasses the ability to distinguish between an individual's own mental state and that of others. It includes the ability to consider the behaviour of others as a product of their motivations, thought, feelings, intentions, and desires. This ability develops from the attachments experienced in childhood. It is a cognitive process that is influenced by environmental, emotional, physical, and psychological factors [(16)]. In this scenario the patient and staff are not able to mentalise each other's internal state. The patient, because of her level of distress and vulnerability, may be

misinterpreting the staff's behaviour as malicious. This may the reason behind her withdrawing consent, and therefore her resistance is a way of reclaiming control of her situation. The staff saw this behaviour as obstructive to their goal for a safe and successful delivery. They may not have considered that her behaviour was a result of her high level of distress. After a few attempts at inserting a spinal anaesthetic, the Anaesthetist called over the patient's shoulder to the Consultant, "Do you just want me to put her to sleep?". To communicate with the patient, the senior midwife placed both her hands on the side of the patient's head and shouted that she needed to have the spinal anaesthetic performed. Perhaps in this moment the concept of mentalisation could have afforded staff the ability to register their own internal state and mentally adjust themselves to align with the patient in order to encourage her participation in the process. This would have dispelled the patient's need to defend herself by withdrawing consent. Eventually consent was gained, and the patient underwent an assisted delivery with no further physical complications.

Addressing birth trauma has implications not only for patients but also their infants. In psychotherapy the attachment style a client shares with their parents often influences their future mental health. Although evidence is limited, a link between postpartum PTSD and anxious attachment styles in children has begun to emerge. This is due to a disruption in the bonding process which begins in pregnancy and continues after birth [(17)]. Studies have particularly focused on the effect of trauma on a parent's ability to mentalise with their child [(18)]. By addressing birth trauma, it may be possible to mitigate the impact that insecure attachment styles have on future adult social functioning and wellbeing.

Reflection

When I visited this patient in Recovery she was physically shaking, detached from her surroundings and could only reply to any verbal interaction that she was cold. Although I was informed this was an effect of the spinal anaesthetic, I sensed that I was observing someone in the immediate aftermath of significant trauma. Instantly I felt guilty. Even though I was attending the birth as a medical student, I felt as though I had intruded on a moment in her life that was highly personal and vulnerable. I thought I needed to apologise for being a bystander in this situation with no practical skills to aid her. I also felt that the patient and I shared the idea that a tragedy had occurred for her, and a mutual sense of loss. I didn't feel I could voice these concerns with anyone in the team because once the emergency was over, normality resumed. I was taken aback when the Registrar congratulated the patient on the birth and happily informed her that she hadn't sustained a perineal tear. I was annoyed when the nurses cheerfully encouraged the mother to breast feed moments after arriving in recovery, when the patient didn't have the capacity to have those expectations placed on her. It appeared the mental wellbeing of the patient was sacrificed to achieve the safety of the mother and child, and this was to be celebrated. On reflection I found this insensitive but didn't feel competent enough to voice my concerns. This made me question whether my reaction to witnessing this birth was appropriate, considering the reaction of other staff members. This experience occupied my mind in the days that followed as I was unsure

of how to make sense of it. I settled on writing this essay to reflect on what I had witnessed and learn about the mental health burden associated with high-risk births. I believe that writing this essay afforded me some agency to alleviate the feelings of inertia I experienced, and pay tribute to the gravity of this patient's situation.

From this experience I learnt how communication and facilitating control for the patient protects their mental health. I was confronted with a case of shoulder dystocia followed by a significant post-partum haemorrhage the week after this event. The situation was similar as I was in the observing role while watching the team focussed on their responsibility during the emergency. As the partner was occupied with the child, I noticed a lapse in support for the mother. By reflecting on my previous experience of this case I felt competent enough to step in. I supported her by providing gas and air when needed, speaking to her in a calm manner about what was currently happening and relaying information to the patient from staff. Although this carried a heavy emotional toll, my motivation was to prevent the level of distress I had previously seen. Despite complications, mother and baby survived. The mother seemed shaken but coherent and remained in an engaging state after the birth. This assuaged some of my residual feelings of the previous birth experience.

On reflection I realise that emergencies are common, with the need for physical concerns to take precedence. This has compounded my resolve to pursue Psychiatry as a career, with particular interest in understanding the development of trauma and the treatment of trauma through psychotherapy. I have arranged to shadow a perinatal mental health team to investigate the long-term effects of birth trauma and the treatment that is offered to these women.

Conclusion

Birth trauma is a common phenomenon that is an unrecognised contributor to post-partum mental health issues. Women who experience loss of control, medical intervention to achieve birth and uncontrolled pain are at risk of developing post-partum PTSD. While physical wellbeing of the mother and baby naturally take precedence in emergency situations, it is worth considering measures to reduce the negative impact these situations can have on maternal mental health. Concepts from psychotherapy can assist in creating these measures. An awareness of the stress response and how environmental factors influence this, such as in Polyvagal theory and the Defence Cascade, could provide staff with early recognition of maternal distress. Integrating skills such as Co-regulation and Mentalisation could improve the relationship between the patient and healthcare staff in emergency situations, leading to more cooperative decision making. The concepts borrowed from psychotherapy could be applied in obstetrics to address and prevent the development of birth trauma and act as a protective factor for the future mental health of infants born under these circumstances.

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Developing a new measure to evaluate Reflective Practice Groups

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Led by a psychotherapist, Reflective Practice Groups offer a space for clinicians to name, process and reflect on their experiences of working with patients. Clinicians take part in these groups to sustain interest in the clinical work, find containment and support, deepen understanding of the interpersonal dynamics, and provide some protection against unhelpful enactments. If these groups are well attended by the various parts of a clinical team, the sessions can help to piece together the shards of a fragmented clinical situation and provide a degree of protection against the team splitting.

But how do we know how, or if, Reflective Practice Groups are working?
As part of a working group looking at Reflective Practice Groups, we undertook a literature review (see Patrick J, Kirkland J, Maclean C et al. 2018). We found a moderate body of qualitative research looking at Reflective Practice Groups. Qualitative studies in this area had largely positive outcomes, concluding that clinicians who come to groups tend to feel supported and may discover new perspectives through the group process. As with any active reflective process, when something meaningful is happening, this does not necessarily feel easy for participants; the sessions involve inviting clinicians to look closely at their own work and the role they play in clinical encounters, and this is not an anxiety-free process. As group facilitators, we find it useful to discuss all these dimensions before starting a group, so that participants are well informed.

However, we found that Reflective Practice Groups were poorly researched in terms of *quantitative* studies. Furthermore, the area lacked a suitable quantitative outcome measure to evaluate Reflective Practice Groups.

The Relational Aspects of CarE (TRACE) Scale
We therefore decided to develop a new quantitative outcome measure to tap into the kinds of processes that Reflective Practice Groups are intended to help with (Polnay, Walker and Gallacher 2021). A review of the literature led us to formulate five key areas:

1. personal awareness of common clinician emotional responses to patients (awareness of countertransference)
2. recognition that having such feelings is a normal aspect of clinical practice
3. ability and opportunity to discuss such responses
4. ability to utilise countertransference to help make sense of interpersonal dynamics
5. personal awareness of the risk of counterproductive enactments that may emerge from unprocessed or unrecognised feelings about patients.

From these areas, we drafted items for the outcome measure. Through consultation with colleagues and pilot-testing we refined this to a 20-item self-report scale, referred to as The Relational Aspects of CarE scale (TRACE).

The TRACE scale contains questions related to the five areas identified above. For example: "When working with patient(s) I am aware of sometimes feeling anxious" (awareness of common countertransference feelings); "Having feelings (e.g. anxiety, anger etc) in response to patients is unprofessional" (recognition that feelings about patients is a normal part of the work; note: scoring is reversed for this item).

The TRACE is distinctive from other existing questionnaires in that the scoring process considers that it is normal and self-aware for staff to experience a range of feelings in relation to clinical work. This contrasts with other existing questionnaires, such as the Attitudes towards Personality Disorder Questionnaire (APDQ), which regards a clinician as less reflective if they acknowledge having so-called negative feelings towards patients.

We evaluated the TRACE scale with a sample of 80 professionals. The factor structure of the questionnaire clustered items logically to the five areas used originally to generate the measure. The TRACE demonstrated good test–retest reliability (intra-class correlation = 0.94, 95% CI = 0.78–0.98) and face validity. Internal consistency demonstrated borderline acceptability. The TRACE showed a slight negative correlation with APDQ, which was expected as the two measures approach the issue of emotions in opposing ways, as discussed above.

Summary

The TRACE provides a straightforward self-report tool that can be used by clinicians and researchers to evaluate Reflective Practice Groups. The TRACE is free to use and can be downloaded via the link in the references.

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Do therapeutic treatments cure disorders or do relationships heal?

A new wave of alliance researchers may have the answer

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Abstract
To explore the efficacy of psychotherapeutic treatment and the within-session mechanisms that bring about change a recent article that balloted members of the Medical Psychotherapy Faculty[1] highlighted the pressing need for more methodologically rigorous research. Despite concerns regarding the degree to which medical psychotherapists are given the opportunity to undertake research activities, I draw the faculty's attention to the encouraging advent of a new wave of statistical techniques that is providing much-needed parametric rigour to testing what are often regarded as opaque within-session mechanisms that account for psychotherapeutic efficacy. My hope is that such statistical advancement may begin to offset the sparsity of fruitful research into mechanisms such as the *therapeutic alliance,* which, as noted by Fok and her colleagues[1], remains at the heart of all psychiatric practice.

A Tale of Two Research Camps

Given that the efficacy of psychotherapy in treating a range of psychiatric disorders is now reasonably established,[2] psychotherapy researchers have turned their attention to identifying the change mechanisms that account for this effectiveness, culminating in a polarising debate between two research camps. A 'necessary-but-not-sufficient' camp[3,4] who argue that relational factors (e.g. therapeutic alliance) facilitate the necessary infrastructure for therapeutic techniques to work. And a 'sufficient' camp,[5,6,7] who regard relational factors as salient to therapeutic efficacy, having the potential to serve as mechanisms for change in their own right.

Although distinct and seemingly incomparable, it was somewhat surprising when several research syntheses[8,9] showed that different psychotherapeutic orientations were fairly equivalent in terms of effectively treating a range of disorders. For many, this therapeutic equivalence indicated that there were no special ingredients relevant to any 'type' of therapy, only underlying common factors shared by all traditions, and therefore the holy grail of modern psychotherapeutic research should be the search for those common factors that make psychotherapy 'work'. It wasn't long before one candidate in particular received much research attention, a psychodynamic concept with an already considerable history, and one that would soon become the "quintessential" common factor[10] - the *therapeutic alliance* between therapist and client.

The Therapeutic Alliance

The therapeutic alliance (TA) has received considerable research attention over the past 30 years, the most notable being the recent attempt to re-conceptualise the TA construct to yield a richer understanding of how therapeutic outcomes are affected by its function. Safran and Muran,[6] for example, in their seminal work on rupture-repair

episodes, proposed that rather than being a static construct based upon agreement and collaboration, the TA is a more dynamic and challenging process based upon 'intersubjective negotiation'. Consequently, some degree of strain on the TA is inevitable and the task of the therapist is to repair these fluctuations (via Rogerian competencies, meta-communication, and responsiveness skills) as they occur. They argue that given that these strains are also common outside of session, the successful resolution of these ruptures can become a profound corrective experience for the client, thus having considerable therapeutic value in itself.

A New Statistical Wave of Research

Despite receiving considerable empirical support for the occurrence of rupture-repair episodes and their association with positive therapeutic outcomes,[5] it wasn't until the uptake of a new wave of statistical methodologies (e.g., longitudinal multilevel and autoregressive cross-lagged modelling), that researchers were able to acknowledge the more complex within-session data which could determine whether the TA does have therapeutic value in itself. Led by Zilcha-Mano[7] the TA was soon re-conceptualised into two distinct parts - trait-like (TL) components of the alliance (representing fixed client traits), and state-like (SL) components of the alliance (representing within-client manifestations occurring through therapy). Zilcha-Mano[11] argued that this reconceptualisation has the potential to personalise psychotherapy treatment via first identifying a client's TL strengths and pathologies (TL signature map) that moderate treatment effects, followed by SL components which are the target of therapeutic treatment. For example, if *deficits* are identified by the TL signature map, treatment outcomes would be more positive if a therapy targets such deficits to provide the desired traits or skills (SL aspects). In conjunction with the analytical strategies that allow for the disentanglement of TL between-individuals variance from SL within-individual variance, advances in machine learning to determine individualised TL mapping signatures have helped clarify that within-client SL improvements across treatment are indeed sufficient for therapeutic success.[12,13]

So, given these new contributions, has the debate between the 'necessary-but-not-sufficient' and the 'sufficient' camps regarding TA therapeutic value been resolved? Well, in terms of both the trait-like, state-like (TLSL) distinction and evidence from clinical subgroups, there does appear to be a case for both sides of the argument. Indeed, clients possessing adaptive object relations traits at baseline (TL aspects) and who are 'ready for change' may have the capacity to resolve ruptures within-session and benefit from the TA indirectly in that it provides an optimal milieu for other therapeutic agents (e.g. behavioural experiments, unearthing defence mechanisms) to work.[14] Alternatively, those possessing poor object relations traits at baseline, such as those with personality, attachment, and eating disorders,[15-17] who may have a lesser capacity to resolve ruptures within-session, may benefit from alliance work and rely on the occurrence of SL changes (via rupture-repair episodes) for therapeutic success.[6,18] So, in short, this new statistical research has been fruitful in demonstrating that therapeutic treatments (techniques) facilitated by within-session mechanisms do have the potential to cure some clinical populations. But, in some cases, the strengthening of the alliance between therapist and client to bring about profound interpersonal SL changes, also has the capacity to heal people in its own right.

