RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

Newsletter

FACULTY OF MEDICAL PSYCHOTHERAPY

Spring Summer 2023

In this edition

Contents

Editor's Welcome

Pamela Peters
Consultant Psychiatrist in Medical Psychotherapy
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I am delighted that it is spring! After a lingering end-of-winter, the sun is finally making a more sustained appearance, warming the ground and our spirits. It is a time of renewal, of greater energy and of appreciating the beauty of the world around us. A beauty that feels more fragile and under threat, but one that also calls out to us to nurture and protect it.

Like everyone else, I am very much looking forward to the Faculty conference; to having the opportunity to meet like-minded people, to be nurtured by learning and reflecting together, and also just to spend time with each other.

Climate change and other current crises in the world are themes that appropriately dominate in this edition, along with staff wellbeing and development. I have included an overview of the Faculty exec working groups, to make people aware of the huge amount of work being undertaken by colleagues.

Matteo Pizzo's reflections on the passing of time and the inevitability of death made me think about how hard it is to "sit with" or bear the tragedy of wasted years or to see, for example, the devastation we have visited on our planet and the impact of social injustice. These things cannot be undone. It is only through mourning that we can start to integrate new ways of doing things to hopefully halt the decline and start to make improvements where possible. Marion Neffgen's article on the climate crisis provides food for thought and is very much a call to action in the run-up to our conference. And look out for a dialogue about Open Dialogue in our book review section by Brian Martindale and Richard Duggins.

Thank you so much to all those who have contributed articles, reflections, news and art… please keep it coming!

Message from the Faculty Chair

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

Welcome to the Spring 2023 Medical Psychotherapy Faculty newsletter. I am delighted to start by mentioning 3 upcoming events organised by members of the executive committee. We are hosting our first annual faculty conference in person since 2019 this Spring, from 17-19 April 2023 at the RCPsych in London. This conference is broad in scope and directly faces some of the challenges we are facing globally…. from climate change, the covid pandemic, the experience of refugees, conflict and poverty, as well as our own experiences as doctors and psychiatrists working with the impact of these realities. The program includes experts in working with the response to trauma and disaster and is aimed at all psychiatrists interested in considering these challenges together. Many thanks to Sophie Atwood, Vikram Luthra, Anne Cooper, Parveen Bains, Sarah Markham and Josephine Fielding for putting together such a relevant and stimulating program. We hope to see many of you there and to enjoy reconnecting with colleagues and trainees.

We have two further events to publicise: the Trainees' conference in Birmingham on 26th May on the theme of Psychotherapy at Play, which promises to be a very enjoyable and creative event for both trainees and consultants. To commemorate the life and interests of our previous faculty chair, the Steve Pearce study day on 30th June 2023 addresses the issue of "Responsibility Without Blame" and links Steve's combined passions for psychotherapy and philosophy with a program appropriately prioritising group discussions alongside the presentations.

What these events have in common is that they are being held in person and provide a real opportunity to renew and to develop our working relationships and the creativity inherent in this, as the restrictions we have faced in recent years and their wider impact continue to recede. The Medical Psychotherapy Executive Committee has resumed holding our meetings in person, and we focussed upon how to maximise our creativity and productivity as a group in our strategy day in January 2023.

Most of our work as committee members occurs in our working groups and this edition of the newsletter focusses upon the working groups – I think you will agree the breadth and scope of these groups is really impressive. Our links with the other faculties and the wider college is also a key priority for service improvement and in supporting our colleagues and I am very pleased to let you know that our campaign to work with the college to address what we see as a drift away from psychological thinking within psychiatry has been accepted as a key priority to take forwards by the RCPsych policy team, which we will continue to actively support. I am very grateful to my colleagues on the Executive Committee for their energy and commitment to the work they do.

Many thanks as well to Pamela for her work in putting together such an interesting newsletter, and to all the contributors. Wishing you all an enjoyable spring.

Message from the Academic Secretaries

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




As Academic Secretaries we are looking forward to welcoming you to the first in person Medical Psychotherapy Faculty Conference for 4 years on 17th-19th April at the RCPsych.
We feel it is really important to all be able to get together again, to share our experiences and to learn together again.

We wanted the conference to reflect many of the issues that are likely to be contributing to our context, wherever we work, to be in touch with our common experience, but also to explore and be curious about our differences.

We begin the conference with Dr Bob Hinshelwood, Psychoanalyst and Medical Psychotherapist, speaking on the topic of 'Supporting patients, supporting doctors; an ongoing crisis'. This theme is then illustrated by Dr Waheed Arian's talk. Dr Arian has written about and presented in forums across the world (including recently on Desert Island Discs) detailing his experience growing up in Afghanistan, fleeing as a refugee to Pakistan as a child, and then on to the UK as an adolescent. Training in medicine, and working today in the NHS, whilst also contributing to healthcare in Afghanistan, by making links across the nations he has called home. These speakers launch us into the themes of our conference.

Tuesday starts with Gaia Vince, who brings together perspectives across multiple academic disciplines - including geography, anthropology, sociology and politics, to give us a wider lens on the climate crisis, migration, and the reality of the times we live in for our species, followed by Dr Anne Patterson speaking on 'Crisis: What Crisis? Turning a blind eye', to consider our response to this.

We follow this with some time to consider and practice mindfulness, before focusing on the experience of doctors in the aftermath of the Covid pandemic. We close the second day with a choice of two workshops drawing on creative processes to sustain and enliven us - music, film, poetry and nature – to allow us to engage together using these different media. There is then the opportunity to join us at the Conference Dinner in the evening.

Wednesday begins with Professor Lucy Easthope speaking about her role in the immediacy of a crisis. As the country's leading authority on recovery from disaster, her work came to the fore in the response to the Covid

pandemic. She considers disaster planning, and what comes next after tragic events. We follow this by considering where Medical Psychotherapy fits into this trajectory, with talks from clinicians using a CBT and a psychodynamic perspective on the months and years that follow.

We circle back to the wider viewpoint that Gaia Vince introduced on the Tuesday: the climate and ecological context, with a talk from our Faculty Sustainability champion, Dr Dasal Abayaratne, before our Experiential Group brings us into the final afternoon. We close the conference hearing from our wider Faculty, with research and topics presented in the conference posters, and feedback on projects that have been awarded small grants by the Faculty.

We are very much looking forward to seeing you on 17th-19th April and sharing our learning together.

We are pleased to invite you to the **Medical Psychotherapy Faculty Conference 2023: Can the current global crisis bring us all together?**, taking place from Monday 17 to Wednesday 19 April.

This conference will take place **in-person** at the Royal College of Psychiatrists, 21 Prescot Street, London, E1 8BB.

We look forward to welcoming delegates to the first in-person Faculty of Medical Psychotherapy conference for 4 years. We have a fantastic, truly inclusive programme of talks and workshops for you over these 3 days, which we hope will appeal to all who place medical psychotherapy at the heart of psychiatry.

Register now: Medical Psychotherapy Faculty Conference 2023 (rcpsych-mail.com)

Feature Articles

Reflection from primary care

Dr Matteo Pizzo
Consultant Psychiatrist in Medical Psychotherapy
Islington Core Mental Health Team (N2)
Islington Integration Lead

When I was a Core Psychiatry trainee, I attended the Institute of Psychoanalysis Introductory Lectures. One of the seminar convenors shared with us the idea of three psychoanalytic truths, which have helped me along the way to orientate (and re-orientate) myself to aspects of reality. They are:

1) 'the baby doesn't blow milk into the mother's breast', aka we're all dependent, even though we might wish we weren't
2) 'our parents had a relationship that didn't include us', aka we're sometimes excluded
3) and finally: 'we all die', aka we all die

It is this last one I want to share some further thoughts about, based on my experience of my work in a community mental health team, co-located at GP practices.

Before we get to death, there's life. However, life only moves in one direction, towards death. Whereas in our unconscious (as manifest in dreams) we can move back and forth in time, or even find ourselves temporally in two different places at the same time, the same is not possible in our conscious lives.

I think this is a huge concept to accept. Once I see how difficult it is to accept, I notice a myriad of ways in which we try to cover up the fact that time only moves forward, that no passing minute can be recovered. If it were really so, then we are forced to face a whole host of (sometimes unpleasant or despairing) realities: I cannot undo what was done to me, and what I did to others; I cannot go back and swap my mother for another; I cannot rub out who I was and cancel myself/my experiences from the fabric of time.

I hypothesise that so much of our activity in medicine, general practice, psychiatry and psychotherapy is complicit in the fantasy that time can go back. *If* I prescribe this pill, the illness is undone. *If* the patient is given the 'right' therapy, the trauma will be cancelled out. *If* I chop off this part of the body, it's as though it never existed. If it doesn't work, then it's because it wasn't the right pill, the right therapy, the right surgery. I believe we have structured much of our healthcare system on the basis of this fantasy, with the implicit denial of the passing of time.

What if we were to take the passing of time seriously? Then we might have to face the very big task of acceptance and mourning. One would have to say 'yes, this is the mother I had'; 'yes, I was abused'; 'yes, the pill I took for twenty years made me numb'.

Acceptance and mourning are relational processes. If we understood most of what happens in medicine, psychotherapy etc. as involving acceptance and mourning (because time cannot be turned back!) then we'd set up systems that are primarily relational: holding - with good boundaries, containing, geared towards 'bearing with'. But if these processes happen well, it's usually in spite of, rather than because of, the way the systems we work in are structured. I propose this is because we have difficulty in accepting that time moves forward, and only forward.

This doesn't mean to say that we wouldn't try to find ways in which pain and suffering can be alleviated, to some extent. Indeed, acceptance, and the work of mourning in and of themselves, can bring relief. Relief can also come about by responses to suffering that could be interpreted as more 'active' or 'technical', such as this 'evidence-based' technique in psychotherapy, or prescribing that 'evidence-based' pill. However, might we not approach our more active, 'specialist' or technical 'interventions' a bit more lightly if we accepted that they cannot and never will reverse time?

What conversations might we have with patients then? For example, asking 'what happened to you?' could lead to being in touch with a story, staying with it, feeling the pain of it. Accepting that the past cannot be undone, what space is there for witnessing, and bearing with? Then the proposal of 'you may be helped by this' might have a different flavour. Less of 'this is the cure/fix' and more 'this might help a bit (perhaps even a lot) …. but it cannot undo what happened….I'm sorry'.

I think the difficulty in accepting that time cannot be reversed happens because if we were to accept it, we'd also have to accept the inevitability of death. Death happens to us all. In my circles of work (general practice, community psychiatry) it's hardly ever talked about. In avoiding it, we miss out on a re-orientation to life. For example, if I were to accept that I will die, what do I then do with my being alive now? Might it be there's an opportunity to let go a little of this battle against the passing of time (the efforts to reverse it, to cancel out the past, to 'fix' it) and instead bring into focus the experience of life as it exists, demarcated by death? What could potentially be borne, together?

I wonder if this acceptance might help us do what we do a bit more gently.

A medical psychotherapist's response to the crises of our times:
An invitation to reflect around the faculty conference

Dr Marion Neffgen
Consultant Psychiatrist in Medical Psychotherapy, London

What times are these, in which
A conversation about trees is almost a crime
For in doing so we maintain our silence about so much wrongdoing!

(from 'To Those Who Follow in Our Wake' by German poet Bertolt Brecht, translated by Scott Horton. Written between 1933 and 1938 in Danish exile)

"Truly, I live in dark times", is how this poem starts, and it couldn't be more relevant for our times. (Brecht, of course, was referring to Nazi crimes and those in his own profession who remained silent about them). Our times are just as dark. With never-ending news about environmental and social disasters, extreme weather events, wars, corporate and political corruption, and terrible human violations and suffering at home and across the globe, it is hard to find anything positive to hold on to. The climate and ecological emergency also lends an urgency to these crises that can feel quite overwhelming.

I am writing this because I believe there is something we can and have to contribute as psychotherapists. We work with and believe in the power of facing our feelings, challenging our defences, and speaking truth. We must strive to see and to speak. Our Annual Conference in April is positioning the climate crisis as one of the central themes. This article is an invitation to start thinking about the associated difficult topics so that we may pick up the thread at the conference.

Once you know

"Once you know", a beautiful documentary about one young film maker waking up to the reality of the climate emergency, and his quest to find a way of living with it, describes how you will never quite be the same *once you know*, and how you can't go back to blissful ignorance. So, before we think about what we can contribute, I believe we must face the truth, we have to know. Here is a fraction of the truth.

The 2018 IPCC report made clear that we have very few years left to turn things around if we want to avoid climate catastrophe. More reports of extreme weather events, in the UK and across the world, demonstrates that the climate crisis is happening now, not in the future, and in many countries across the global south it has long been a devastating reality. Keeping global heating below 1.5 degrees has all but become wishful thinking. Instead, in the words of UN Secretary General Antonio Guterres, "we are on a highway to climate hell with our foot still on the accelerator" and may have already passed 5 climate tipping points of irreversible damage.

Interconnected with the heating climate and the destruction of our life support systems is a global social justice crisis. Just over half the cumulative global CO_2 emissions stem from the last 30 years, mainly driven by the rich world's overconsumption and addiction to high carbon transport. The richest 1% of the global population is responsible for more than twice the carbon emissions of the poorest 50% over a similar period. The impact of the climate crisis is also unequally distributed, affecting poorer, more vulnerable communities most, both globally and locally, including children, communities of colour, and individuals with chronic mental and physical health conditions.

It is also becoming increasingly clear that our exploitative, extractive, globalised economic system fuels the climate and ecological crises as well as social inequality, and perpetuates racist and neo-colonial domination in the global south. We may not want to, but the reality is that we in the wealthy global north are benefitting from this system. To defend against the guilt and shame this triggers, we switch off the bad news and turn a blind eye. We all do. When we buy a new phone, strawberries in winter, a garment from Bangladesh, or jump on a plane.

Psychoanalyst Sally Weintrobe writes about three forms of climate change denial: "'Denialism' (…campaigns of misinformation…funded by commercial and ideological interest)". 'Disavowal' (turning a blind eye whilst minimizing its significance). And 'Negation' (the denial of reality to protect oneself from the pain of loss and anxiety). Weintrobe embeds these processes in a "culture of disavowal" - disavowal of our own destructiveness and disavowal of our feelings of guilt and shame about our destructiveness; as well as a "culture of uncare" and "neoliberal exceptionalism" describing a ruthlessly extractive mindset that is driving the environmental collapse.

But we need to look; we can't be bystanders in this emergency. "Climate change is the greatest public health threat of the 21st century" warn doctors, public health professionals and scientists. According to a 2022 WHO policy brief, the climate crisis carries serious risks to mental health and well-being, and countries are urged to include mental health support in their response to the climate crisis.

The mental health and psychological threats of the climate emergency include PTSD, depression and addictions as a result of environmental disasters; climate distress due to witnessing the worsening destruction of our planetary support systems; as well as feelings of betrayal and experiences of moral injury due to government inaction, particularly significant in children and young people. Additional threats are related to the social consequences of climate breakdown like food insecurity, desertification, deforestation, and sea level rises, which are likely to increase conflict, displacement and create more climate refugees.

The UK government has attempted to silence and criminalise environmental protests with laws that have led human rights organisations to warn of authoritarian shifts and threats to civil liberty. These laws do nothing to mitigate racialised police practices and the criminalisation of refugees and minorities. A judge has forbidden protesters to mention 'climate' in their defence in court, and defamatory language has been used against protesters, stoking division, and twisting the narrative in order to distract from contentious policies.

The government is also handing out over 100 new fossil fuel licenses, subsidising fossil fuel extraction with billions of pounds; energy companies are raking in billions of pounds in profit whilst paying little or no tax; politicians are found lying again and again, whilst environmental laws are being watered down; health and education systems are stretched to their maximum; and large parts of the population thrown into poverty and hunger, further increasing health and wealth inequalities and societal division. The list could go on and on, and it all sounds quite depressing and hopeless. I am probably not the only one asking myself what I can possibly do in the face of such obstruction, misuse of power and overwhelming environmental danger. But I think there is some hope.

More and more people are refusing to continue to turn a blind eye. Ordinary citizens in their thousands have realized that asking politely with petitions or peaceful marches has not made any difference to business as usual. They are taking to the streets with acts of civil disobedience and non-violent direct action - doctors and other health professionals, scientists, teachers, grandparents, families, artists, trade unionists, amongst many others, are demanding urgent action on climate change and social justice.

Fiona Godlee, the former editor-in-chief of the BMJ, and supporter of Doctors for Extinction Rebellion, urged "us all to act as individuals in our different spheres of influence, … to hold those in authority to account", and to lead by example. She emphasizes that there is a particular responsibility for health professionals "to promote and protect health, given our trusted and privileged position in society".

I believe as health professionals we are uniquely placed to raise our voices to call out injustice and inaction and educate about the dangers of the heating climate. We are awarded epistemic trust by a large part of the population, like probably no other profession. Medical activism has made use of this trust in the past, the campaign against nuclear war by the IPPNW and allied groups during the 1980's being one example. Their campaign highlighted the deadly dangers of nuclear war and played a vital role in countering misinformation and misleading government messaging.