Conclusion

The therapeutic alliance has received considerable research attention over the past few decades and the modern generation of TA researchers, with the help of recent statistical and methodological advancements, should be applauded for re-conceptualising the TA construct and for enriching our understanding of within-session TA processes that may account for the efficacy of psychotherapeutic treatment. This is certainly encouraging for the clinical community who may value the implications such research has for their practice. My hope is that guideline and medical bodies take heed of such research and offer funding/research opportunities for medical psychotherapists to undertake more research in this area, to ensure that the therapeutic alliance does indeed remain at the heart of all psychiatric practice.

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Johannes Kepler, the cosmos hidden inside the skull and a subtle link to today's psychiatry

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In a letter to Dr Johannes Brengger, dated December 1610, the famous astronomer, mathematician and astrologist Johannes Kepler wrote:

So you see, my dear Doctor, how far ahead I have pressed in our science. I think, indeed, that I have gone as far as it is possible to go, and I confess, with some regret, that I am losing interest in the subject. The telescope is a wonderfully useful instrument, and will no doubt prove of great service for astronomy. For my part, however, I grow tired rapidly of peering into the sky, no matter how wonderful the sights to be seen there. Let others map these new phenomena. My eyesight is bad. I am, I fear, no Columbus of the heavens, but a modest stay-at-home, an armchair dreamer. The phenomena with which I am already familiar are sufficiently strange & wonderful. If the new stargazers discover novel facts which will help to explain the true causes of things, fair enough; but it seems to me that the real answers to the cosmic mystery are to be found not in the sky, but in that other, infinitely smaller though no the less mysterious firmament contained within the skull. In a word, my dear friend, I am old-fashioned; as I am also, yours, Kepler.

Being neither an astronomer nor a mathematician nor an astrologist, but a psychiatrist with a special interest in psychotherapy, I have been struck by the above quotation ever since first reading it in John Banville's biography of Johannes Kepler.

What struck me was firstly the question of what drove Johannes Kepler to turn his powerful intellectual curiosity from monitoring painstakingly the movement of the planets and then brilliantly describing these movements in mathematical terms, towards an interest into the organ contained within his skull – an organ which he had probably never seen in his lifetime, and which – even if he had obtained a glimpse of it – would not have revealed its way of working.

Santiago Ramón y Cajal's pioneering discovery of the cellular basis of the brain occurred only centuries later and so did Alan Hodgkin's and Andrew Huxley's elucidation of the electrical activity of the neurons.

This leads me to the second aspect of the above Kepler quotation that struck me, namely, Kepler's use of the term cosmos in order to describe what is contained within the skull. Johannes Kepler could not have known that the brain does consist of billions of neurons which does, indeed, represent a cellular cosmos.

Kepler would not have had the benefit of insights into the micro-foundations of the brain, but, possibly, his imagination provided him with an intuitive grasp of the fine structure of the brain. Alternatively, magnificent powers of imagination enabled him to visualise in his mind spaces that somehow reflected the huge expanses of the universe which he observed when looking at the stars.

Amazingly, Kepler's superb achievements in the field of astronomy and mathematics and his statement about the cosmos hidden inside the skull demonstrate his astonishing ability to generate profound insights into the outer and the inner worlds.

There is a third aspect of Kepler's reference to the cosmos hidden inside the skull that struck me because, implicitly, by referring to the structure hidden inside the skull – whilst not referring to any other structure of the human body – Johannes Kepler underlined the unequalled role of the human brain, a creation that represents the jewel of evolution.

Celebrating Johannes Kepler's brilliant scientific achievements in an article on the 300th anniversary of Kepler's death Albert Einstein concluded his article with the following words:

"Our admiration for this wonderful man is joined with another feeling of admiration and veneration, not for any person, but for the mysterious harmony of nature into which we were born. In ancient times, men already thought about lines of the simplest conceivable regularity. Among these, the foremost, next to the straight line and the circle, was the ellipse (and also the hyperbola). We see these latter forms realised, at least in close approximation, in the orbits of the heavenly bodies.

It seems that human reason first has to independently construct the forms, before we can detect them in things. Kepler's marvellous life's work shows us especially beautifully that cognition cannot blossom from sheer empirics, but from the comparison of what is imagined, with what is observed."

Albert Einstein, like Johannes Kepler, revolutionised the understanding of the external world, and he, too, – as the above quotation shows – generated profound and penetrating insights into the workings of the mind.

The implicit recognition of the fundamental importance of the brain, so brilliantly exposed more than 400 years ago by Johannes Kepler, and re-emphasised in Einstein's above quotation, makes me wonder why we are still living in an age where the brain is not universally accepted as the most important part of the human body. The huge and important continent of mental health is still undervalued, underfunded and neglected. Psychiatry, its subspecialities and related disciplines are still laggards when it comes to

funding, ranking, esteem and influence although these disciplines' focus of care, commitment and concern is the human brain, the most complex organ created by evolution – not forgetting the important spectrum of tasks required to create the provisions for healthy brain development from early on in life, and to ensure the maintenance of adequate provisions throughout the whole life span.

Although Kepler's world of astronomy and mathematics is far away from my work in mental health, his notion of the cosmos hidden inside the skull exerts a profound resonance as it makes me aware that, however much I may endeavour to gain complete insight into the workings of this inner cosmos, I shall never be able to succeed. Likewise, however much I may learn about psychological and psychopathological phenomena, I shall never attain a complete insight into the workings of the minds of people I am working with. However comprehensively and precisely the relationship between a mental health professional and her or his client may be explored, this will, in its final analysis, always contain mysteries as each cosmos harbours its own mysteries.

Nevertheless, Johannes Kepler's concept of the cosmos contained inside the skull may initiate and inspire a process to overcome the painful historical neglect of mental health, to reinvigorate psychiatry and its related fields and to assign them a proper, overdue and well-deserved place of recognition as disciplines caring for the crown of evolution, the human brain.

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Maudsley Cultural Psychiatry Group in full bloom: the role of medical psychotherapy as a bridge between policy, training and community

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In UK mental health services, there exist longstanding inequalities in access, experiences and outcomes for people from Black and minority ethnic backgrounds (**1, 2**). South London and Maudsley NHS Foundation Trust (SLaM) provides secondary mental health care to 1.2 million people with a diverse range of ethnicities. In turn, SLaM is a leading pilot site for 'PCREF' (Patient and Carers Race Equalities Framework); cutting edge NHS England policy, supporting Trusts to improve ethnic minority communities' experiences of mental health care (**3**).

The Maudsley Training Programme is the largest psychiatric scheme in Europe with over 200 trainees (**4**). An integral part of training is led by the Medical Psychotherapy Service

who provide supervision to trainees in Psychodynamic Psychotherapy and reflective practice; this serves to integrate the use of a psychotherapeutic perspective into wider psychiatric practice. In 2020, the Maudsley Cultural Psychiatry Group was founded to focus on issues of race and culture in training and education; this group comprises medical psychotherapists, psychiatrists and psychologists with dual backgrounds in public health, sociology, anthropology and cultural studies (**5**). The group has been funded by Health Education England, endorsed by the Care Quality Commission and published in Lancet Psychiatry (**6**).

Why is psychotherapeutic reflection an integral component to our work? The complex interplay between an individual's internal world and external society has provided a steady anchor to our group process; in particular, introspection around the intersection between multiple aspects of identity, that shape dynamics between individuals, groups and society. Key to establishing trust has been regular reflection on power dynamics between service users, carers and staff. Co-production has been at the heart of this process, including regular consultation with community stakeholders, e.g. SLaM Recovery College and Black Thrive Global. The group regularly draws on a broad range of psychoanalytic literature and supervision to enrich its work (including individual, group and systemic theorists such as Fakhry Davids and Guilaine Kinouani).

On a more personal level, this process has been one of internal integration between multiple aspects of my own identity; east and west, creative and scientific, symbolic and practical. The seed of this group was planted as ten people gathered with poetry and prose under an oak tree in Peckham Rye Common; imbued with a sense of curiosity, hope and resonance across time and place. The aspiration has been to host a space that enables a free and authentic expression of a rich range of cultural identities, creating waves that reverberate within and beyond us. As such, the external manifestation of this group has been both emergent and dynamic, shaped by a range of humans who endeavour to remain open to shaping themselves. We have been lucky to be housed within a milieu of rich psychotherapeutic training, academic resource and NHS policy in SLaM that provide invaluable infrastructure for this plant to grow.

Output has included annual teaching on the Maudsley Training Programme and reflective spaces based on creative material. In 2023, the group launched a seminar series in collaboration with the Institute of Psychiatry, Psychology and Neuroscience (Professor Stephani Hatch, Vice Dean for Culture, D&I) to address inequalities in coercive practice and psychotherapy, the role of religion/spirituality in mental healthcare and advances in law. The audience comprised over 600 people from across the globe who experienced a complex symphony delivered by clinicians, service users and researchers (including Professor Camara Jones, ex-President of the American Public Health Association). Feedback demonstrated benefits in staff knowledge and confidence on race and culture in mental health practice, alongside increased connection with local communities. Such initiatives convey how psychotherapeutic reflection, co-production and inter-disciplinary thinking can form a bridge between NHS policy and training, aiming to redress longstanding inequalities and better meet needs of increasingly diverse populations.

If anyone wishes to join our mailing list or contact us, please email: (maudsleyculturalgroup@kcl.ac.uk) or follow us on X @maudsleyCPG.

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Climate and Social Justice

Update from the Medical Psychotherapy Faculty working group on Climate Action and Sustainability

Dr Marion Neffgen and Dasal Abayaratne
On behalf of the Faculty working group

Despite a summer of extreme weather events and records broken across the globe, we hope that you are all keeping well. The working group would like to share some information about climate action, events and resources that faculty members may find helpful.

Global Climate Symposium

On 14th October 2023, there was a global climate symposium with the title "From couch comforts to climate leadership". This event was organised by a global network of psychologists and psychotherapists (GlobalPsyFuture), with many people from the UK (several from the Climate Psychology Alliance) and Europe involved in organising. It was a public event held in 2 time slots to be accessible in different time zones. Sally Weintrobe gave the keynote, joined in the first event by an Environmental Psychologist from the Philippines. Please have a look at their website (https://psyfuture.org/).

Ethical banking initiative

Below is a link to a petition to encourage the RCPsych to move their banking away from Barclays. This was started by psychiatrists who are members of the Psych Declares* group, around the time of the International Congress.

A brief explanation of why this matters:
Barclays is one of the main funders of fossil fuel companies in Europe earning them the title of 'Europe's dirtiest bank'. Based on RCPsych having an estimated £20 million in the Barclays account, the banking carbon footprint is 4752 tonnes of CO2/year, which is the same as flying from London to Rome 23,760 times.

A few regional committees within the college have already endorsed this move and we have been told by college representatives that it is more likely to happen if many members/ divisions demand this. Members of Psych Declares and the PHSC have been lobbying the college around this for a while and most senior people in the college (including John Crichton, Calum Mercer, Lade Smith, Paul Rees) are in agreement that the college should move banks. However, there is no clear timeline, and the finance department is prioritising other big tasks. We hope to get a lot more signatures of individuals before the next council meeting and the Net Zero meeting in December.

Please feel free to share the petition with colleagues/ other members of the college. https://www.change.org/p/as-members-of-the-royal-college-of-psychiatrists-we-ask-that-the-college-move-its-bank-account-from-barclays-to-an-ethical-and-sustainable-bank

If you would like to find out more about the impact of ethical banking and how your own bank is doing - please check out these links:
https://bank.green/
https://www.mymothertree.com/

**Psych Declares* is a member of *Health Declares Climate and Ecological Emergency*. We are a group of mental health professionals from across the UK, who recognise that the climate and ecological crises are health emergencies requiring urgent action. We are committed to acting and advocating protection of planetary and human health. We are calling on our healthcare organisations and institutions to declare, divest and take action. To join, visit https://healthdeclares.org/psych-declares/

Free Climate webinar and resources

A session on 'Climate anxiety, nature-based approaches for mental well-being and climate action', that was presented and recorded at the International Congress 2023, is available as e-learning for college members.

Fossil fuel non-proliferation treaty

The UK Health Alliance on Climate Change UKHACC (of which the Royal College is a member) are championing the Fossil Fuel Non-proliferation Treaty and asking health professionals to sign as individuals and organizations. This could be supported by the faculty and is also open to individuals for signing. https://fossilfueltreaty.org/health-letter

UKHACC also have lots of helpful information about climate action on their website. https://ukhealthalliance.org/

Book Review: "Uprooting" by Marchelle Farrell

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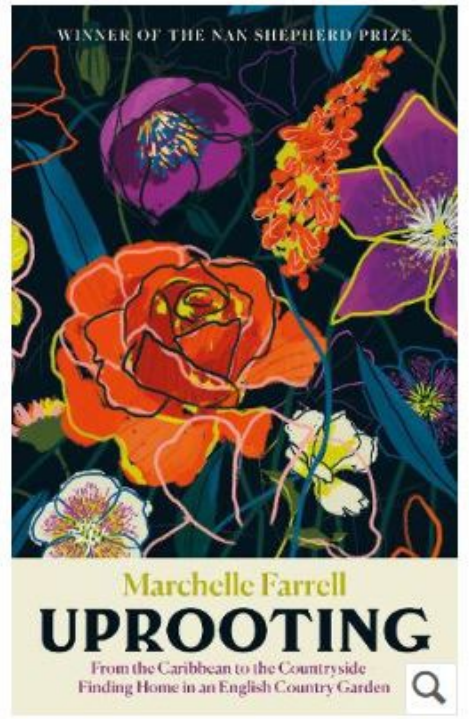

Having trained in psychiatry and medical psychotherapy, and burned out from many years of working in the NHS, Marchelle Farrell takes a leap and moves with her husband and young family to a cottage nestled in the Somerset countryside, complete with a large garden. Arriving in winter and initially despairing at the seemingly barren landscape around her, she charts the changing relationship between her internal and external landscapes over the next year. She observes how her work in the garden triggers profound emotional revelations, while trying to grapple with the trauma of the pandemic, with her husband working as a medical consultant on the front line.

Weaving in unexpected links between her childhood in Trinidad and what she discovers in an English country garden, she explores ideas around home, belonging, community and the impact of colonialism and racism.

She champions a more relational approach to the land as she starts to put down roots there, developing a reciprocal relationship with the garden as a living entity with its own responses and needs. Drawing on her training in psychotherapy, she writes about how we can learn to listen more deeply and attentively to the landscape, and how this nourishes us in turn. It seems fitting therefore that the book won the Nan Shepherd prize for underrepresented voices in nature writing in 2021 - Shepherd's writing about the Cairngorms in 'The Living Mountain' is similarly remarkable for describing a relationship of mutuality with the mountains, rather than the more typical narrative of summiting and conquering them. This is a beautifully written and moving book, both deeply personal and widely resonant, and a timely call to recognise our interdependence with the land and with each other.

Trainee Voices

Introduction from the Editors

Dr Hafeesa Sameem
ST4 General Adult Psychiatry, Wales Deanery
Dr Eleanor Riley
ST4 General Adult Psychiatry, North Western Deanery

Welcome to Trainee Voices, Autumn 2023.

It seems like 2023 has pretty much whizzed past and we are fast approaching the end of the year. Autumn bears close resemblance to this event as it starts preparing for the inevitable end by shedding and baring its soul in winter before resurrecting itself once again in time for the new year and new season. As humans, that is a transition we all go through as well, time and time again. There is no denying the year has been tough with the rising cost of living, political instability across the world, strikes becoming almost the norm in our day-to-day life - the list could go on. But as demonstrated time and again, there is always hope that this too shall pass and there will better times just around the corner. On a positive note, changes in the form of our new Royal College President with a fresh perspective and the new RCPsych curriculum for core and specialty training being positively viewed by trainees are beacons of hope that as a faculty we can continue to grow and excel despite the adversities.

Thank you to the trainees who have contributed to the voices heard in this section; hopefully you will find the articles insightful.

We would like to welcome submissions from others on their training journeys in the form of reflections, commentaries, reviews, art, poetry or other forms that can be gathered for the Spring Newsletter.

Digital Addiction in the UK: The New kid on the Mental Health Block

Dr Hafeesa Sameem
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Gone are the days when sitting in a train or a park meant being nosy and observing the person sitting next to us and wondering where they got their shoes and clothes from. Gone are the days when I could sit in a cafe and mindfully enjoy my coffee or actually concentrate and read a book. These days I find myself glued to my phone and thanks to wireless pods, I have constant audio feed while I try to get through the mundane tasks of day-to-day life while convincing myself that I should be proud of utilising my time so effectively. Until I realised that I was looking at endless reels on Instagram till 2am and wondering why I felt so tired the next day!

There is no denying that we live in a super-fast digital age. The world has shrunk to fit into our smartphones. We see our family and friends on social media platforms more than in person, and gaming consoles have become so alluring that the outdoors doesn't stand a chance! So it is no surprise that digital addiction has won a place fair and square on the list of addictions that cause profound impacts on mental health.

Digital devices have become akin to vestigial organs attached to our very being. And I can only imagine the numbers being on an upward trend for years to come. The analogy to vestigial organ is probably incorrect as with the arrival of the smartphone the poor basic phone once used for simple communication has been elevated in its status to become an integral part of our life.

We do not buy books or head to the library to learn anymore. Work emails are configured on our smartphones ensuring efficiency at work. Entertainment and social interactions are other vital functions performed by the smartphone. Gaming today is serious business and has come so far from Pac-Man and dropping bricks to being a fully immersive experience that keeps gamers glued to their high-tech gaming set-ups for hours on end.

Given all these functions, it is no wonder that many use digital technology to the point of addiction, leading to detrimental effects on physical, mental and social well-being. We cannot assume that anyone who uses digital devices excessively is addicted, but it is important to acknowledge that a significant portion of the UK population is showing signs of problematic usage. Gaming has already been acknowledged as an addiction problem by WHO and is due to make its debut in the ICD-11.

An associated concerning addiction is addiction to social media, characterised by excessive usage of social networking platforms. Almost compulsive scrolling through reel after reel on Instagram or video after video on YouTube is the norm these days. Many go a step further and depend on social media for validation, going to great lengths to create a picture-perfect post for comments and likes. The stress of maintaining that

facade on social media and the constant need to garner attention spells disaster for people's mental health.

Digital addiction has not exactly been covert so there is awareness bringing to light some the following adverse effects such as:

1. Isolation: This one is a no-brainer really as someone who is glued to their devices tends to neglect real relationships, leading to loneliness that exacerbates mental health issues.
2. Depression and Anxiety: Pressure to maintain an image of an idealised life leads to feelings of inadequacy, poor self-esteem, anxiety and low mood. These people are also constantly checking their social media feeds for fear of missing comments, leading to more anxiety.
3. Sleep Issues: Using digital devices before bedtime interferes with the sleep cycle making it difficult to fall asleep leading to poor sleep and sleep debt.
4. Poor Concentration and Focus: Digital addiction hinders productivity at work and at school due to inability to focus.
5. Cyberbullying: The anonymity offered by the online world offers a platform where one can be mean, troll and harass people without fear of consequences. For the victim, there are severe, long term psychological effects.

Some suggestions to try and curb digital addiction and its detrimental effects on mental health are:

1. awareness campaigns to educate the public about controlled, healthy digital usage
2. specialised programs to address and support digital addiction by mental health services
3. educating parents to monitor and control their children's screen time and access to addictive programs
4. digital detox as a useful way to break the cycle and be more present in our environment and with other people.

In conclusion, I think it would be useful if we as a mental health faculty recognise this new addiction, and try to proactively prevent it reaching mammoth proportions in the general population. It may be worth considering not just raising awareness but also having easily accessible support for those struggling with their digital usage. It is also worth considering how psychotherapy can aid in the de-addiction process and pave the way for a balanced and healthy relationship with the digital world. Digitalised life is the norm and is here to stay, so we have to learn constructive ways to live with it.

On Kindness
(Wakley Prize submission 2022)

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CT2 Psychiatry, East London Foundation Trust

During the fourth year of my medical training I began to think seriously about a word: 'Kindness'. On one hand it was one of the greatest revelations I have had in both my personal and professional journey, limited though that may be, and on the other there still exists in me a disbelief in the power of something so simple. It is possible that it is a naïve lens through which to navigate the world, but I wish to present the case that it is anything but. It is difficult to escape a narrative of a world marred in injustice, suffering, corruption and, more recently: an economy in a state of disrepair, a war with rippling consequences to our pipelines and pockets, and an invisible enemy which has tested our physical and emotional resilience, leaving an undercurrent of isolation and disconnection. These are powerful and moving forces sometimes beyond our control, but I believe that they can be met with equally powerful and *productive* forces, often relegated to aphorism and idealism. I refer to compassion, connection and community to name but a few, but my focus here will be *kindness*, a force which encompasses all.

A word which we all know and have used, it first came to my attention as a concept to be understood and explored whilst attending a 'Medicine Unboxed' conference several years ago as a medical student. It is an event which until a few years ago enjoyed a decade of bringing together an audience from many backgrounds to explore the important questions of our humanity interwoven with medicine. Like a child in the proverbial candy store, I would sit in wonder for what seemed to me the ticket of the year soaking up the atmosphere of stimulating conversation with writers and moving performances of dance and spoken word, all under the reassuring canopy of the Parabola Arts Centre in Cheltenham. I have a vague recollection of a comedy sketch delivered by a ventriloquist and his puppet companion and soon after of a speaker announcing words along the lines of "we need more kindness in the NHS". An unexpected applause and murmurs of acknowledgment stirred in the audience, as if this was a truth hidden in plain sight, one which perhaps I had not been privy to yet. I had been anointed, there was no return.

To start a sincere analysis of kindness we must begin, as with all things, to define it. The Cambridge dictionary defines kindness as "the quality of being generous, helpful and caring about other people, or an act showing this quality". At first glance this seems like a relatively natural and desirable characteristic of the medical professional. I have had encounters with incredibly kind and compassionate colleagues and have been humbled by some of the interactions I have had with clinicians I have been treated by in my own patient journey. Therefore, I would argue that there is no lack of humanity within an increasingly overstretched and pressured system. I wish to present the case that kindness is more than a 'soft' skill, limited to exploring a patient's ideas, concerns and expectations. Rather it is a way of being and of practicing; a resource to draw upon which allows deeper connection and exploration of the doctor-patient relationship with a potential for powerful therapeutic results. Kindness is not the same as being nice, or

pleasant, or a state of selflessness. It can be challenging, sometimes painful and requires firmness and exploration of discomfort.

I will present the case for kindness from my own experience and learning, and how my understanding of its meaning and practice has evolved since first starting to explore it with intention. The first question is whether we choose to be kind or not, the more complex question especially in the clinical setting, is *how* to be kind. The journey will be different for everyone, but for myself there have been three identifiable stages of the maturation of kindness so far.

In my early exploration of kindness, soon after the conference, I decided to integrate kindness into my daily encounters with patients. That is not to say I was not kind before, but it became a part of my toolbox in my then half-hour appointments as a medical student. Kindness became a synonym to doing 'to the best of my ability with the resources I have available', expressed in the previously mentioned definition as *generosity.* There was a noticeable shift in the nature of my consultations and the feedback I received was better. Though the physical resources remained the same, the addition was real presence with the patient. Watching myself in video feedback, I appeared softer, relaxed and more engaged in what the patient was saying. In the moment, the most important thing was active listening and non-judgement, refraining from jumping to conclusions which so often happens in the early stages of learning how to make a diagnosis or formulate a treatment plan.

I carried this attitude into my practical exams that year, and to this day I believe kindness got me through. Surrounded by nervous students engaging in last minute cramming of knee exams and heart murmurs in the waiting area before being called up, I had made a commitment to kindness. I would read the scenario on the door to the stations reminding myself of the question "How can I demonstrate kindness to this patient?". Again, kindness here meant doing the best I possibly could for the (simulated) patient in front of me, as opposed to what is the examiner expecting of me. A simple shift in perspective, but one which helped me to progress.

I believe this to be an immature stage of the kindness journey, likened to birth and the child stage of development, with movement into the adolescent stage as the practice became more refined. I do not doubt the authenticity of the kindness in the examples above, but it was kindness as a means to an end, and in a way, in service of self. I liken this process to Aristotle's idea that in a child's moral development he must be habituated first to the action through practice and repetition before being able to appreciate the virtues of moral actions in and of themselves. In the adolescence of kindness, there is movement from service of the self to service of another.

The next and more challenging stage of the kindness journey is one of maturation, akin to the process of entering adulthood. It is a unifying of the concepts discussed previously, kindness in service of another with equal emphasis given to kindness to the self. The challenge here is balancing the two natures and it requires constant renewal and self-awareness, so the currency of kindness is not allowed to stagnate.

This learning presented itself to me during a busy on call weekend where manpower was in short supply and the list of jobs was long. I went to see a patient who required blood tests daily, not expecting to be greeted with a disgruntled customer who initially refused blood to be taken, muttering obscenities. However, with some discussion and mutual agreement I was given just one shot at obtaining the prized elixir, with the expectation from the patient that it would be no easy feat given the others who had tried and failed before me. Despite my self-assurance that I would be able to take the blood with no problem, the patient was right. I used up my one precious attempt and left with the intention to return to try again if the patient and my workload would allow. To my surprise I was bleeped to see the patient again shortly after I had left. He had specifically requested to speak to me with no further context given.

I pause here to express the importance of acknowledging the feelings of resistance I felt at the prospect of another challenging interaction. The behaviour towards me felt unjust when I was trying to help. I had a long list of jobs to get through and wondered if this was a cry for attention rather than a genuine request for assistance.

On my return I was met with almost a different personality: one which was open, humble and desperately in need of help. He had noticed an issue which was becoming worse over the past few weeks and wanted me to have a look at it, and when I conducted the necessary examination, I realised it was more serious than I imagined and so the relevant tests were arranged, and advice sought. The key message here was two-fold: on one hand this was a patient who had kept his symptom hidden for weeks, and on the other hand I had pre-judged him based on the initial encounter which had affected my capacity for kindness. Despite this, he reached out to me, and I wonder now if he saw a kindness in me I could not myself connect to at the time which allowed him to trust me enough to open up.

In hindsight, this patient taught me that amongst the pressures of the environment, I had lost touch with the kindness I had carefully been nurturing. I now understand this to be a neglect of kindness to myself masked as a noble pursuit of the selfless giving in one direction. We must continue to nourish and support ourselves, as kindness is a valuable but limited resource if the well is not continuously renewed. This symbiosis of kindness between self and the other, I feel, is the mature, adult representation of kindness.

Kindness may appear to be a simple concept, but I've learned it is not an easy journey and one which requires constant reimagining and renewal, often accompanied by growth and deep maturity. It can be challenging to remain kind in increasingly pressured settings and when striving to meet personal and professional demands, so when we forget, which we all do, I urge my colleagues and friends, to please continue to be kind.

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Relation of MBT to classical narcissistic defences

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As part of my CT3 year I worked in a Tertiary Personality Disorder Service focusing on patients with moderate to severe interpersonal difficulties. I spent the year working both individually and in group sessions with patients whilst also training in Mentalization Based Therapy and ended up working my long case in this style. What was illuminating to me was to draw comparisons between MBT and classical narcissistic defences, and this was the focus of my assessments and also a case study I wrote for an essay prize I won in Northern Ireland.

I conducted individual therapy with patients and also delivered the MBT-I Psychoeducation Group which was an 8-week course explaining the basic tenets of MBT to patients. They then went into an 18-month rolling MBT Group Programme which involved both facilitation and weekly 1:1 sessions, with the idea of helping a cohort developing their ability to mentalize, on which I shall elucidate further. Developed by Peter Fonagy and Anthony Bateman, MBT is rooted in attachment theory and cognitive psychology.

In MBT therapy, the therapist encourages the client to explore their thoughts and feelings, fostering an increased awareness of their own mental states and the mental states of others. This process, known as mentalization, helps individuals develop a more accurate perception of themselves and their relationships, leading to improved emotional stability and healthier interactions with others.