There are psychotherapists and psychoanalysts who have spoken out in the past. Psychoanalyst Hannah Segal is well known for raising the alarm over the threat of nuclear catastrophe, where she contributed to the understanding of the unconscious destructive impulses and projections, driven by paranoid-schizoid anxieties on both sides of the nuclear arms race. But she also made a plea for the psychoanalytic community to "contribute something to the overcoming of apathy and self-deception in ourselves and others". In her 1985 paper named "Silence in the real crime" (words borrowed from N. Mandelstam, *Hope against hope*, 1971), she warned that the silence (of the psychoanalytic community outside of Germany during the Nazi era) must not be repeated. She wrote, in words that ring true in this moment:

"We are at a crossroads. We must try to find means to mobilize our life forces against the destructive powers. To do that we must confront those powers and dangers without denial, hoping that the realization of what we are about to do to ourselves will mobilize our life forces and our reality sense. What role can we, as analysts, play in this tragic drama? I think first we must look into ourselves and beware of turning a blind eye to reality." And she urged that "we psychoanalysts who believe in the power of words and the therapeutic effect of verbalizing truth must not be silent".

So, what can we do as medical psychotherapists?

In her reflection on the early response to Covid-19, Jo Stubley wrote about the powerful defences that can operate to protect us against the "life and death" anxieties provoked by the threat of the virus and that "as a society, we need to understand what impact the threat has on us and the ways in which these powerful defences can be used to manage these anxieties but often at the cost of a more nuanced and compassionate way of seeing each other and the world around us". She reminded us that it is much more difficult to hold a "compassionate and thoughtful position" when we feel under threat, and when our brains react to a perceived traumatic situation with a threat response.

The climate crisis represents a trauma foretold. Would we have prepared ourselves, our services, and our organisations, and perhaps even our patients for the pandemic, had we known it was coming? I would hope so.

As psychotherapists we have experience in helping others contain and digest overwhelming feelings and experiences, in order to move from defensive reacting to more flexible thinking and acting. We are also uniquely placed to contribute to the understanding of the unconscious forces at play in these multiple crises, to prepare for the trauma that's unfolding at a massive scale and to enable the mourning of losses already incurred and those to come. Our skills in having difficult conversations, finding a way of challenging defences and making space for different perspectives will be helpful for this. And we need to nurture these psychological skills and resources together as a community, to support each other and to contain this work.

I also personally believe that, as we are heading into difficult times, we have a duty to break the silence about wrongdoing at political and corporate level, and call out power grabs, authoritarian developments, and defamatory and divisive language that is detrimental to the fabric of our society.

Maybe the questions we need to ask ourselves are something like:
How can we have those difficult conversations with each other?
How can we speak to our patients, our colleagues, our institutions, our families, our children?
How can we support each other?
How can we hold power to account and speak truth to power?
How can we take action outside of our consulting rooms?
How can we act without going into a fight/ flight reaction but hold on to our reflective capacity which may support a more cooperative and compassionate approach, as well as offer challenge where this is vital?

This is an invitation to start to have some of these conversations at the Annual Faculty Conference and find a way of continuing them and the work of breaking the silence beyond the conference.

> *The woods are lovely, dark and deep, but*
> *I have promises to keep,*
> *and miles to go before I sleep, and*
> *miles to go before I sleep.*

(From the poem 'Stopping by Woods on a Snowy Evening'. Written by Robert Frost in 1922)

P.S. For those who would like more information, here are links to some organisations:
Ethical banking: https://bank.green/
planetaryhealthhub.co.uk for more info
XR Psychologists: https://xrpsychologists.co.uk/
Psych Declares: a member of *Health Declares Climate and Ecological Emergency* https://healthdeclares.org/psych-declares/
Climate Psychology Alliance https://www.climatepsychologyalliance.org/
MEDACT - Health workers for health justice: https://www.medact.org/
Doctors for Extinction Rebellion (XR) (name recently changed to Health for XR): https://www.doctorsforxr.com/

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Update on regional staff wellbeing hub

Dr Richard Duggins
Consultant Psychiatrist in Medical Psychotherapy, Newcastle upon Tyne

I thought it may be of interest for me to share some of my experiences working as Clinical Lead of our Regional Staff Wellbeing Hub over the last year. 40 Regional Staff Wellbeing (or Mental Health and Wellbeing) Hubs were launched in England in 2021 to support health and social care staff as a response to the pandemic.

Our North East and North Cumbria Regional Staff Wellbeing Hub has so far supported 7,829 members of staff. Our popularity is growing, with self-referrals increasingly rapidly month on month. Despite the pandemic quieting, we are doing the opposite, with exhausted and disillusioned staff pouring into our service. Staff come with challenges related to work and home, and the two most common reasons for staff seeking support are emotional distress (including burnout, anxiety, and low mood) and relationship issues (at work or home). As time goes on, we are not only seeing more staff, but also more distressed and suicidal staff.

We offer a relational approach, with staff getting rapid access to a conversation with an experienced clinician within a day or so of contacting us. There are no hoops to jump through, no wrong doors. These initial conversations focus on what matters to the staff member calling and feedback on them has been outstanding. This relational approach has also allowed us to attract some wonderful staff to come to work with us, rather bucking the trend in recruitment to the NHS.

The Hubs have three roles - support, signposting and therapy. There is a lot out there for staff and it can be overwhelming - our signposting role is to know what is available so we can easily point staff in the right direction. We follow everyone up to make sure they have managed to access what they need. Our therapy provision is not to replace other services, but to fill gaps. If a staff member feels they cannot access a local service because of confidentiality or shame we will step in, and we will also act if the wait for therapy in mainstream services is too long. We have managed to recruit a dream team of CBT, IPT, psychodynamic, EMDR, DBT, Systemic and CAT therapists, so we can offer a good choice. We offer CBT groups for insomnia and long-covid and we are expanding our group provision because the feedback and outcomes are great.

One of the other things we offer in the Hub is for staff to directly book into what we call wellbeing offers. These include yoga, mindfulness, dance, art, poetry, walk and sports. These have been incredibly popular. Our research shows the staff accessing these offers are also burned out and exhausted. It is our impression that these offers are a way of supporting staff who would rather "do" than come through to talk.

I am loving the work in the Hub. I clinically oversee the MDT and I tend to see the people with complex, risky, regulatory or addiction presentations. I am involved in our strategic engagement and educational work. I offer a Balint Group to support staff-supporting-staff in the region (so for occupational health, staff counselling or health psychology).

For information on your local Wellbeing Hub please go to NHS England website.

A reflection on Panorama: Young lives in crisis

Dr Richard Duggins
Consultant Psychiatrist in Medical Psychotherapy, Newcastle upon Tyne

"Because of these criticisms that I have expressed I would like to be foremost in recognition of the extreme difficulty inherent in the task of the psychiatrist, and of the mental nurse in particular. Insane patients must always be a heavy burden on those who care for them. One can forgive those engaged in this work if they do awful things. (Winnicott, 1947, p194)

I might regret writing this. I feel a need to try and digest some of my raw feelings a few days after watching the Panorama Programme about inpatient mental health care in a large NHS Trust. I realise what I saw on screen is only a snapshot of the wards featured. I also know there are multitudes of unseen examples of dedicated clinicians and fantastic care, often against the odds, in this Trust and the NHS. I also know I will have medical psychotherapy and adult psychotherapy colleagues in the Trust in question, and their opinion will be much more valuable than mine.

I was shocked to see such awful things on screen. Actions by NHS staff that are not acceptable in any way. I witnessed verbal, physical and sexual abuse. I viewed humiliation, and I watched alienation.

We were powerfully introduced to narratives that I suspect had been previously unheard. Desperate family members shared their experiences and introduced us to their loved ones' developmental stories. Through these narratives we were able starkly to see how humanity had mostly become lost on the wards and replaced by objectification.

My initial feeling was of shame. Shame that this could happen in the NHS. My NHS. In the programme the viewer was protected from feeling shame. Shame was replaced with blame. Or as James Johnston (2010) states in his paper on reflective practice with mental health teams, the risk of "shame on us" was safely diverted to "shame on you." We did not get into a discussion of society's attitudes to the vulnerable, or the related consequences of the chronic underfunding and resultant understaffing of the NHS. We were told this was mainly the fault of the nursing staff and nursing assistants on the ward. The explanation was that the staff were bad apples. We could rest assured the Trust and CQC were taking action.