I hearken it to somewhere between mindfulness on a personal level and fostering empathy for others. The Mentalization process involves trying to "depolarize" patients. By this I mean that there are numerous poles that we oscillate between, e.g. Self vs Other and Cognitive vs Affective State. Patients with EUPD generally gravitate towards one extreme, losing an ability to mentalize. This characterises a lot of the breakdowns in friendships and family relations.

There are numerous ways (defensive modes) outlined by Fonagy and Bateman in which mentalization can be limited and break down, and they warrant some level of individual discussion.

The first is the idea of the "teleological mode" which is more simply expressed as only deriving validation through public acts of affection, e.g. a reply to a text message. This mode generally conceives of a specific response from the other as the only validating or loving response and when not met, can result in anger, dissolution and rage. From my previous studies in philosophy of law, it can be thought of as the opposite to a deontological approach where one can conceive of a general good or understanding that the lack of specific response could be part of a more general problem - the person may be busy etc…

Secondly, the "hyper-mentalized mode" which is an extreme movement to the cognitive pole and away from the affective pole; it uses a hyper-rationalized response to emotional uncertainty and tries to deflect from something that might result in emotional pain. It shows a lack of ability to work through the pain. The therapist's job in this instance is to attempt to engage the affective state of the patient, often through contrary moves and posing hypotheticals, and this can be done in a manner that does not antagonize the patient.

Thirdly, there is "psychic equivalence" where a patient may project their difficult affect state onto others and assume this to be the truth. "I hate myself therefore you hate me." This has been most interesting to draw out in group sessions: "You seem quite upset, what's that about?" and gently drawing this out has helped the individual resolve the fallacy they have established.

Prior to retraining as a doctor, I was a solicitor, working mainly in criminal law. I think that undertaking training in MBT and working to that model has been very beneficial to my own understanding and sense of self, as well as helping me communicate with and understand patients. This deep-rooted and psychologically imbued model of therapy has also demonstrably helped patients.

In terms of metrics, I conducted an audit project looking back at the 18-month MBT programme. The average time spent in inpatient admission days prior to starting therapy for 18 months (n=19) was 21.74 days, this decreased to 6.53 during therapy and 3.68 post-therapy (at 12-month follow-up) = 5.52 adjusted for 18 months. This represents a reduction of 74.61%, thus showing tangible effects.

The average number of crisis contacts and Emergency Department assessments were 2.63 in the 18 months before commencing therapy, 1.26 during therapy and 0.58 in the 12 months post-therapy, 0.87 adjusted for 18 months. This represents a reduction of 66.92%. Patient satisfaction is equally high.

I'd like to end by commenting on my own experience of MBT and how it resonated with myself and with the song 'Brothers in Arms' by Dire Straits:

There's so many different worlds; so many different suns
And we have just one world; but we live in different ones

And that summates MBT to me. The balance of solipsism (we have just one world) with a phenomenological approach and the conception of others' experiences, which I find fascinating, and which is key to a greater interpersonal understanding that appears to be borne out by patient experience.

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When life calls 'Code Red': Psychological housekeeping for the Day of Trouble

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It is no news that the world seems to be in a state of ongoing crises, similar to the multiple uncontrolled tonic-clonic seizures caused by disorganised electrical discharges in the brain. According to the United Nations World Economic Situation and Prospects (WESP) 2023, "a series of severe and mutually reinforcing shocks: the COVID-19 pandemic, the war in Ukraine and resulting food and energy crises…" amongst others, "battered the world economy in 2022".[1]

Although the nature of the crises has vacillated from economic, environmental, and sociological to the aftershock of the pandemic and everything in between, communities and individuals who have been tossed from the abrasive arms of one form of difficulty to another are having to pick up the pieces of their lives, while learning to live with the harsh realities presented by their new worlds.

The World Health Organisation, in a publication over a decade ago, stated that "the economic crisis is expected to produce secondary mental health effects that may increase suicide and alcohol death rates".[2] With the magnitude of blows the world has suffered in recent times, one can only imagine that this prediction is fast becoming a reality. In 2022, the president of the Royal College of Psychiatrists warned that "the cost-of-living crisis poses a threat of pandemic proportions to the nation's mental health".[3] One imagines that this would also be the case in many other countries experiencing similar economic challenges across the globe.

And while it may seem farfetched, for the person sitting next to you, a relationship breakdown they are struggling to come to terms with could be a crisis of hurricane intensity. For that colleague in the coffee line, it may be the examination result they just checked or the diagnosis their loved one recently received. For your co-worker staring across the multidisciplinary team (MDT) meeting table, it may be an issue with parenting, or childcare or something unrelated. And for the person who almost cost you a ticket on your way to work with their bad driving, it might just be all of life. But we never know; partly because professionalism, like good makeup, helps us cover all the char and soot and broken pieces with which these crises riddle our lives and communities.

Though it all seems like gloom and doom, through the ages, humankind has continued to find ways to manage and survive as a species, even in the face of unimaginable disasters. Like Darwin's theory of Natural Selection, whether these adaptations have all resulted in positive traits or not, is a topic for another discussion. However, as psychiatrists, and indeed, as people, we can choose to apply one of the positive principles of Natural Selection, which is to preserve and multiply the incidence of beneficial mutations.[4] While governments and international bodies scamper to do what they consider best to tackle the fires in various spheres of life, we could pitch in our individual contributions to make the next person's burden somewhat lighter by applying these or other creative ideas:

Learn to practice 'conscious positive projection'. Although not in any way the official meaning or opposite of the Freudian term, we could borrow from parts of Freud's concept by creating a habit of deliberately searching out the positive qualities in people and highlighting or focusing on these, where appropriate, regardless of how 'small' or 'big' these qualities are. This could help shift the equilibrium in our outlook and theirs, while delivering some positivity to help manage stress in other areas. As the golden rule in Matthew 7:12 says, 'do to others whatever you would like them to do to you'.

'Be the thermostat, not the thermometer'. Professionalism and maturity help to ensure that people generally 'play nice'. But with the increasing pressures, chances are that in a heated situation at home, work or elsewhere, we could become the victims or perpetrators of a sporadic act of negative displacement. These 'micro' or major mental injuries add to the existing emotional burden a person carries. So, when faced with these unpredictable experiences, it is worth remembering that your mature response might be the game changer for the next person. Take a few steps back mentally and try to respond in a constructive way - even if they do not seem to deserve it.

Intentionally create new positive 'reciprocal roles' for others. In his beautiful piece on Reciprocal Roles, Steve Potter stated: "Tony Ryle intended reciprocal roles to help us to think relationally; to see how our self-knowledge is derived in relations with others".[5] Although reciprocal roles are usually formed early in life, we could actively interact with people with the aim of leaving a lasting healthy impression on them that could serve as a safe mental space for them.

In the 2006 animation, 'Everyone's Hero', Babe Ruth, the American professional baseball player was quoted to have said, **"never let the fear of striking out keep you from playing the game"**. Rather than sticking to the script let us learn to embrace the discomfort of uncertainty around starting honest conversations, and reach out to people when we get that gut feeling that things may not be as settled as they look.

And finally, as Lilo said in Disney's 'Lilo and Stitch' said, "… **no one gets forgotten or left out**", and that includes you. Be kind to yourself.

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Oral Presentation at World Congress of Cognitive Behavioural Therapies

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I am delighted that I have successfully presented in the World Congress of Cognitive Behavioural Therapies in summer 2023 as a core psychiatry trainee. I am also very lucky to lead the discussion of the Clinical Symposium at the Congress. With my clinical experience spanning 4 different countries worldwide, and unique assets to approach the topic from both a clinician's standpoint and a trainee's perspective enhanced the discussion, and infused it with diverse insights.

In my endeavor to contribute meaningfully to the session, I sought to impart a substantive and well-rounded comprehension of the subject matter. I took the opportunity to share my experiences in the realm of Cognitive Behavioural Therapies, incorporating a global and culturally sensitive perspective garnered from diverse educational and cultural settings. Furthermore, I led the discussions in the clinical symposium that was focused on current limitations and propose future directions for CBT education with a global and cultural emphasis.

The World Congress of Cognitive and Behavioural Therapies (WCCBT) is an international congress which has been dedicated to the promotion of health and well-being through the scientific development and implementation of evidence-based cognitive behavioral strategies designed to evaluate, prevent, and treat mental conditions and illnesses.

The scientific congress theme of 2023 was *Global CBT Dissemination, Accessibility and New Technology.* It was important in several ways; CBT is evolving at a rapid pace, and yet there is a vast unmet global need that requires an innovative and comprehensive dissemination strategy; Effective and equitable dissemination will require a significant focus on making CBT interventions and training widely accessible across diverse geographical, population, and individual dimensions; The variety of problems, including both mental and physical disorders, being targeted with CBT interventions by worldwide health systems are constantly expanding.

In this WCCBT 2023, researchers, clinical psychotherapists, trainees and consultant psychiatrists worldwide have had opportunities to gather and share extensive discussions that enhanced the scope of the clinical and scholarly knowledge, as well as developed a worldwide network to share evidence based information.

Abstract of my oral presentation in the Clinical Symposium at the World Congress of CBT 2023: The Limitation of Generalising CBT to Culturally Diverse Populations

Cognitive Behavioural Therapy (CBT) has gained widespread recognition as an effective treatment for various mental health conditions worldwide. However, it has often been applied within the context of Western cultural concepts, necessitating a more diverse and inclusive incorporation into the therapeutic framework.

Despite living in an era of rapid globalisation where the world seems increasingly borderless, distinct cultural aspects persist and are increasingly valued. The notion of diverse culture extends beyond ethnicity or race, encompassing diverse heritage, religion, and social norms closely intertwined with individual values, lifestyles, and social beliefs—elements that constitute one's unique identity.

Globalism entails an exploration of various patterns of meaning, an attempt to understand the intricate interconnections of the modern world, and an effort to highlight the underlying patterns therein. Multiculturalism promotes the belief that all cultures within a society should be accorded equal importance. Consequently, recognising and adapting to the proportional pattern of global diversity and carefully modifying the CBT model in accordance with emerging trends is of paramount importance. Such adaptation holds the potential to yield positive therapeutic outcomes. An essential component of this endeavour is the creation of a framework that enables clinicians to address the diverse worldviews and experiences of their clients while remaining mindful of their own cultural backgrounds and identities.

This clinical symposium addresses several crucial aspects related to the limitations of generalising CBT to culturally diverse populations within a broad therapeutic scope. The symposium covers the following key points:

1. Global Diversity Trends: An exploration of global trends contributing to increased cultural diversity and their implications for therapy.
2. Understanding Diversity Terminology: A deeper understanding of the terminology used to describe diverse populations, fostering clearer communication and cultural competence.
3. Socio-Environmental Value Dimensions and Personal Identities: An examination of differences in core socio-environmental value dimensions and personal identities across cultures, and how these differences impact therapeutic approaches.

Additionally, the symposium presents a case study that delves into the key factors limiting the generalisability of CBT, along with further considerations of disparities and contraindications in therapeutic perspectives.

In conclusion, this symposium aims to emphasise the critical need for adapting CBT to address the diverse needs of our clients effectively. By acknowledging and addressing these challenges, we can enhance the therapeutic potential of CBT across a rich tapestry of cultural backgrounds. Thank you for joining us on this journey toward more inclusive and effective therapy.

My journey as an EMDR therapist: a reflective account

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"In order to change, people need to become aware of their sensations and the way that their bodies interact with the world around them. Physical self-awareness is the first step in releasing the tyranny of the past."
Bessel Van Der Kolk: 'The Body Keeps the Score'

I was privileged to be able to attend my very first (in person) EMDR conference in Glasgow earlier this year. I have been interested in Eye Movement Desensitisation therapy from an early stage in my psychiatry career. My mother-in-law (a colonel in the US army) sent me a book about EMDR and its effectiveness in treating PTSD in war veterans that piqued my interest.

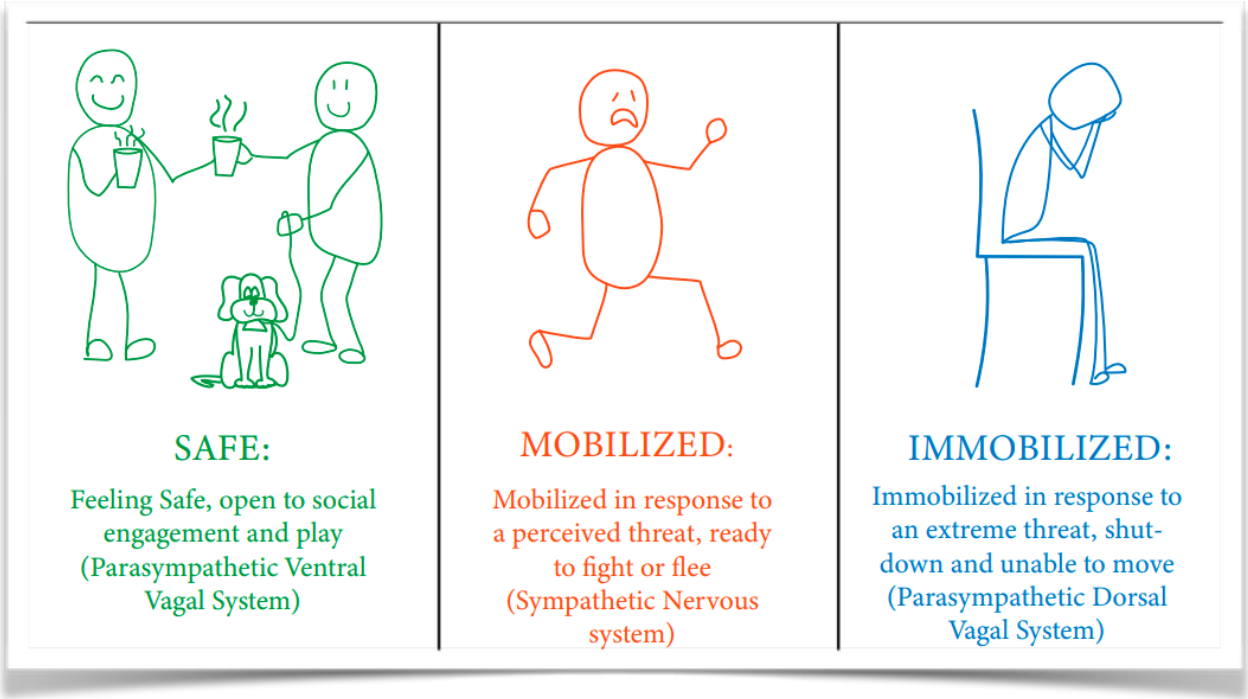
Mental health has had a love/hate relationship with social media, often being glamorized in recent years by various television series e.g. 'To the bone', 'Virgin suicides', '15 reasons why' and 'Euphoria'.

The recent media spotlight on the rifts within the royal family have brought EMDR to awareness with Prince Harry being filmed during part of a therapy session. Often the misunderstanding is that EMDR consists only of BLS (Bilateral stimulation) and butterfly tapping. This is only a small part of the 8-phase protocol.

I have been reading Van Der Kolk's book on trauma, where he puts together a robust case on the mind-body connection in trauma. Medicine, and certainly the treatment of disease is holistic, and each diseased part needs to be treated in the context of the whole. As mental health practitioners perhaps it is a natural ability enhanced by training. We need to value this approach and teach it to future generations of clinicians - if we are to de-stigmatize mental health, we must ensure it's every clinician's responsibility.

The trauma-informed approach has been instrumental in helping mental health practitioners treat patients without re-traumatising them. This approach also helps protect clinicians from burnout as a result of exposure to traumatic narratives.

At the Glasgow EMDR conference this year, I had the amazing opportunity to listen to *Rebecca Kase* (EMDR consultant and trainer). The focus of her talk was on integrating the *polyvagal theory* of Stephen Porges (American psychologist and neuroscientist) with EMDR. Healing lies in learning to connect and befriend one's nervous system.



The Autonomic Hierarchy: Basis of Polyvagal Theory
-Iuffyboy-Wikimedia Commons, 2021

Both EMDR and PVT focus on memory storage and integration. The autonomic nervous system works in a predictable, hierarchical fashion. The ventral vagal keeps us safe and connected, in the middle is the Sympathetic nervous system that is responsible for the fight/ flight response i.e. the familiar feeling of a dry mouth, racing heart and a faster respiratory rate. Finally, at the bottom rung, is the dorsal vagus nerve that is immobilization and disconnection from the environment. This autonomic hierarchy further influences the storage of memory.

The ability to successfully transition between states is based on cues from the individual's environment. A diagram can help patients to understand what their nervous system is telling them when faced with a threat, or an overreaction to stimuli from the environment, which is a problem with conditions like PTSD, anxiety, dissociative states etc.

> ***The past affects the present even without our being aware of it."***
> ***— Francine Shapiro***

EMDR was invented by ***Francine Shapiro*** an American psychologist in 1987. While experiencing disturbing thoughts, she went for a walk in the woods and realised she was able to manage these thoughts alongside saccadic eye movements. This was coined BLS and is meant to mimic REM (random eye movement) that naturally occurs during the sleep cycle, and which is helpful in the retrieval, processing and storage of memories.

EMDR relies on using the senses to process the memory. Attention is given to TICES (Trigger, Image, Cognition, Emotion, Sensations). There are modifications that may be used for patients that struggle with imagery (i.e. autism) or are too distressed to process a recent traumatic event.

I would encourage practitioners delivering this therapy to undergo EMDR for themselves to understand and experience the therapy firsthand. I have felt it has improved my clinical practice and made me more self-aware.

Recommended Reading/Resources:

- Francine Shapiro: EMDR; Basic Principles, Protocols and Procedures
- Polyvagal Flip Chart; Deb Dana
- The Body Keeps the Score ~Bessel Van Der Kolk

Freedom as a word must sound appealing in each of the 7,000 or more languages that exist. We say 'Azadi' in India. The word and the emotions it stirs holds a special place for us.

Azadi

Dr Sarah Farheen
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We were an injured and plundered country when we celebrated our freedom. The emotion of feeling free has remained fresh through generations of retelling, even after we had come through 200 years of imperialism. On the eve of independence, our first prime minister, Pandit Jawaharlal Nehru, declaimed: *"The service of India means the service of the millions who suffer. It means the end of poverty, ignorance, disease, and inequality of opportunity."* As of August 15, 2023, celebrating our 77th year of independence from colonial oppression, we have come far, but we still battle poverty, ignorance, disease, and inequality of opportunity.

A few years ago, some university students got out on the streets to protest the social issues with which India is constantly grappling. The students quantified India's updated fight for freedom in a slogan titled "Azadi". While the reasons for the protest remain beyond the scope of this piece, the slogan makes sense. It inspired some, and strangely irked some too. Its popularity resulted in it being romanticised into songs, the rights of which were bought by the people it irked. It asks for freedom from violence, injustice, casteism, starvation, inequality, saffronization of education (ideological education), classism, and patriarchy. These are big issues, and it is my hope that as we are on our way to becoming the second-largest economy in the world, we must fight these demons. It will not be an easy task. It is interesting that as I speak about large-scale revolutionary changes in my country, I also ponder about freedom at the individual level. Freeing oneself strikes me as a task that is hard to achieve.

As mental health professionals, when we write risk assessments, we come across violence toward the self, starving oneself, and injustice toward the self, way too often. And it is a risk we find uncomfortable because it is hard to undo.

I have an inclination to create fictional characters, and I conjured up Sofia, who hails from India, to understand the impact that depriving the self of freedom can have. Sofia grew up in a family that normalized physical abuse. She was frequently hit at home for not completing her classwork and flogged on the knuckles with a wooden ruler in school for not doing her homework. As a child of 13, her mother trained her in cooking daal and scrubbing the dishes, while she fought wars with her aching and bleeding body. She watched her father and brothers sit on the couch, watching TV and discussing the stock market, while she made round rotis. She had to wait for her father and brothers to finish their dinner and then share the leftovers with her mother. When she finally gathered courage to ask her loved ones about what was happening to her, she was a grown young woman. But instead of an answer to her question, her marriage was arranged with a man she didn't know, let alone be attracted to.

Now, as Sofia is on her own, left with a distorted understanding of herself, she doesn't need her elders to flog her knuckles or compromise her nutrition. Once she is left to herself, she takes freedom away from herself, and begins the cycle of stopping her own

well-being. She doesn't ask for a break when she needs one; she doesn't eat when she needs to. No-one gets an inkling of her period cramps as they eat away at her insides. She doesn't wish to experience sexual pleasure. She doesn't believe she has the intellect to understand the workings of the stock market. In fact, she finds more comfort than unease in driving herself into financial dependency. She has two lovebirds. She wonders why she silently stares at them as they restlessly flutter around in their cage.

Are the lovebirds, you, Sofia, and I—as free as we think we are? Is Sofia fictitious, but not as fictitious as I'm making her out to be?

In an ideal world, the practice of democracy and the attainment of freedom should run parallel to each other. The healthy practice of democracy in the world and in families should bring an end to nuclear war, racism, patriarchy, and caged birds. Would a democratic model work for freeing the mind too?

As I was playing tennis with these reflections in my mind, I happened to be doing my rotation in medical psychotherapy. I spent a day every week with our Trust's Complex Needs Service, which is a specialized service for people with complex mental health difficulties including personality disorders. Apart from individual and group mentalization-based treatment, the service also offers therapeutic communities. I worked in the TC for close to 5 months. And what stood out to me about therapeutic communities was that they work on the tenets of a healthy democracy. A TC could be defined as a group therapy setting designed to help individuals with complex mental health difficulties, where one is encouraged not just to normalize personal ownership but also empowerment and leadership whilst upholding the principles of democracy.

At the start, I couldn't help feeling uneasy at the absence of the usual hierarchical system that operates within most health systems. Despite the unease, I also felt an appreciation for the absence of this hierarchy. After some reading, I found a perfect way to describe the approach used in staff-client relationships in TCs: it is the deinstitutionalized approach to interactions. I believe this is a breath of fresh air, and is so underrated and unexplored.

I have never been prouder of my patients, as I was with my patients at the TC. We did therapy together, played rounders together, made art, laughed, and cooked together. Most importantly, we healed pieces of our trauma together. I was surprised at how much I unconsciously healed myself while with the TC. And believe me, I needed some healing.

Of course, there are times when difficult conversations need to be had. There are times when the democratic system doesn't function at its best. There are disagreements, there is stress, there is chaos in the outside world, and there are dark thoughts. There is also disengagement, and there is rupture. But with rupture, there is also healing. There is no corruption, no politics, no revenge, no toxicity, and absolutely no self-help jargon. Just good therapy and good food.

Oftentimes, mental health professionals, for fear of being held accountable by the black-and-white nature of the legal system, hesitate to take reasonable risks and unfortunately end up being part of the apparatus that places patients in an unhealthy loop of care-seeking. But as a therapeutic community is a democracy, it provides the right space for this vicious loop to be undone.

Therapeutic communities have been around since their origin in 1946, and have been widely used in rehabilitating individuals who struggle with substance misuse. The umbrella of personality disorders comes with risks and challenges such as high morbidity, higher risk of substance misuse, low quality of life, and significant harm to oneself. And as much as we want to help our patients with pharmacological support, the crux of the difficulty remains unaddressed. Beyond the cry for help, lies a dwindling understanding of personal responsibility and the concept of empowering oneself.

Community of Communities, is a quality improvement project and an accreditation program for TCs not just in the UK but overseas too. 27 accredited TCs are in the NHS. But waiting lists are building. How about considering practising more democratically? How about deinstitutionalizing our interactions with patients, taking reasonable risks, giving room for the development of personal responsibility, and empowerment? Then our patients wouldn't need to wait years for help, and they would be putting in work between their many ups and downs and their many juggles from service to service.

And here's hoping that while we endeavour to train to make other lives more meaningful, purposeful, and more 'Azad' (free), we might do so with our own lives too.

Conference review

An Introduction to trauma-sensitive and compassion-focused therapy on forensic patients

Dr Ioana Toma
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Violence and mental disorder have long been conceptualised as part of a symbiotic yet dysfunctional marriage. Interpersonal violence continues to be difficult to contemplate, mainly because it is an uncomfortable part of us all that we wish to avoid. Simplistic strategies and binary arguments influenced by media headlines ("mad and bad") dodge complexity and serve as defences that have a substantial impact on therapeutic processes.

The vast majority of patients in forensic institutions are treated pharmacologically,[1] and antipsychotic treatment has been considered crucial in managing and containing physical violence, aggression and high levels of risk.[2,3] There is limited evidence on the impact and outcomes of psychological interventions; however current approaches are shifting towards trauma-informed and compassion-focused practice.[4] This one-day training delivered by Dr Jon Taylor, Consultant Forensic Psychologist and Psychotherapist on the 22nd of August had the ambitious and vital aim of introducing the public to pioneering concepts underpinning compassion-focused therapy in a forensic context.

In the first third of the conference, mental health and criminogenic presentations were introduced from a neuroscientific and evolutionary perspective. Dr Taylor explained that human nature has evolved to satisfy certain motives which can be categorized into three main clusters - those associated with survival, resource gathering and opportunities to rest and regenerate.

Motivational systems then recruit certain emotions and attitudes which serve as survival strategies in particular contexts - such as anxiety (to avoid threats) and detachment/dissociation (to avoid painful feelings). The brain and its sophisticated "software", the mind, are continuously modelled to learn to respond to a variety of contexts, some of which nurture an incredible capacity for harmfulness. This leads to the notion that the myriad states of distress and suffering that we have come to label "symptoms of mental illness" are actually highly organized functional responses to adverse experiences, which once had been life-preserving and safety-promoting. In their original context they were strengths, not deficits, because they served a self-protective function. This has enormous implications on types of interventions offered, as we conceptualise the function of a behaviour rather than employing systems that focus on categorizing and diagnosing psychopathology.

"Trauma" was explored by Dr Taylor under a meaning-making framework inextricably linked to the significance that the individual attached to his experiences. A key point was that we are not to blame for our own nature and the strategies we learned in childhood, but we are responsible for the consequences of this, and for developing more pro-social attitudes. A compassion-focussed approach endeavours to shift the matrix of emotions from shame to guilt, the differences between them being emphasised. Shame is primarily an egotistical emotion whose focus is to preserve the social status of the individual and serves to distance and protect him from the magnitude of harm caused to others, whilst guilt is genuine engagement with this harm, and the foundation for reparation. Criminogenic needs, which are dynamic factors underpinning criminal behaviour, become invaluable tools in deciphering entrenched patterns of being-in-the-world that kept us safe from threat.

In the second part of the talk Dr Taylor focused on language and identity difficulties stemming from diagnostic labels. He explored how categorization of "mentally-disorder offenders" into this semantic societal label has an effect on the meaning and experience of distress. Overidentification with a label has the potential to diminish someone's sense of agency for their own state of mind and the consequences of "enactments of the mind".

This led Dr Taylor to ask the audience a philosophical question: "Who are you as an individual?" which stimulated the audience to identify creative ways of describing themselves. The various accounts gave rise to the revelation that we can elicit infinite roles which are ever-evolving and that will or won't define who we are (or who we want to be). This again has a fundamental implication for psychological interventions in forensic settings, i.e. that instead of worsening the patient's distress and telling them how they should feel, think and who they are, we need to empower and inspire them to devise a narrative of their authentic, non-harmful and compassionate self. This can sometimes come with a harrowing, but necessary cost: helping to bear the psychic pain that comes with insight.