This formulation, although comforting, is wrong. We let all our patients down if this is the only response to this programme. I believe the staff in this programme did not go into healthcare to abuse patients, but they did end up there. We need to be curious and compassionate about why this happened. We need to understand the severe emotional demands placed on inpatient staff by their work. It is over 60 years ago that Tom Main (1957) warned us about the disturbing countertransferences inpatient staff are trying to manage, and Isobel Menzies Lyth (1960) showed us that staff teams develop behaviours that are harmful to care in order to defend themselves against overwhelming emotional experiences . Skogstad (1997) observed sexual acting-out as a defence against painful feelings in healthcare staff. Hinshelwood (2004) in his excellent book Suffering Insanity stressed the "painful hard slog" of psychiatric work.

I think what I saw on screen was the consequence of an isolated, undervalued and unsupported staff group faced with emotionally unbearable demands. I associated to the Lord of the Flies island. Winnicott helps us understand that a mother with a new-born baby needs her partner, family and/or friends for support. Only when she is contained can she contain her baby.

The programme portrayed a cut-off claustrophobic environment with only two sides - nursing staff and patients. The absence of a third space was striking. Where were the facilitated reflective groups, and the psychologically-informed formulation meetings? Where was the MDT: the psychiatrists, the psychologists, the psychological therapists, the AHPs, and the managers? I suppose I am asking where was the care, support and containment for the nursing staff so they could care for, support and contain their patients? So they could be good-enough.

Faculty exec working group updates

Working Groups:

- Parity of Esteem For Psychological Thinking within a Biopsychosocial approach to Psychiatry
- Support for doctors under investigation
- Reflective practice
- Sustainability
- Psychedelics
- Data Collection
- Open dialogue/ psychosis
- The Medical student area of the Medical Psychotherapy Faculty website
- Royal College information leaflets
- Ethnicity and diversity
- Wellbeing
- Psychological professions group representation

Parity of esteem for psychological thinking within a BIO-psycho-social approach to psychiatry

Report from the Medical Psychotherapy Faculty strategy group - March 2023

Chair: Jo O'Reilly

Working group: Rachel Gibbons, Jessica Yakeley, Simon Heyland

In our strategy day in 2021 the Medical Psychotherapy Faculty Executive Committee discussed the importance of psychological understanding within a bio-psycho-social approach towards psychiatry, and shared our concerns that there has been a drift away from psychological thinking within psychiatric practice. This decline is not just an issue for the medical psychotherapy faculty, it represents a significant threat to UK psychiatry, to patient care based upon understanding and holistic case formulation and to our professional activities and identities as psychiatrists.

The outcome of the strategy day was to form a working group and to launch a campaign for "Parity of Esteem for the 'Psychological' Aspects of the Biopsychosocial Model of Psychiatry".

The first two aims of this campaign were to influence the main decision-making bodies within the College to secure agreement that changes need to be made, and to then work within the College to begin to bring about these changes and influence the profession more widely. We are delighted that there has been significant progress with these aims.

Central aspects of this campaign consider strategies to embed psychologically informed approaches across psychiatry and include:

- To place bio-psycho-social formulation at the heart of clinical understanding and management planning across psychiatry
- To ensure that new psychiatrists emerge from training with the skills and confidence to apply psychological treatments
- To encourage consultants to develop further skills in psychological treatments though job planning and CPD
- To promote developments in psychological treatments and understanding across RCPsych event programs and communications
- To work with patients and carers to establish the expectation that psychological approaches are embedded in psychiatric services
- To support culture change to reduce the pressure on mental health clinicians, and promote reflective practice

Since then the campaign has been presented to the Policy & Public Affairs Committee (PPAC), the International Congress in Edinburgh, the College Council, and informally to a number of groups and individuals including service users and carers , the Psychiatric Trainees Committee (who published an interview with Jo in the latest copy of The Register magazine on this topic) ,the college officers (Dean, Registrar, and President), the CEO, and the heads of faculties. In each setting it has received strong support. Most recently it has become embedded as part of the work of PPAC. Our impression is that we are responding to concerns widely shared across psychiatry and we look forward to continuing this work with our colleagues, service users and carers and the College leadership team.

Reflective practice

Chair: Simon Heyland

Working group: Jo O'Reilly, Rachel Gibbons, Florian Ruths, Jan Birtle, Clare Gerada, Neil Greenberg, Josie Fielding, Alice Levinson, Tennyson Lee

This workstream began life as one of our faculty working groups. Following a presentation in July 2021 to the RCPsych Workforce & Wellbeing committee it has been adopted formally as a RCPsych working group. This change in status gives the group admin support and increases its influence, both of which are very welcome. The group now includes as members trauma expert Neil Greenberg and RCGP President Clare Gerada whose vast expertise has enriched and widened the scope and ambition of the working group. Our activities have included:

- Advising RCPsych in Scotland about planning a reflective practice event on race and equality
- Input to the college's workforce wellbeing position statement
- Designing and facilitating (assisted by Chris Holman and Diana Menzies) a workforce wellbeing event for NHS leaders in May 2022, jointly hosted by the college and the charity Doctors In Distress. This event was reported in detail by our faculty chair Jo O'Reilly in the autumn 2022 newsletter.
- Supporting the mindfulness retreat organised by Florian Ruths in January 2023

Future work includes gathering data on current UK provision of reflective practice by medical psychotherapists, lobbying for a college policy on availability of reflective practice for psychiatrists, and linking with the CCQI to explore setting quality standards for practice.

Support for doctors under investigation

Chair: Swapna Kongara

on behalf of the working group with Rachel Gibbons

Allegations, complaints and investigations are an inevitable part of a doctor's career. Neither this eventuality nor the outcome (which often takes months and years) changes the fact that it is an incredibly traumatic experience for the doctor. More often than not, GMC investigations are under the spotlight, but significant things happen at organisational level which escape the much-needed scrutiny of internal processes and the responsibility of organisations in taking supportive measures.

On behalf of the Psychotherapy Faculty I am leading a work stream to develop awareness and education among doctors regarding the investigation processes and enhance the support received by doctors under investigation. As a first step, I am in the process of conducting an initial survey to understand the experience of the doctors under investigation, including the support available to them, and seeking suggestions and recommendations for further well-being support for these doctors.

Sustainability

Dasal Abayaratne
on behalf of the working group with Nora Gribbins

The sustainability working group is new to the faculty and is allied to the college's Planetary Health and Sustainability committee, working to promote the links between mental health and the climate and ecological crises. The group hopes to build on its successes over the past year and champion medical psychotherapy's important contribution to this field, collaborate across the college and explore how medical psychotherapy trainees can be supported in gaining the curriculum's new sustainability competency.

The upcoming faculty conference has two talks on climate change and a 'climate cafe' group to both inform and help attendees experientially connect with the topic. A college CPD module, written by the group, on how psychotherapy applies to climate change is due to be published shortly. It is hoped future faculty and trainee conferences will also include this topic, and more learning materials can be published. If you wish to find out more or join the group, please contact dasa.labayaratne@shsc.nhs.uk

A guiding principle to the group's work is an understanding that the wealth of established knowledge and experience in existing psychological models of change might helpfully ground, shape and enhance emergent psychedelic therapies. Emphasising the quality of the therapeutic relationship and containment offered when the mind's defences are lowered and powerfully affecting material emerges, will likely be key to harnessing the treatment's potential and maximising patient safety.

Psychedelics

Jonny Martell
Working group: Jo O' Reilly (chair), Simon Heyland, Frederico Magalhaes, Roberta Murphy, Sarah Markham

Since October 2020 a medical psychotherapy faculty working group on psychedelics has been meeting on a quarterly basis. The group membership comprises medical psychotherapy consultants and trainees, as well as a CAMHS consultant and a patient representative. Members have experience of working on psilocybin and MDMA assisted psychotherapy clinical trials for depression, anorexia nervosa and PTSD at Imperial and King's Colleges.

The group's principal task has been to discuss, formulate and promote the role of the psychotherapeutic process as an indispensable part of the (re-)emerging treatment paradigm of psychedelic-assisted therapies, to maximise benefits and minimise the inherent risks. Work has included surveying psychiatrists' experiences of working in psychedelic clinical trials; guidance for trainees looking to get involved in the research; and guidelines for good practice. Group members have published evidence on the importance of the therapeutic alliance in outcomes of a psychedelic clinical trial and an opinion piece on the importance of developing carefully considered approaches to understanding the treatment's potential and risks, considering the excitement this work can generate.

In November of last year, the working group ran a day conference as part of the Psychodynamic Psychiatry day series, titled Psychotherapeutic aspects of Psychedelic assisted Psychotherapy. It featured talks, interviews, discussions with a trial participant and plenaries. The hybrid event was well received by a diverse audience, many of them trainees showing an appetite to learn more about the complexities, challenges and therapeutic promise of the research.

A guiding principle to the group's work is an understanding that the wealth of established knowledge and experience in existing psychological models of change might helpfully ground, shape and enhance emergent psychedelic therapies. Emphasising the quality of the therapeutic relationship and containment offered when the mind's defences are lowered and powerfully affecting material emerges, will likely be key to harnessing the treatment's potential and maximising patient safety.