In the last part of the conference Dr Taylor highlighted the need for holistic formulations and risk assessments. This was discussed in connection with transference and countertransference in forensic settings. Mitigation of risk has been central to forensic psychiatry and psychotherapy, comprehensively formulated within "a milieu of security for the sake of society". Countertransference in forensic settings is a problematic concept which has not been widely empirically studied. Professionals may experience a "default" negative countertransference when faced with patients who have committed violent or sexual offences or have a diagnosis of personality disorder[5], ranging from hostility, anger and disgust to helplessness and burnout. These evoked negative feelings put a strain on the therapeutic relationship, and can overestimate and distort the risk of violence. Conversely, risk of violence might be under-recognised in patients who elicit positive feelings. Forensic staff are equally susceptible to developing feelings of shame and guilt due to their latent emotions. There is an inherent assumption that clinical professionalism entails neutrality about patients which is supposed to translate into objective risk assessments. Dr Taylor explained that "the elephant in the room" is our experience of our own unresolved issues and misconceptions about violence, mental

disorder and trauma. Paying close attention to the dynamic of the therapeutic relationship by allowing time to digest and reflect on material is key to gaining access to more genuine feelings and to develop healthy, balanced reality-testing strategies.

The training ended with the following reflections. We all acknowledged that helping someone recreate their life without callousness and cruelty, and then building on the courage to experience and contain the whole spectrum of human emotions is essential. To bear witness to such transformations is fundamentally humanising and at the forefront of a compassionate approach. Human responses to trauma are natural and understandable, and the attempt at explanation does not amount to exculpation. Seeking to define and describe who we are and what our identity is might be better condensed into the most difficult existential task: to just be.

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Book and Film Reviews

Black Box Thinking: The Surprising Truth About Success

Matthew Syed, John Murray Press, 2015

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It was during a Christmas meal for a well-known East Midlands engineering company that I found myself surrounded by aerospace engineers and pilots making small talk. Conversation with my closest dining companion turned to the parallels in culture and processes between the aerospace industry and healthcare and he recommended a book that he thought I'd enjoy.

The name of the book comes from the aviation "black box", which is the orange (not black!) memory unit inserted into aeroplanes which stores flight data from multiple operating systems and cockpit voice recordings. This allows incident analysis following accidents, looking at the causes and any errors or issues that contributed. This can then generate change on both a micro- and macro-level and reduce errors in the future. For me, this theme resonated, as I could see great similarities with psychological formulation, which includes its own black-box analysis of why a particular difficulty has occurred and what may be maintaining it. This can then guide future interventions and help address any precipitating or perpetuating factors.

The book opens with the case of Elaine Bromiley, a mother of two in her thirties going for routine ENT surgery. However, the anaesthetic team are unable to intubate her. They become so focused on attempting this that they lose all situational awareness and cannot consider any alternative solutions to creating an airway. The chapter gives its own black-box analysis of what occurred during the failed intubation, which unfortunately ends with Elaine becoming hypoxic for a prolonged period of time and dying. Her husband Martin, an airline pilot who has lectured in systems safety, begins asking questions about why this happened during a routine operation. He recognises that this incident may not have been a stand-alone situation, having the potential to occur again. He is rebuffed when he requests an investigation into her death. Martin thinks that this could be used as a learning opportunity for similar circumstances arising in future, and could help guide future training and responses.

Syed reflects on the absence of data collection and analysis in healthcare compared to aviation and how this limits our ability to learn from and improve systems. Discussion of the differences in safety culture between the two industries showcases a grave difference, not only in actual accident rates but also in the culture around mistakes. The author reports the aviation error rate as one accident in 8.3 million plane take-offs versus one in ten patients being killed or injured in acute care settings in UK hospitals. He addresses the cultural factors in healthcare institutions which can help or hinder openness around mistake-making and the impacts of this. Syed discusses systems with "closed-loop" thinking errors or failures not examined or learnt from, often due to worries around blame. In contrast, in teams who are culturally low-blame and open about mistakes ("open-loops") this error information can be used to facilitate learning.

Syed remarks on the two key components needed to learn from mistakes: having a system to examine those mistakes and the percolation of that learning throughout a system. Information dissemination is an area that we remain notoriously bad at in healthcare, and he discusses a number of case studies around this.

The tale of a catastrophic flight is then told, this time using actual data recorded by the black box on board. The chapter highlights the need to break down barriers to speaking up in hierarchies, which is highly pertinent to the multidisciplinary teams in which we work. Syed gives an example from Elaine Bromiley's tragic case, where the most experienced theatre nurse fetched a tracheostomy kit and informed the doctors that it was ready for use. Unfortunately, they did not register what she had said, and she did not feel able to mention it again due to her more junior position in the team hierarchy.

Syed discusses the use of checklists to reduce the chances of omissions or errors. These were introduced into aviation following a number of crashes in the 1930s, and then into other industries including healthcare. He cites the introduction of a 5-point central line insertion checklist which led to a significant fall in infection rates, from 11% to being consistently 0%.

In the next section of the book the psychology of, and reasons behind, mistake-making is reflected upon. Syed examines cognitive dissonance in the criminal justice system and how wrongful convictions still happen, despite forensic evidence to the contrary.

The middle section of the book looks at how errors can be used as a tool to drive innovation in design, system or process. Syed draws on a wide variety of examples, as diverse as nozzle design for Unilever's washing powder manufacture, monkeys writing Hamlet and the creation of the file storage site 'Dropbox'. He takes an in-depth look at James Dyson and the "creative power of error" that led him through 5,127 prototypes before the Dyson vacuum cleaner that we know was born.

However, the book is not solely focused on errors but also addresses what can be learnt from success. Syed gives a fascinating look into how the British cycling team used the theory of marginal gains to dramatically improve their performance and win the Tour de France. This was accomplished by improving on a number of small areas which seemed unrelated to the ultimate goal, e.g. improving sleep by changing mattresses and washing the cycling uniforms in skin-friendly detergents to improve comfort levels.

The book closes with an exploration into blame following errors, looking at this from both an internal and wider cultural viewpoint. Syed discusses what happens when we fail to use errors as a learning opportunity and considers how a growth, rather than fixed, mindset can help us learn from our mistakes.

I can heartily recommend this book to colleagues, as it provides a fascinating insight into the psychology of learning, errors and success. Syed reminds us that failure is merely part of the process of learning and growth, and this will be a lesson I keep in mind for the future. Martin Bromiley has publicised the final report into his wife's death, and I will leave you with its final sentence, which beautifully sums up the book. "So that others may learn, and even more may live."

Setting Out to Sea Again: Reflections on Writing a Book

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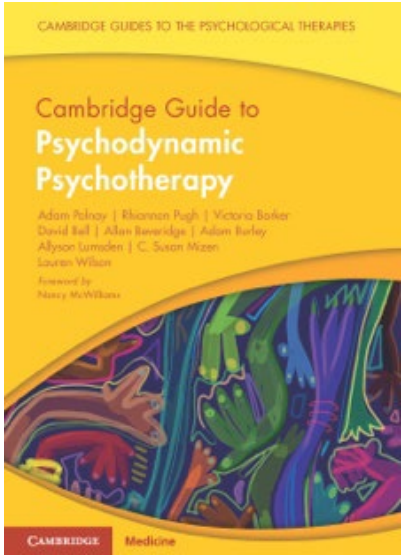
As clinicians involved in training and supervision, we have observed in others and ourselves how starting psychodynamic psychotherapy with a patient is often anxiety-provoking for both parties. This experience may leave new therapists in particular feeling de-skilled. Learning a new style of working can add to a feeling of being at sea. It is perfectly understandable to feel anxious going into any therapeutic situation, no matter how experienced a therapist one is. For those clinicians starting out on their journey as therapists, it may be reassuring to know that although the anxiety can, and indeed should remain, the sense of being 'deskilled' and lost tends to lessen over time.

During our own training, both of us were on the look-out for engaging and contemporary psychodynamic resources. We enjoyed books and papers that could de-mystify the process and provide some containment. Works such as *Learning from the Patient* by Patrick Casement, texts by Nancy McWilliams and Glen Gabbard, or *Introducing Melanie Klein: A Graphic Guide* by R.D. Hinshelwood and colleagues. All these authors use direct language or illustrations to convey a humane approach to encounters between patient and therapist.

Now, as medical psychotherapists and clinical supervisors, we feel privileged to have been offered the opportunity to co-write and edit a new psychotherapy textbook. This allowed us to engage with the object of our curiosity in a different way – that is, influenced by the writers we appreciated earlier in our psychotherapy journeys, to now attempt to create a book ourselves. As well as being designed to be welcoming and accessible for clinicians new to psychodynamic work, we also hope the book will be useful for experienced psychotherapists and generalists – perhaps in particular those who are seeking a fresh take on the 'basics' of psychotherapy (see later).



Our book, *Cambridge Guide to Psychodynamic Psychotherapy*, forms part of a new series of texts on the psychological therapies. All the books in the series have the same basic format and describe various therapeutic approaches including cognitive-behavioural therapy, mentalization-based treatment, schema therapy and interpersonal therapy. We felt the style of the series communicated an inclusiveness and a recognition of the important contributions of different therapeutic approaches – psychodynamic psychotherapy included – and as such we were keen to be part of this wider project.

Nancy McWilliams provides the foreword, setting contemporary psychodynamic psychotherapy in perspective. Our book is a collaborative effort with clinicians from diverse NHS settings including out-patient psychotherapy, in-patient psychiatry, secure hospitals, and the

homelessness sector. The book covers core psychodynamic history, theory, and practice, and explores a range of clinical presentations, including anxiety, depression, and the dynamics of borderline states. There are contributions from David Bell on the supervisory process and Susan Mizen on narcissistic difficulties.

The final section of the book goes beyond one-to-one therapy to address relational approaches to care within teams and services. This includes chapters on the dynamics of anger and aggression, reflective practice, homelessness, and psychologically informed environments.

(Re)discovering the 'basics' of therapy

During the writing of this book, we realised that, although we came to the project with a degree of knowledge, some concepts were fuzzy and uncertain to us. It was a valuable learning experience for us to study these areas, and through this process, clarify our own understanding, or in many cases, encounter new ideas.

Additionally, we were struck by the joy and value in re-visiting the so-called 'basic' concepts and practices of therapy. A realisation of, *"Ah, this is why we wanted to become psychotherapists in the first place"*. From discussion with colleagues, we think we are not alone in observing how we as therapists may, over time, come to take the basics for granted, or even 'forget' them. Familiarity can creep in that diminishes the fresh shock of clinical encounters when working with one's first psychotherapy patients. There is a tendency for any activity we practice repeatedly to become automatic.

But perhaps there is also a dynamic aspect to this drift away from the basics. It is well recognised that interpersonal pressures may accumulate from working closely with patients over a long period of time. As clinicians, we may identify with (projected) experiences such as disinterest or a lack of curiosity that characterise the inner worlds of some of our patients. We think all these dimensions may contribute to the basic premises of therapy fading imperceptibly from time to time in the therapist's mind, and hence the need for continuing re-discovery of these essentials.

To conclude, the process of writing a book has, in a good way, led us to feel less experienced, more 'on the edges of knowing and not-knowing' (French and Simpson 2000, drawing on Bion 1980). Bion argues that this is a helpful disposition for the therapist, although it is not necessarily easy. As French and Simpson (2000) put it: *"Just at the moment when working at the edges between knowing and not-knowing can allow space for a new thought, it can also let in the anxiety of one's nakedness."*

Maybe the feeling of being at sea has something going for it.

Reference

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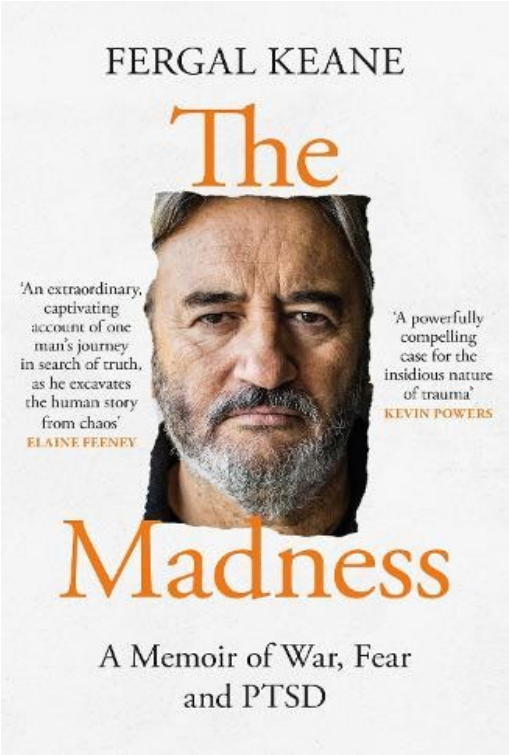
Cambridge Guide to Psychodynamic Psychotherapy (2023) is published by Cambridge University Press. Polnay, A., Pugh, R., Barker, V., Bell, D., Beveridge, A., Burley, A., Lumsden, A., Mizen S., Wilson, L. www.cambridge.org/9781009108508

BOOK: The Madness; A Memoir of War, Fear and PTSD

Keane, F. (2022) London: HarperCollins Publishers

Dr Walid Abdul-Hamid
Consultant Psychiatrist, Central Team, Combat Stress, Tyrwhitt House, Leatherhead, Surrey



In his book 'The Madness; A Memoir of War, Fear and PTSD', Fergal Keane (OBE) wrote an extensive description of the role of psychotherapy in the treatment of his PTSD. He acquired this disorder through his journalistic work as a war correspondent in Rwanda, Sudan, South Africa, Somalia, Iraq, Afghanistan, and more recently Ukraine (with which he started the first chapter of his book). The author was born in London and was educated in Ireland. He is one of the most distinguished BBC correspondents, covering most of the world's conflicts in the last thirty years. As a result of his ongoing struggles with PTSD, he announced in 2020 that he was stepping down as the BBC's Africa editor. The publication of this bestseller followed the release of his documentary film 'Living with PTSD', broadcast in May 2022. He has also authored several other bestselling and award-winning books.

Fergal Keane described the Rwanda events that he covered as the source of the moral injury that he sustained and exhibited. He wrote that it was 'the sense of human failure that I felt after Rwanda, the question of moral injury'. He reported witnessing horrific events in which he was 'convinced that my courage had failed me… in the town of Butare. I learned that many of the people we had filmed at the Préfet's office in Butare were murdered in the fortnight after we left. One account describes how they were crowded onto buses, even forced into the luggage compartments, under the eyes of Préfet Nsabimana — the man whom I believed at the time represented a glimmer of decency — and then driven away to be killed. I met a Butare survivor in the Rwandan capital Kigali years later. She had been raped by the Interahamwe and was now suffering from AIDS.' (p206-7)

The author was diagnosed with complex post-traumatic stress disorder (CPTSD), a condition arising from exposure to multiple traumas, experienced over a long period. CPTSD is more difficult to treat than the simpler PTSD resulting from a single traumatic episode. He was diagnosed in 2011 and has attended numerous courses and types of therapy and taken several antidepressants which he wrote 'made me emotionally numb, and physically constipated, but which also prevented me from reaching a stage of desperation where I might harm myself' (p4).

He described his various experiences with psychotherapies in chapter 14 of the book entitled 'Trials'. He wrote, 'I was introduced to group therapy for those experiencing PTSD. I sat with soldiers, abuse victims, car crash survivors, murder witnesses, and mostly listened' (p204). He described it being useful when the therapist was 'willing to challenge us, however gently, when we try to isolate and avoid the issues which brought us to hospital' (p205).

Group therapy seems not to have worked with the author because of his 'defensive tactics of avoidance, obfuscation and intellectualising'. So he saw a therapist for one-to-one therapy using Cognitive Behaviour Therapy (CBT). He described CBT as 'an attempt to replace negative thoughts with positive ones' (p205). However, for the Rwanda trauma the therapist decided to try EMDR to treat the moral injury aspect of the trauma.

The author quotes American psychiatrist and eminent psychological trauma expert Dr Bessel van der Kolk who described the work of EMDR: 'EMDR loosens up something in the mind/brain that gives people rapid access to loosely associated memories and images from their past. This seems to help them put the traumatic experience into a larger context or perspective' (p205). This meant in practice that Fergal, in between each set of bilateral stimulation, was recalling his Rwandan experiences. He described his EMDR experience as taking him 'back to the faces of the living, the killers and the doomed, back to who I was then, in all my relentless energy and craziness' (p206). Each EMDR session ended with him being taken to his safe place to make sure he was calm enough to leave the therapy room. Fergal Keane's verdict on EMDR is: 'I cannot say EMDR cured me. But it took me safely into and out of places I would have unhealthily avoided for the rest of my life' (p206).

FILM: In a Better World

2010. Director: Susanne Bier

Dr Sara Elsheikh
CT2 Liaison Psychiatry, Royal Blackburn Hospital, Lancashire and South Cumbria Foundation Trust

Susanne Bier, holding fast to the human, throws an eye at humanitarian belonging. She sheds light, in this film, on human relationships in tales of the Third World, arguing that they are an integral part of her tales about death. These tales are represented by her characters in their commitment to the locale. Tales that embody the voice of fear and conflict in solid dialogue and robust scenarios. Africa of Death, where Anton's work brings him to face the dying innocents in a camp for the displaced victims of gangs that kill women and children. Anton's separation from his wife Marion is factored in. On the other side, Christian, whose mother has recently died of cancer, moves from London to live with his grandmother in Denmark where he meets Anton's son Elias at school.

Christian's speech at the church reflects the poeticism of cinema, linking the aridness of the desert with the gloominess of funerals. While Anton faces the odds in African

camps that ooze the stench of death, he confronts the rising superego in his primary school son Elias and tries to fill the imbalance between good and evil in him. Anton's high sense of virtue and his self-denying conscience freeze him into inaction towards harm. But Christian comes to balance Elias's self-love and thus help reduce the scrambling of injustice and the rampant bullying of his friend at school. Elias' mother has separated from his father due to his repeated infidelities. But the question is why they happened? Were they existential drives provoked by the spreading death in his field of work? Has he resorted to sex as an instinct that aids him in the struggle with death? He who has been a life giver; a physician.

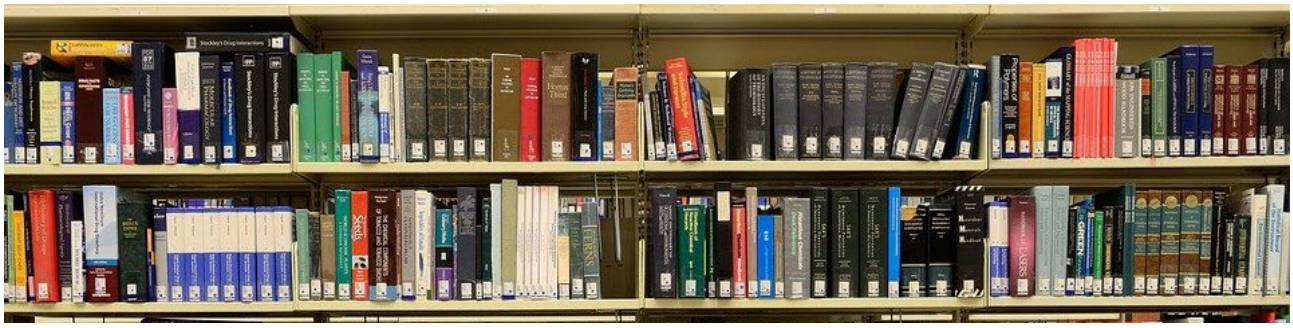
Christian is the child who is angry with his own father, thinking that he participated in the killing of his cancer-stricken mother. Christian directs the anger caused by the death of his mother to ward off death from his loved ones as if that will bring back his mother's tormented soul. But, meanwhile, his father resumes his normal life and lets the death of his wife dry up completely, too soon.

All these characters have looming death as their strongest driver. The higher the moral motive, the deeper is the human sense. And all these deep human emotions are closely captured by Bier's lens in the features of her characters; their sadness, joy and anger, feelings of humiliation, when they soothe wounded dignity or when they show tolerance. Bier also uses a shaky camera to express the disordered emotions of her characters in search for the desired equilibrium. Even the colours are lacklustre to convey emotional disorder and sadness.

Movie Specs:
In a Better World 2010.
Winner Golden Globe Best Foreign Film (BFF) 2011.
Winner: Oscar for BFF 2011.
Genre: Danish drama
Written by: Oscar-winning screenwriter Anders Thomas Jensen.
Directed by Susanne Bier. Her movie After The Wedding won winner of Oscar BFF 2007.

(This is a translation from a blog published in Arabic.)

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.

Poetry/Art

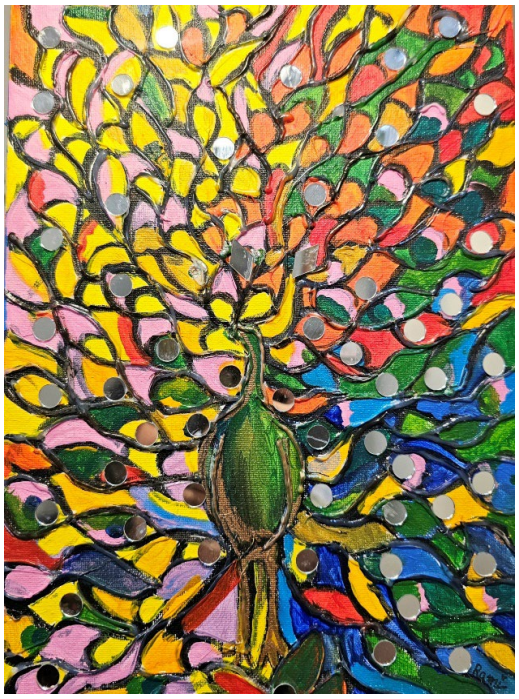
Cascading Dreams: A Canvas of Unwinding Thoughts

Dr Raminderjit Kaur
CT3 Psychiatry, St George's Hospital, Midlands Partnership NHS Foundation Trust

Amid the ripples that dance in my mind's vast sea,
I watch them cascade, wild and free.
Through hues they traverse, a vivid display,
Splashing upon a canvas, a mesmerizing array.

As thoughts unravel, a kaleidoscope of grace,
A tapestry of colours, in intricate embrace.
The unwinding symphony weaves a wondrous tale,
A masterpiece of creation, where dreams set sail.

In this canvas of emotions, where worries find their way.
I find solace and freedom, in art's gentle sway.
For in this world of colours and swirling emotion,
I find my escape, my innermost devotion.
To express, to create, to set my spirit free.
In the art I pour, I discover the real me.



Poems

Dr Jen Dunn
CT1 Psychiatry, NHS Grampian

Limerence

What a word - limerence,
it sits somewhere between
reflected light and
silliness. But I seem

unable to shake the
muttered little moans
of child-like recognition, or
my weed-choked daydream home.

As all the rivers meet the sea
and run their earthy flight
into smothered blues,
so I'll drown in limerent night.

Free Association

Free association is a scam -
I'm all tied up in myself

pulled by taught thought-cords
of life into more constraint.

I need you, Lord, to sympathise
with so much fettered freedom,

in this exchange of hostage-dreams
don't break the ties but heal them.

Transference

I could get lost in you,
but you'd be wise to it-
it's your job to catalogue
the torn pieces of the mind.

You'd know at once, see me slipping
between the layers of myself,
pasting them together with
your mannerisms and careful words

which harden into interests
then crystalise as views.
I want to wrap myself in your
analytic omnipotence

to be held and to buckle-
a diving bell surrendering
to all that piled sea
and dreaming darkness.

Take me in your arms,
let long-limbed curiosity
unfurl in the wake of
action seizing fantasy.

Just tell me where I am,
what you want me to be.
Then I'd change and call it love,
blind to borrowed intimacy.

Starting Psychotherapy Training

Dr Sarah Winfield
CT2 Psychiatry, Mersey Care Specialist Perinatal Team, Warrington

My experience being that of a core trainee,
I feel the weight of my responsibility.
To learn the different therapy modalities;
Whether that be CAT, psychodynamic or CBT.

Psychotherapy presents a new challenge to start.
Us working together and both taking part,
To help you look after your mind and your heart,
And feel less like your world is falling apart.

You're probably feeling as nervous as me;
Coping with hopelessness, fear or anxiety.
Through our sessions, I am excited to see,
How we develop and grow to be the best we can be.

So dear client, I want you to know,
You no longer have to suffer alone.
I'll try my best to learn all that I'm shown
To help you achieve the goals of your own.

This is her (Self Portrait Collection)

Dr S Moon
CT3 Psychiatry, Swansea Bay University Health Board

This is her - The Self Portrait Collection (*the most recent collection of her professional art exhibition)* delves into the relationship between human beings. Dr Moon's interpretation of self-portraiture is that her relationships with those around her define her identity. To express her presence transcending time and materiality, she has arranged metaphors that depict the interaction between herself and those around her without depicting external appearances. The collection also implies that everyone is precious and unique. Each individual is composed of numerous choices and their identities, which are both independent and interactive, are verified through relationships.

Dr Moon is a Canadian Contemporary Artist with 18 years of professional art exhibitions, based in the United Kingdom and currently a CT3 in Psychiatry in Swansea Bay University Health Board, South Wales. In summer 2023, she successfully completed 3

Self Portrait 230 - Mixed Media, 61cm x 61cm

Self Portrait 231 - Mixed Media, 61cm x 61cm

Self Portrait 232 - Mixed Media, 61cm x 61cm

Self Portrait 233 - Mixed Media, 61cm x 61cm

Self Portrait 234 - Mixed Media, 61cm x 61cm

Self Portrait 235 - Mixed Media, 61cm x 61cm

art exhibitions in London and 1 in Milan, won the Audience Choice Award 2023 *(awarded by Swanfall Art*) from the most recent art exhibition at Mall Galleries which is on The Mall, Buckingham Palace, London.

Earlier in her life, she specialised in environmental design and completed a degree in Art & Design in Canada. Since completing her professional degree, she worked as an abstract fine artist and a designer. She has further expanded her education in medicine, practising as a doctor in Mental Health in the UK.

As part of her artwork, she is highly dedicated to increasing public awareness of mental illness and fighting against the stigma associated with mental illness that has spread throughout society.

This extraordinary background in Art & Medicine and her interests have been well harmonised, delivering public awareness through her artworks with altruism and empathy for mentally ill people in society.

Professional Art Exhibitions Worldwide:

2023:

- "Audience Choice Award" 2023 *Swanfall Gallery, Mall Galleries, London, United Kingdom*
- The Holy Art, Art on Loop Showcase, Milan, Italy: *1-3rd September 2023*
- Mall Galleries, <Through the Looking Glass> London, United Kingdom: *28th August-2nd September 2023*
- The Brick Lane Gallery, <Self Portraits Collection> London, United Kingdom: *15-28th August 2023*
- Boomer Gallery, <The New Renaissance> London, United Kingdom: *7-12th July 2023*
- Migi Art Gallery, <Self Portraits Collection> Seoul, South Korea: *4-26th November 2023*

Past:

- Harvard University, Graduate School of Education Monroe C. Gutman Library, Harvard University - Cambridge, U.S. *2013*
- Massachusetts General Hospital, Residency Artist Exhibition at Cancer Center Boston, U.S. *2013*
- Cedar Ridge Gallery Toronto, Canada *2012*
- Artscape Triangle Gallery, <Life, Dessert, Voice> Toronto, Canada, *2011*
- Art Square- Toronto, Canada, *2011*
- Artcure Exhibition Juried Show - Aurora, Canada *2011*
- Toronto Art Expo Toronto Metro Convention Centre Toronto, Canada *2010*
- OCAD University Graduation Show Sharp Centre for Design - *Toronto, Canada 2006*

The CASC

Dr Shauna Monaghan
CT3 in Northern Ireland

Study, practice, mock
Journey by plane, train, then tram
Membership's in reach

…through mind

Dr Veronica Ramadan-Mitrache
CT3 Psychiatry, Leicestershire Partnership NHS Trust

….tomorrow's white rainbow
Wiped away the trail of scattered rain
In the deepness that yesterday flooded their mind!

…tomorrow they believed in the silence
That merged on the guitar's strings…and…
Sings dreams and shadows.

…tomorrow they were looking at the unconscious
Through an opaque thought …from their heart
…it hurts!
And yet they tried to reach the illuminated conscious!
…through LOVE!