Data collection

Chair: Jo O'Reilly

Working group: Rachel Gibbons, Vikram Luthra, Cath Smith, Alasdair Forrest, Seb Viola, Jacquie Jamieson, Janet Seale, Michael Milmore

The MP Faculty has been aware for a long time of inequalities in the provision of psychological therapies across the UK, as well as in the waiting times to access these. Whilst the IAPT program has sought to address this with the development of CBT services at primary care level across England, the provision of other psychological therapies such as psychodynamic, mentalisation based treatment, trauma focussed therapy and others seems patchy and dependent to a large extent upon geographical location rather than clinical need or a coherent plan for service provision. The faculty mapping exercise of medical psychotherapy consultant posts (available on the faulty website) has also demonstrated the very uneven distribution of these posts with implications for service provision.

In order to address this issue we need data, and the Medical Psychotherapy Faculty Executive Committee has established a working group to set about this task. We are developing surveys which we propose to send to medical psychotherapists, psychology leads and service user networks across the 4 nations in order to gather information about service provision and service user experiences. Some of you holding these roles may receive these surveys in the coming months and we would be very grateful for your support with this important work.

The medical student area of the Medical Psychotherapy Faculty website

Chair: Vikram Luthra
Working group: Gerti Stergen, Anne Cooper, Sophie Stokes, Josephine Fielding, Daniella Borges, Jessica Sinyor

We set up a working group last year looking at the creation of a medical student area on the medical psychotherapy website. We have met on several occasions now over zoom and have involved a medical student (the current psych star) who can inform us from the coal face what they would be interested in knowing/ finding out more about.

We have had a meeting with the digital transformation manager and content officer at RCPsych which was incredibly useful to manage our expectations of what we can do with the website. Out of interest they informed us that Medical Psychotherapy is the 4th most visited faculty on the website.

Following on from the conversation with the digital leads we requested a medical student tab be set up on the faculty homepage along with a "contact us" form giving students the option to ask generic or specific questions relating to the speciality, with the working group then responding to these questions. We don't yet know what amount of traffic this will generate, and it may be that we point the student to their local medical psychotherapist if they are seeking further experience in their area. We have put together a FAQ for med students which will be inserted onto the medical student homepage.

We have also started to create an A-Z library of therapies for students, together with signposting to various links on the website. We are considering putting on podcasts or audio description. We might approach people in the faculty for support with this.

Open Dialogue/psychosis

Chair: Miomir Milovanovic
Working group: Rachel Gibbons, Ms Jacquie Jamieson, Ms Sarah Markham, Ms Janet Seale, Dr Sebastiao Viola, Dr Becky Cunningham, Dr Charles Le Grice, Dr Anna Crozier

Open Dialogue approach refers to a particular therapeutic approach, and also how a mental health service is organised around this approach.

ODA stems from the Need Adapted Treatment model developed by Professor Alanen and his team in Finland in the 1960s, which proposes integration of different therapeutic approaches in a setting which involves the patient, his family and important others from his community and clinical team, who meet together on a regular basis. It takes a systemic approach to the understanding of development of symptoms as well as recovery, and emphasises open and active involvement of all these stakeholders in decision making and treatment.

This working group has met three times, the most recent meeting on 29.3.23 with Drs Russell Razzaque and Gareth Jarvis, who are leading important ODA groups and research. The number of members in the working

group has increased from 5 to 9. In this phase we are making links with ISPS and ODA groups to see how we can work in an integrated manner with associations /groups outside RCPsych.

National Psychological Professions group representation

Vikram Luthra and Cath Smith

The National Psychological Professions workforce group was set up following the Psychological Professions Vision for England 2019-2024. The group aims to inform and support the National Lead for the Psychological Professions, NHS England and Health Education England on the delivery of the England Vision for the Psychological Professions, including the enabling workstreams and related projects, in partnership with other key stakeholders. The group meets on alternate months.

The Psychological Professions Vision relates to the 12 psychological professions in the NHS which did not have formal representation within NHS England. The 12 professions in this network are: clinical psychologists, counselling psychologists, forensic psychologists, health psychologists, cognitive behavioural therapists, counsellors, child and adolescent psychotherapists, adult psychotherapists, systemic family therapists, psychological wellbeing practitioners, children's wellbeing practitioners, and education mental health practitioners. The Psychological Professions Network is a membership network for all these groups and other stakeholders in NHS-commissioned psychological healthcare. Medical psychotherapy was not included in the original make-up of this group as it is represented elsewhere; however we thought it was vitally important to be part of this network.

We, Vikram Luthra and Catherine Smith, are the medical psychotherapy representatives on the psychological professions workforce stakeholder group: Vikram since 2021, joined last year by Cath, given the importance of this network and workforce plan on the NHS provision of future psychological therapy and psychotherapy. This representation was agreed by the national lead for psychological professions (Adrian Whittington).

As the medical psychotherapy faculty representatives, we regularly attend these workforce group meetings. We have delivered a talk on medical psychotherapy to the group. We have also become embedded in the terms of reference for the workforce group. We feel that moving forward the Medical Psychotherapy Faculty needs continuing engagement with this work, locally, regionally and nationally.

We are looking for further interested volunteers from the medical psychotherapy faculty to join Cath and I in our working group.

Trainee Voices

Introduction from the Editors

Dr Eleanor Riley
ST4 in General Adult Psychiatry, North Western Deanery
Hafeesa Saleem
CT3 in Psychiatry, Wales Deanery

Welcome to the Trainees' Voices, Spring 2023.

Spring is a season closely associated with new growth, as we reflect on what has passed and consider the potential of the year ahead. Undoubtedly, we have all been influenced by the Pandemic in direct and indirect ways, and clinical contact and training have been (and still are) particularly affected. Whilst this year sees the return of the annual conference to an in-person format, most formal teaching continues to be held virtually. Trainees across the 6 years of postgraduate Psychiatry training have reported ongoing difficulties fulfilling the required psychotherapy competencies, coinciding with changes to the national RCPsych Core and Specialty Training curriculae introduced last August. For the first time in recent years junior doctors and allied colleagues have directly expressed their dissatisfaction and concern in the form of widespread industrial action. The start of 2023 has been a stormy one.

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 spanning the training journey in the form of reflections, commentaries, reviews, art, poetry or other fruit that can be gathered for the Autumn Newsletter.

Artificial Intelligence: The future of Psychotherapy in the NHS?

Dr Chirag Shroff
Specialty Doctor, Southport Liaison, Mersey Care NHS Trust

Artificial Intelligence (AI) refers to the development of computer systems that can perform tasks that typically require human intelligence, such as visual perception, speech recognition, decision-making, and language translation. AI systems are designed to learn from data and use that learning to make intelligent decisions or predictions.

There are two main approaches to AI: narrow or weak AI and strong AI. Narrow or weak AI is designed to perform specific tasks and is optimized for that task. For example, a narrow AI system designed to play chess would be trained specifically to play chess and would not be able to perform other tasks. On the other hand, strong AI, also known as artificial general intelligence, refers to the development of AI systems that can perform any intellectual task that a human can. In Psychotherapy, a combination of narrow and general AI could be of potential benefit.

One of the primary benefits of using AI is its ability to provide personalized treatment. AI algorithms can analyse a patient's data, such as their medical history, symptoms, and behaviour patterns, to create a tailored treatment plan. This can lead to faster, more effective treatment and better outcomes for patients.

Another benefit of AI is the increased accessibility to mental health care. With AI-powered virtual therapists, patients could receive treatment from the comfort of their own homes, without the need to travel to a clinic or wait for an appointment. This is especially important for people living in rural or underserved communities, who may not have access to traditional mental health care services. Additionally, AI-powered virtual therapists could provide round the clock care, making it easier for people to get the help they need when they need it.

AI also has the potential to make psychotherapy more cost-effective. By automating some aspects of the treatment process, AI can reduce the amount of time and resource needed to provide effective care.

Consideration does need to be given to the disadvantages of using AI in psychotherapy. For example, virtual therapists may lack the empathy and human connection that are so important in psychotherapy. Additionally, ethical issues such as biased algorithms perpetuating existing health inequalities must be taken into account.

It is my view that despite these concerns, the potential benefits of AI in psychotherapy are too great to ignore. As the field of AI continues to advance, it is likely that we will see more and more applications of this technology in the field of mental health care.

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Just another IMG in Psychiatry

Naarani Rajarajeswaran Thangarajah
CT3 trainee in Psychiatry, ABUHB

At the tender age of 10, I moved from a humble yet hardworking town to a big city - from my hometown, Jaffna, a small town in the Northern part of Sri Lanka affected by the civil war, to the capital of Sri Lanka, Colombo. Until then, I studied in my mother tongue, Tamil. I was enrolled in a small "International School" in Colombo, which meant I would study in English medium, an entirely new language for me. I don't remember being afraid of the changes, nor not being able to communicate with my peers in English – 'I am a Jaffna girl,' I say proudly. I carried the values engraved in me in my childhood.

It was a classroom of around 20 children; I sat there waiting for my English teacher to start her lesson. As she stepped into the class, I stood up. This was a reflex – we had been taught to stand for the teacher when they entered in my previous school. Soon, I realised I was the only one standing. I looked around and noticed the other kids were staring at me, but I couldn't get myself to sit until the teacher sat herself down. I could hear a few giggles. Don't get me wrong: the kids weren't being mean- they just weren't used to this. My teacher, aware of my background, brought me to the front of the class, embraced me and said to the class, "You have a

lot to learn from her! ” Ever since, I do not remember being looked at as behaving oddly. In fact, given that it was a very humble school, the teachers encouraged such values in the children. I was home again.

Fast forward two decades. I am in my first MDT meeting in my first job in the UK as a junior doctor in an Adult Psychiatry ward. Not sure when I lost all the guts I had when I was a kid; I sure was anxious and a little scared this time. I was speaking to one of my new colleagues when my consultant (supervisor) walked into the room. Without thinking, I sprang up as soon as I saw him! Inquisitive eyes met me, not knowing why I got up so suddenly. A little nod from my consultant as a gesture to speak up, as it looked like I stood up to say something. I just smiled. I had nothing to say. I sat down as soon as he sat. There was an awkward silence, and the meeting began.

This felt like Déjà vu, except I did not have my teacher to explain my behaviour to the others. I could not concentrate for the rest of the MDT meeting. I thought I would make a good first impression, but where did I go wrong? I wondered, am I appreciated for being respectful, or depreciated for not giving the same consideration to the rest of the MDT, even if there was no ill intention? My self-consciousness button was turned on. I was clueless - I thought I should know everything about all the patients, but others were doing “my job”, and I had nothing to say. Thus began my struggle to adjust to an entirely new environment—something I was unprepared for, maybe due to my blind trust in myself. This was just one example, but the struggles felt profound.

I had started my medical career in India and then worked in the government sector in Sri Lanka, which offers free medical care to the public. It’s a community struggling to come out of the decades-long civil war. At one point, I worked as the sole junior doctor in a medical ward, taking care of in-patients, attending two different clinics, doing on-calls once every three days, and attending to medical emergencies in the HDU. The local community knew me and acknowledged my work. It was apparent I understood their struggles, and I was doing something I knew well to help. I felt needed. I felt like I was making a difference.

The decision to move to England came to fruition finally; I say finally because of the tedious process of balancing my time, finances, exams, paperwork, more exams, visa application and more paperwork: The need to prove myself repeatedly almost made me feel worthless, though I do understand that it’s needed. My confidence did take a little blow then. It was a hard decision because I was leaving my support network and home, something I had taken for granted. My parents are getting old, but I wanted to convince them to join me when I settled in the UK. I had a plan. And now that it’s done, how hard will practising medicine in another country be? I have already worked in two countries. And I am a people person; this made me lean towards Psychiatry.

I moved to a beautiful city in the South of England- it was immaculate, but I felt out of place - I looked different, dressed, and spoke differently. I felt the need to be extra cautious with my actions as I feared being judged. Walking into a supermarket or clothing store was overwhelming! This was the first time I had been given this many choices. A part of me was angry about the discrepancy in the availability of material goods from one part of the world to the other, and another part of me felt guilty for indulging in the luxury that was not available to my family or the people back home.

I unintentionally carried this feeling to work – I struggled to understand the struggles of some of my patients, especially those in touch with reality. There was a rigid structure around me, which made me feel restricted, something I had not felt before working as a doctor. I did what was expected of me, but I was starting to be dissatisfied with the system - why were my patients being readmitted? Why were they relying on the hospital so much? Why were we not helping them build resilience and be independent? Should we be giving a bit of tough love, just like that expected of a parent? But I had no say; I still didn’t understand the system entirely, and I could be wrong. I was now part of the system and felt useless and insignificant.

Who could I speak to about this? I had a few acquaintances, but before they could become friends, I had to move on to my next rotation. A new set of people who would need an explanation about my habits, for I still can't sit down in the presence of my senior. I wanted to speak to my family, but I did not want to worry them about all this. I am a Jaffna girl, known to be strong by my family and friends. Besides, I was not there to care for them when I should be with them. So, I saved all my annual leave to visit my parents for a couple of weeks—something I envied when others could see their family without so much effort. While focusing on the two main things in life, career and family, the rest were neglected – 'Do I know how to build my credit in the UK? Why is my salary different from my colleagues with the same years of experience?' I left all that to be dealt with later.

Sitting for exams in the UK is another hurdle I had to get through, for I have been trained differently for over a decade. Everyone advised me to get the exams done, so I applied for the next round. Just MCQs and EMIs? How do I study for that? I'd never been this stressed before an exam, as I thought I had to prove myself by getting through the papers in one go. I have always managed to pull through at the final moment; I was sure I would get through my paper A with last-minute preparation. I was unhappy with my preparation, but I couldn't take many days off to study as I needed those days to visit my family back home.

But I have lost my knack for getting through exams at the last minute. My heart sank when I received the result that I had not passed. Did I not deserve to pass? 'I genuinely care, and I'll make a good psychiatrist,' I thought. Now I must explain myself to my family, friends, and colleagues and explain that I am not dumb; I didn't prepare enough. It does take a massive toll on your confidence.

As a trainee, you feel everyone needs a bit of you. It's an uneasy feeling of not being able to give 100% in everything you do. But I was told it's the process and worth it once you complete your training. So, I managed to find the courage to go on. Two years into my training, I am still the same odd person doing things as I was taught in primary school, except now I explain it to my colleagues and have a good laugh about an awkward situation. I also ensure I give the same consideration to all in the room. I still struggle to address my seniors by their first names even when they insist; I sound very unconvincing. But I am not doing anything wrong here; how can you offend someone by showing respect?!

I am learning the art of studying for exams in the UK: "give it the respect and time it deserves", I was told by one of the consultants, and I managed to clear papers A and B. I felt my confidence build up again slowly. It might also be due to a better understanding of the subject and the system. Most importantly, having seen many patients from all walks of life, and speaking with many professionals, I began to understand that suffering is the same all over the world; the reasons may differ, but that doesn't matter.

My first client for my psychotherapy long case discontinued after one session due to lack of time – it might be so, but I couldn't help but take it personally. I gave all I had for my second client - I genuinely empathised with her and saw her come out of the sessions stronger and more resilient. The satisfaction I had when we discussed her progress over the therapy sessions was indescribable. It was all worth it. Now I am learning the skills to be helpful in my field.

What has changed in the last two years? My perspective and taking control of what I can. I don't blame myself, for I understand it is the normal process of adapting and learning in a new environment. I still have the same questions about how the system could be more proactive than reactive in Psychiatry, but I recognise I am still learning. Irrespective of this, I do not need to be a part of a perfect system; I can be a part of the improvements that are to come.

Balint as a leadership opportunity for psychiatry core trainees

Alina Vaida
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Dr Syed M. U. Nasser
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Introduction

Balint groups are essential to psychiatry training, introducing reflective practice and psychotherapy training. They are mandatory for CT1s, as attendance and assessments are a curriculum requirement [1] and are strongly encouraged after that, including in higher training. Setting up and quality assurance of Balint groups is the remit of the local psychotherapy tutor.

However, starting from the "Balint model" [2], there is wide variability in what happens in each group, depending on the leader's style, the seniority and psychological openness of the group and the nature of the cases presented.

My experience of Balint groups and developing my leadership style

In my own training, I experienced a variety of Balint-type groups. I joined such a group as a core trainee, led by a renowned medical psychotherapist, Dr M. Dr M's knowledge and insight into the patient's inner world fascinated me. At the end of the group, she usually summarised with a comprehensive psychodynamic formulation. I was both mesmerised and left wondering how she could reach such profound conclusions based on what seemed like some random feelings and reflections. Later, she had a co-facilitator, one of the specialist registrars, who took over leading our group. I remember him feeling closer to us, at least in training grade. Between an ST6 and CT2/3, there was still an experience gap, but not such a wide one. It felt easier to talk, although I missed Dr M.