Events, notices & dates for your diary

Forensic Psychotherapy for Psychiatrists

Dr Katy Mason
Consultant in Forensic Psychiatry and Medical Psychotherapy, Lancashire and South Cumbria NHS Foundation Trust

We would like to invite you to a series of events designed by psychiatrists with dual expertise in Forensic Psychiatry + Psychotherapy. These events will be free, and held in person at the Royal College of Psychiatrists (21 Prescot Street, London, E1 8BB). We have already had our first event which was well received and have a further three days available:

- **Day 2: Friday, February 16th, 2024 (the body)**
  Eventbrite booking link: https://forensicpsychotherapythebody.eventbrite.co.uk
- **Day 3: Wednesday, May 22nd, 2024 (the organisation)**
  Eventbrite booking link:
  https://forensicpsychotherapytheorganisation.eventbrite.co.uk
- **Day 4: Monday, September 16th, 2024 (the mind)**
  Eventbrite booking link: https://forensicpsychotherapythemind.eventbrite.co.uk

The aim of the series is to equip psychiatrists to integrate forensic and psychotherapeutic models of mental illness when working with patients with complex needs and high risks, advocating for biopsychosocial approaches and person-centred care. This course will incorporate psychiatric and psychological models of understanding the mind, mental disorders and forensic systems. It will also develop the skill of participants in meaningfully conceptualising risk and is aimed at doctors of all grades who want to develop in this area.

Booking for these three events is now available. Each event is designed to stand alone and be part of a series, so you do not need to attend the whole series, but there would be benefits in doing so. The cost is **free** as we are piloting the course, but there are a maximum of 50 places available and you will **need to book** via Eventbrite.

Programme for each day:
09:30 - Gather
10:00 -12:00 - Speaker and Q+A
12:00-13:00 – Lunch break (lunch not provided)
13:-00-15:00 - Speaker + Q+A
15:30 – 16:30 – Reflective group

If you require additional information, please contact katy.mason@nhs.net

Editor's note: Other college conferences and events can be viewed at Conferences and training events | Royal College of Psychiatrists (rcpsych.ac.uk)

Bristol Balint Study Day 2023

Dr Judy Malone
Psychoanalytic psychotherapist and Lead organiser for Bristol Balint study day

The study day will be of interest to clinicians and trainees from a range of disciplines and backgrounds and working in a variety of settings. The study day welcomes all who are interested in Balint, in leading Balint groups and/or supervising Balint leaders.

Date: 1st December 2023

Study day: 09:30 – 16:15

Venue: Engineers House
The Promenade
Clifton Down
Bristol BS8 3NB

Cost (inc. lunch): £100 member
£130 non member
£35 undergraduate student member
£60 undergraduate student non member

We will bring themes of inclusion and diversity into our introductory talk and the study day, thinking about how the Balint society has changed with a wider range of clinicians and professionals now involved. The day will also focus on the usefulness of Balint as a form of reflective practice, the ongoing work of Balint, how we work as Balint leaders, with whom we are working, what they are bringing to the groups and how we think about all of this.

The introductory talk will be followed by participation in Balint groups with time and space for discussion. There will be groups suitable for everyone depending on their experience of Balint. Groups will include a classic/regular group, leadership group, supervision group and a specific group for doctors in training.

The Balint Society AGM 2023 will take place at the end of the study day.

Please book your place through the Balint society website at balint.co.uk events

Rethinking Non-Recent Childhood Sexual Abuse

Dr Maria Eyres and Dr Jo Stubley

Illustration by Jenissa Paharia

When we first highlighted the need for a College Position Statement on Non-Recent Childhood Sexual Abuse (NRCSA) to the Policy and Public Affairs Committee in 2018, we would have never predicted how protracted this process would become, which inevitably reflects the complexities in this field. Work on the document started in 2020, with Jo and I as co-chairs. The group is made up of experts by experience, researchers and College staff, and we are hopeful that we will complete our work by the end of the year. The document will then be sent to all faculties of the College, various other organizations, and key individuals in the area for comments. We will then review the comments and finalise the document.

In the meantime, Jo and I have been active in the Non-Recent Childhood Sexual Abuse Network established in 2021, with Jo being one of its two co-founders. We are an independent collective of survivors, clinicians and academics who contribute our time, energy and thinking to promote change in this area by improving understanding of the impact of childhood sexual abuse on adults and alleviating the suffering of survivors. We aim to achieve this through education and raising awareness of this important issue in both the public and private domain. Please see the link to our online presence which is full of useful resources - *Network for NRCSA*. We hosted our first conference in May 2022 and are in the process of preparing a book on the subject to be published in 2024.

We also wanted to reach a wider audience to convey our message about the truth of NRCSA in a simple and accessible way, and settled on producing a zine. Zines are informal, non-commercial publications of original texts and images, often online, which can be freely and easily distributed by photocopying. We felt that using different mediums, including quotes from survivors and text from practitioners, enriched by research and combined with poetry and visual art, would bring additional dimensions to a complex and often misunderstood subject, making it more approachable and relatable.

In summer 2023, one of our group members secured a small grant from the University of Bristol to produce a zine. We spent a Saturday with visual artist Jenissa Paharia, whom we commissioned to design our publication entitled 'Breaking Silences: Survivors, researchers and practitioners speak about Child Sexual Abuse'. Jenissa listened to and contributed to the process of creating the text of the zine and produced illustrations

inspired by the content of the day. One of our colleagues contributed a drawing which became the first page of the zine, while another donated a poem. Bristol university design team helped with the overall layout, and we are now proud to release our zine to the wider world. The illustration in this article comes from our zine.

We hope you will find our zine useful, and even inspiring, and we want to encourage you to distribute it as widely as possible. We would like to see it in GP surgeries, in clinics and on hospital wards, being used by blue light services and in any other setting you think it might be useful.

Please find the link to the zine below, it is in a booklet form which makes it easy to print. Breaking Silences: Survivors, researchers and practitioners speak about Child Sexual Abuse

Medical Psychotherapy Faculty medical student essay prize

Academic secretaries

Essays of up to 5,000 words are invited on the topic of: ***How might power and conflict have a place in Psychotherapy?*** You can use clinical examples to illustrate your points.

Further information is available via the link below and the Academic Secretaries ask that you please circulate to your local medical students.

Medical psychotherapy faculty prizes | Royal College of Psychiatrists (rcpsych.ac.uk)

Maudsley Learning Podcast

Anya Borissova (she/her)
Academic Clinical Fellow, CT3 Psychiatry, South London and Maudsley NHS Trust / King's College London. Co-host Maudsley Learning Podcast - https://lnk.bio/tOJq

A team of psychiatric trainees in South London runs the Maudsley Learning Podcast. Episodes focus on psychotherapeutic concepts and technique. Recent episodes include:

All platforms: A Psychotherapeutic Defence of Free Speech - The Thinking Mind Podcast | Podfollow

E64: Jo Brand on Comedy, Dating, Relationships, Political Correctness & Mental Health - The Thinking Mind Podcast | Podfollow

Your Brain is a Prediction Machine - The Thinking Mind Podcast | Podfollow

(Also available on Spotify)

Psychiatric Placements for SAP psychotherapy trainees

Leigh Money, SAP

Observing psychiatrists and other mental health professionals working in inpatient settings is an invaluable experience for psychotherapy trainees. We are looking for psychiatrists who can offer a work shadowing placement to psychotherapists in training at the Society of Analytical Psychology. In return, trainees may be able to co-facilitate groups, take notes, or get involved in other ways. Placements should be a minimum of 6 months, up to one day a week.

If this sounds like something you may be able to help with, please contact Leigh Money at email: leighmoney@gmail.com

Faculty Group

Faculty group: The group for consultants and higher trainees in Medical psychotherapy continues to meet on the fourth Thursday of the month at 5.30-7pm. If you would like to join, please contact Mark Morris on mpfacultylargegroup@gmail.com.

BPA Outreach events

Catherine McKisack DClinPsych
Psychoanalyst

Start: 10th January 2024 8 pm – 9.30pm
End: 3rd July 2024 (two terms)
Online, via Zoom
Cost: £35 - £550 | individual lectures, a set of 5 or terms can be signed up to (student and NHS trainee discounts available)

This series of lectures introduces fundamental psychoanalytic ideas and explores a range of topics in greater depth. Delivered by BPA Psychoanalysts, presentations are followed by a group discussion.

The series is organised so as to build up a systematic knowledge of the field over two academic terms or self-contained lectures that can be attended individually. Whether you already have some understanding of psychoanalysis or are simply curious,

we hope that these lectures convey a sense of contemporary psychoanalytic thinking as well as what it is like to practice as an Analyst in 2023.

Click here to register: The Introductory Lectures Series – BPA (psychoanalysis-bpa.org)

Start: 8th January 2024 8 – 9.30pm
End: 8th July 2024 (two terms)
Who is it for: This course is for those who have some knowledge of psychoanalytic ideas and would like to deepen their understanding; relevant clinical experience is helpful.
Online and In-Person (NW5 3NT)
Cost: £450 - £550 (Student and NHS Trainee discounts available)

The Pre-Foundation Course is made up of a series of analyst-led discussion groups run over two terms on a Monday evening with applicants joining either an online course or in-person.

Discussion groups offer the opportunity to consider how psychoanalytic theory can be applied to our everyday lives and experiences. Participants will take it in turns to bring an example of their own to the group for discussion; this may be a particular work situation, a clinical vignette or an encounter from everyday life and, together, we will consider this material in the light of psychoanalytic ideas.

Click here for further information and to book.

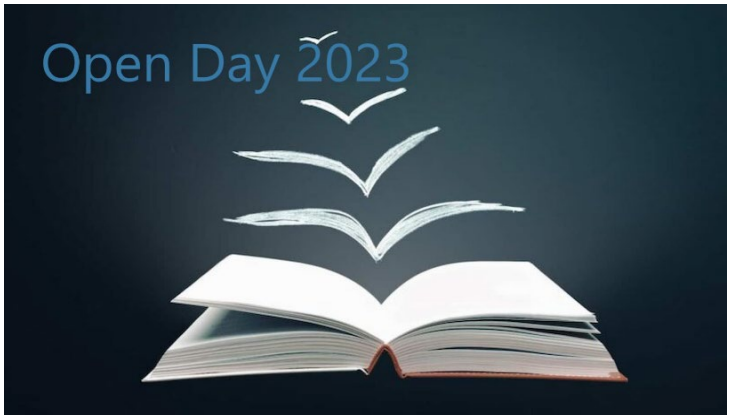
Start: Sept 2024
End: July 2025
Who is it for: This course is for those who are interested in training to be a psychoanalyst and are working towards being ready to apply

Cost: £650 for the full course. £585 for NHS workers, students or unemployed (confirmation of status will be requested).

This course is aimed at applicants who are interested in training to become a psychoanalyst but do not yet have all the requirements for entry to a full training. It is clinically focussed and will provide an opportunity to explore what it means to train and work as a psychoanalyst in the present day.

We welcome applications from all sectors of the community and positively encourage those who are hesitating to take this next step in their career.

Click here for further information and to book.

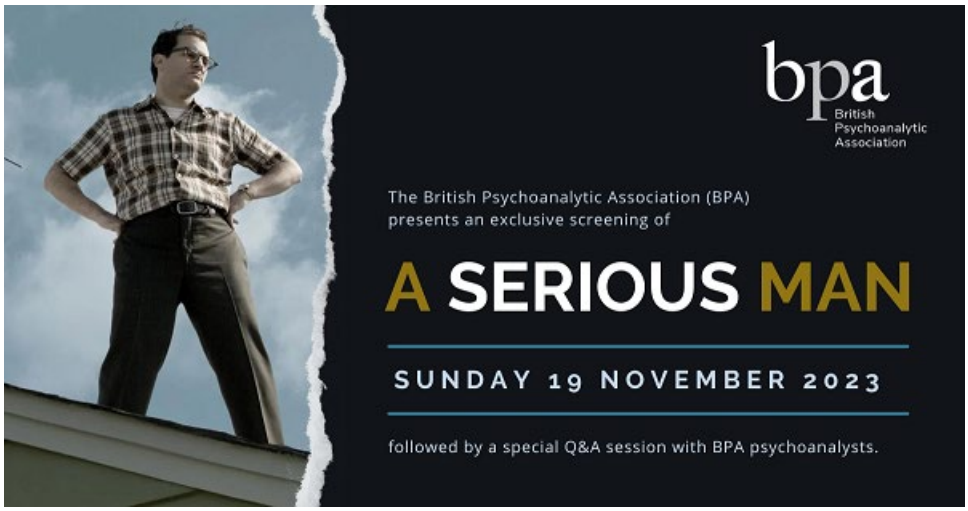


Time: 11th November 10.30am – 1pm
Cost: FREE
Online via Zoom

Come and meet the BPA and hear about our organisation, our training, our pre-training courses and our post-training opportunities.

You will learn about the application process, hear from candidates about their experience of the training and from analysts about life working as a psychoanalyst.

Click here to reserve a place.



Time: 19th November 2023 9.30am – 12.50pm
Location: Everyman Theatre NW3 6TX
Cost: £30 (student discount available)The **British Psychoanalytic Association** (BPA) presents an exclusive screening of:
A Serious Man
Directed by the Coen Brothers
At the Hampstead Everyman Cinema, 5 Holly Bush Vale, NW3 6TX

(Tube: Hampstead Northern Line)

Sunday 19th November 2023 9.30 am (for coffee, tea and delicious pastries) for 10.am start, finish approx. 12.50pm

The screening will be followed by a special Question & Answer session with David Morgan (psychoanalyst), Noel Hess (psychoanalyst), Mayessi Svoronou (candidate psychoanalyst) and Joan Thompson as Chair (psychoanalyst).

Book your ticket here: Film Screening - A Serious Man Tickets, Sun 19 Nov 2023 at 09:30 | Eventbrite

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 spring/ summer edition. The deadline for submissions is **31st January 2024.**

All contributions can be sent to me at pamela.peters@cpft.nhs.uk.