I had several experiences co-leading or leading Balint groups during my registrar years. When I co-facilitated the CT1 group in Birmingham, it took me a while to be brave enough to talk, as I saw leading the Balint group as very complex and requiring many years of training. My confidence grew over the years, through leading several types of group. I attended training with the Balint Society and noticed that styles differed. The format was the same, but there was no "magical formulation" at the end, at least not for the groups I attended. The Balint's Society description of Balint groups says, "*The session ends, like a therapy session, when time has run out. […] The leaders may ask for a follow-up and thank everyone. They do not attempt to tie the loose ends or give a reassuring summary.*" [2] Without a formulation at the end, it felt somehow incomplete. Of course, there are benefits to not having a psychodynamic formulation, as everyone in the group can reach their own based on the group experience; and it means that psychotherapy or psychoanalytic experience is not a must for leading such groups, opening up this role to a wide range of experiences and professions.

I joined a supervision group for Balint leaders for about a year, led by facilitators accredited by the Balint Society. We discussed experiences from our respective groups, following the same Balint format. What was different was that we took turns leading the group; the group members remained the same, barring explained absences, but the leader changed. It gave everyone a chance to lead and be a group participant. It opened up the idea that everyone can be both a leader and a group participant.

My current role of leading Balint groups as a psychotherapy tutor

I started my current role as a psychotherapy tutor at CWPT in September 2021. There are 2 Balint groups, divided geographically, so in both groups there are trainees ranging from CT1 to CT3. There are pros and cons to having a mixed group like this, but I won't go into this now. I want to focus on the experience of CTs as (co)leaders of Balint groups. The first attempt wasn't carefully planned, but the result of going through another bout of Covid and not wanting to cancel the group after I had cancelled the previous week due to my planned leave. My thoughts went from "I wish I had a co-facilitator" to "some of the trainees are so good, they could easily be co-facilitators" to actually asking the question and one trainee saying yes. Dr Nasser stepped up to be a facilitator, and I joined as if I were a trainee, sharing my feelings and thoughts about the case. Arguably, this was not planned, and I wasn't sure if it was a good idea if repeated in a planned way.

I thought about it afterwards, about the benefits and risks of having trainees co-leading. The main counterarguments were about breaking the usual structure, creating uncertainty, and trainees feeling anxious about leading and being led by a colleague. The groups felt safe, and the feedback from trainees outlined that. It wasn't something I wanted to jeopardise. Other worries were about having particularly difficult cases discussed and trainees feeling out of their depth. On the other hand, I was there, even when "acting as a trainee". The pros were that it allowed me to model what I expected from them by sharing my feelings and thoughts about the cases. It removed some of the time pressures I had as a leader, as this role is easier to fulfil with less training and allowed me to connect with the cases more. Some unexpected reflections were about my leadership style, as all the trainees who led had their unique style, which made me think more about their expectations. Did they want me to summarise at the end, or did they prefer the presenter to end the session or to end when the time was up? Was I perhaps too active while leading the group? In one of the sessions, the case story reminded me of my family history, which was a good reminder that these groups can trigger personal difficulties and to remind trainees that they can reach out to me in between sessions if they need to.

How did we do it?

I offered the opportunity to more senior trainees (CT3s), on a voluntary basis. We agreed on who was going to lead and when, and I asked if they preferred to be the main leader or if they preferred to co-facilitate. All four trainees who (co)facilitated did it at least twice. We had a feedback meeting after each session when we reflected on the experience. Each trainee who (co)led wrote their reflection on the experience and sent it to me. I have collated their responses in this paper. Interestingly, they shared similar views, but I will let you read their own words.

Trainees' reflections on their roles as Balint group leaders:

Leading Balint – Dr Syed M. U. Nasser, CT3 Psychiatry, CWPT

In the Balint group I co-led, we discussed the case of a trainee's paternal feelings towards a young patient. I found the experience challenging but rewarding. I have been in this group for three years as a trainee. It had always been a safe, non-pressured space, where there was no obligation upon me and where I did not typically feel anxious. Suddenly I was leading the group, and I did feel somewhat anxious about my performance. Looking back, I think I was worried about how I would be perceived, both by my colleagues and by the regular Balint leaders. This transformed what had been a very safe environment into one of self-consciousness, and the contrast was a bit jarring.

Leading the group also made me feel less engaged with the emotional content. Trying to manage timings, ensuring some semblance of structure was kept, while tracking contributions was surprisingly cognitively

demanding. It felt like a challenge to perform well, and I think the demands of leading the group took priority over emotional engagement. This is not a bad thing per se, but I wonder if with more experience one is better able to do both together.

I also found the role switch brought with it a real sense of responsibility. I have always been quite an active contributor towards Balint as a trainee, and didn't want to confuse the roles – talking as a trainee but with the privileges of a supervisor. For this reason, I was conscious of the old saying in jazz music – '*It's not the notes you play, it's the notes you don't play*.' Translated into this situation, I understood through this experience that space and silence are often what are really needed; that intervention may be less fruitful than restraint.

Despite some anxieties, I did find the experience quite rewarding. It gave me confidence that this was something I was able to do to an adequate standard. This wasn't a given going in, but judging the session as going quite well, and from the feedback I got informally, the participants seemed to be pleased with the running of the session. I gained some confidence from this.

I also valued the experience as it was the first time having to consider the psychology of a group as a whole. Balancing the group dynamic with individual considerations, as well as trying to ensure that structure and time were kept, required a lot of skill. While it will take a lot more time and experience to become truly competent at this, it was nice to make a start and I hope to develop it more in the future.

I do feel mildly anxious about the prospect of leading this group again, but interestingly, I don't have the same anxiety with the idea of leading a different group of which I have not been a part. In that case, the role transition will be done out of sight, while in this case, it was seen in broad daylight, heightening the age-old medical problem of 'Imposter Syndrome'! In conclusion though, I do recommend leading such groups to other trainees, especially more senior Core Trainees. The experience is both challenging and rewarding, and will help to develop skills one cannot exercise as a participant.

Experience of leading Balint Group – Dr Megan Stevens, CT3 Psychiatry, CWPT

It felt very different being a Balint group leader; the process enhanced my listening skills as I found myself listening to more of the finer details of the history and others' comments. I felt a little apprehensive about meeting the other trainees' expectations of what Balint group should feel like and knowing when to prompt for meaningful in-depth reflective comments from trainees. Leading the group enhanced my confidence in my ability to do this. I learnt the importance of silence and how long to hold silence before prompting and assisting the conversation. I noticed that some trainees appeared more uncomfortable with long silences than others. From witnessing others lead, I have noticed that acknowledging that silence can feel uncomfortable has been beneficial to keeping trainees relaxed and reflective. I noticed that trainees could sometimes deviate off-topic. I learnt how to gently guide them back to the Balint structure when necessary to prevent the structure from being lost. It felt like a fine balance between keeping a clear structure and not offending the trainee/making them feel like their contribution was not valid.

Overall, I found that leading a Balint group allowed me to develop my advanced listening skills, pick up on any subtle feelings that may have developed in the room and help to guide the conversation accordingly.

Reflection on leading Balint – Dr Kate Kerrigan, CT3 Psychiatry CWPT

Balint group is something I have always enjoyed and valued as a trainee, and so when I was offered the opportunity to facilitate a group, I immediately agreed. I was therefore very surprised at how daunted I felt when I initially started. My main difficulty was switching from a friend and colleague to taking leadership of a discussion. I would potentially have to deviate and structure discussion, which is not something one would be normally doing when conversing with colleagues.

In my first session I found myself clock watching quite a bit. There were times when the seconds seemed to drag, and I feared the awkward silence that might occur. On reflection this would not have been due to my own lack of ability to facilitate a conversation with my colleagues but part of the overall process.

It can be hard to hold yourself back when facilitating the group as it is only natural that you want to join in, in earnest, with the discussion. I struggled with the temptation to ask directly, and involved the more reserved and quiet group members. I was also acutely aware that I had to be very careful not to impose my own personal views and try to remain neutral. It was difficult when summarising as I was aware that my interpretation might conflict with another colleague's experience of the same discussion.

It is a privilege to be a part of a group where colleagues feel comfortable opening up about events that they have found difficult. When facilitating, I found I had a sense of anxiety that I might say the wrong thing or not respond in the correct way. I do not have this anxiety when joining in as a group participant. I wonder if part of it was that I was so focused on the times, structure and who said what that I found it harder to connect on an emotional level where expression and empathy therefore come more naturally.

Although there were initial worries when starting I actually found the experience very rewarding. It gave me a greater understanding of the overall process and I am now more aware and able to embrace some of the uncomfortable feelings that can arise. Going forward, I would now feel more confident in facilitating my own group and would encourage other trainees to take up the experience.

My Experience of Facilitating A Balint Group - Dr Nathan Hodson, Academic Clinical Fellow, Department of Mental Health and Wellbeing, Warwick Medical School

Miles Davis once famously remarked that "It's not the notes you play, it's the notes you don't play" [3]. His statement reflects the idea that sometimes, the most powerful moments in music can be found in the space between the notes, in the silences that allow each instrument to find its own melody. This same counterintuitive approach is also required in psychotherapy, as I discovered while facilitating two Balint groups.

A challenge I face arises from my temperament as an external processor. I prefer to test ideas aloud and notice my own mistakes best when I hear myself saying them. That risks creating a chaotic and domineering facilitation style. When I play jazz piano, band leaders have suggested I "overplay" and could leave more space. I actively work to control the same impulse in psychotherapy.

There are different ways of leaving space. It was important to give the participants the opportunity to express themselves and to develop their own thoughts and themes without being cut off or interrupted. Similarly, I aimed to avoid asking too many questions. As the facilitator, I already had a platform, and it was important not to dominate the conversation or control the discussion. The point of the group was to improvise within a structure, to uncover different ideas and perspectives, and to benefit from the responses of each member. To be sure, I wanted to encourage quieter participants or reflect back the comments, and often I wanted answers to questions about the case, but the deeper answer was to be found in the free interplay of our emotional reactions. So throughout the session I experienced a sense of holding back.

Finally, I wanted to avoid overusing or imposing theory. While it is important to bring different theories and perspectives to the table, it is equally important to privilege intuition, trial-and-error, and reasoning over book learning (not unlike Miles Davis' "modal jazz" style eschewing traditional scales and embracing a range of alternative sets of notes). The Balint group developed a richer understanding of the relationship in question by approaching the case on its own merits, despite my urge to fit events into a theoretical schema.

If the connection I'm developing is legitimate and facilitating a Balint group is a bit like playing jazz, then I think taking the lead is an important way to learn about the psychological mechanisms at play. Personally, I became more aware of several tensions which emerged from the need to leave certain notes unplayed.

Anonymous feedback from group members

I collect yearly feedback from Balint group participants. This year I added some questions about their colleagues (co)leading.

The response rate was 18 out of 21 possible answers (85.71%)

"When your colleagues are leading the group, how safe to talk do you feel?"
Average 4.38 out of 5 (17 respondents, the guidance was to skip the question if they did not participate in a group co-led by a colleague)
"When your colleagues are leading the group, do you feel supported?"
Average 4.38 out of 5 (17 responses, as above)
"Would you like to co-lead the group in the future?"
Yes 61.1%, No 16.7%, Maybe 22.2% (18 responses)

Summary:
Although the experience proved anxiety-provoking for trainees, their rich reflections and positive feedback suggest that it can be a valuable experience in their training. The best argument in favour is that most of the trainees said they would like to lead in the future, or didn't exclude the possibility (Yes 61.1%, No 16.7%, Maybe 22.2%). There were many important points reflected on by the trainees who (co)led the groups: the role of silence or "the notes you don't play", the balance between leading and not imposing their own views, the delicate balance between guiding the discussion and not being "offensive" to colleagues, the importance of feelings versus theory, to name a few.

By having the experience in training, in a safe and supervised way, the trainees will be better equipped to lead their own groups in the future, making the reflective groups more accessible.

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The forgotten relative of psychotherapy - music therapy

Dr Amarenna Celsi
CT3 Psychiatry, NHS Greater Glasgow & Clyde, Scotland

Music and art are both something I treasure deeply as they give me peace and headspace. The creative arts have always sparked my interest. To me they seem like the yellow brick road between art and medicine. Part of psychiatry training involves working within its various specialties and with other professionals from varied disciplines. During my learning disabilities placement, I came across a music therapist that attended the ward to do regular weekly sessions with our inpatients. This sparked my curiosity and reignited my motivation to work in this area of therapy.

Although everyone (staff and patients on the ward) were aware of the music therapist, he functioned like an independent entity visiting the ward, rather than joining in as an integral member of the team. My curiosity drove me to explore what this, at least from a psychiatric trainee perspective, fringe therapy was about. Fortunately, both my Consultant and the music therapist were receptive to my interest. I don't wish to spoil the plot, but this experience fundamentally changed my views on the potential of music therapy to change people's lives and strengthened my belief that there is a place where science and art live together.

On-calls and leave aside, I spent my Monday mornings there for 6 months. Due to the layout and other circumstances particular to the ward, these were 1:1 patient sessions. The degree to which each patient engaged varied, and progress was subtle at times. There were a couple of patients who attended regularly. Some would sit quietly and listen to a song while others would tap along on the xylophone or a drum. My role varied over

time and progressed alongside the patients. I went from periods of focused observation to active participation in the music. We reflected after each session. We discussed the content of the session, behaviour during the session, our clinical aims, the methods used and broader music therapy practice.

A quandary for me was how we would detect and monitor progress, as in mental health it can be quite hard to quantify this, even with scales. My answer came from the most unlikely source and in the most unusual way. Two patients stood out for me and in looking back their progress answered my question. The first one was rather bashful, mostly listening to songs and only sitting with us for a few minutes before leaving. After a few sessions he started to stay longer and eventually he began to tap along. One day to our delight he asked if he could try a different instrument. Eventually he started singing and asked us to play songs he enjoyed from The Greatest Showman. The second patient usually enjoyed singing along to Elvis songs but one day he unexpectedly joined us with a tambourine. In the process he changed into one of the happiest people I have ever seen. A remarkable transition from the flat uncommunicative individual who had begun this journey. These were lightbulb moments for me, giving me an insight into the benefits this therapy could provide for patients as well as an awareness of the nuances of the therapy.

Music therapy allowed me to forge bonds with my patients and understand them and their difficulties in a different light. Considering the struggles we can have in communicating with our patients I found this to be a valuable alternate form of communication. From beginning to end there was a shift in my therapeutic relationship with the patients who attended, for the better, which had a lasting impact beyond the sessions. They were more open, more receptive and I felt more confident, more empathic. It became evident to me how helpful this therapy can be for patients who struggle to engage with other formats or to express their inner world.

The sessions benefitted me as well. I learned to be more flexible as each patient was so different. During sessions I had to listen closely and respond to the patient using rhythm, song forms and improvisation. All with the purpose of making them feel comfortable, valued and encouraged while expressing their own creativity and musicality.

During my discussions with the music therapist we reflected on how much music therapy takes from psychotherapy principles, looking at situations through a similar lens, and we wondered whether it tends to be forgotten amongst other types of therapy. Looking at the current issues for therapies within NHS Mental Health Services with long waiting lists, resource constraints, and other therapies having to self-sustain by being offered in private, I wonder whether we already have tools and services, such as the creative art therapies, at our disposal which are silently looking at us, hoping their voice could be heard by the rest of us.

Conferences (upcoming and reviews)

RESPONSIBILITY WITHOUT BLAME
Ethical positions in mental health

Date: Friday 30 June 2023

Time: 9:30am – 4pm

Venue: Royal College of Psychiatrists

Event type: In person
Lunch and coffee/tea included

Title: Steve Pearce study day on 'Responsibility without blame'

We are delighted to announce the first 'Steve Pearce Study Day' held in memory of our late Faculty chair. This event offers an opportunity to hear expert presentations and to come together with colleagues to explore the concept of 'responsibility without blame' in a managed clinical setting such as the NHS.

Internationally renowned speakers will offer their thoughts and ideas from a philosophical, ethical, and clinical perspective. This will provide the platform for interactive small and large group discussions of links between philosophy and psychological/psychodynamic thinking as applied to our clinical work.

Steve Pearce was a Consultant Psychiatrist in Medical Psychotherapy and chair of the Psychotherapy Faculty and had a wide interest in matters related to psychiatry. This Study Day seeks to honour Steve's memory by preserving and extending his legacy in psychiatry, psychotherapy, and philosophy, as well as celebrating his achievements in psychotherapeutic group work, therapeutic communities, research, and teaching.

Speakers:
Hanna Pickard, Bloomberg Distinguished Professor of Philosophy and Bioethics at Johns Hopkins University, USA

Matthew Broome, Professor of Psychiatry and Youth Mental Health, Director of the Institute for Mental Health, University of Birmingham UK

Cost:
Consultants/senior managers: £125
Trainees/non-medical staff: £80

To book a place please go to Eventbrite – Responsibility without blame ethical positions in mental health

Medical Psychotherapy Trainees and Trainers Conference 2023 "Psychotherapy at Play"

Friday 26th May, Midlands Arts Centre, Birmingham

We are delighted to announce that booking is now open for the 2023 Medical Psychotherapy Trainees and Trainers Conference.

This year for the first time we are hosting a collaborative conference, organised jointly by medical psychotherapy trainees and **PsychArt**, a trainee-led organisation celebrating the arts in psychiatry.

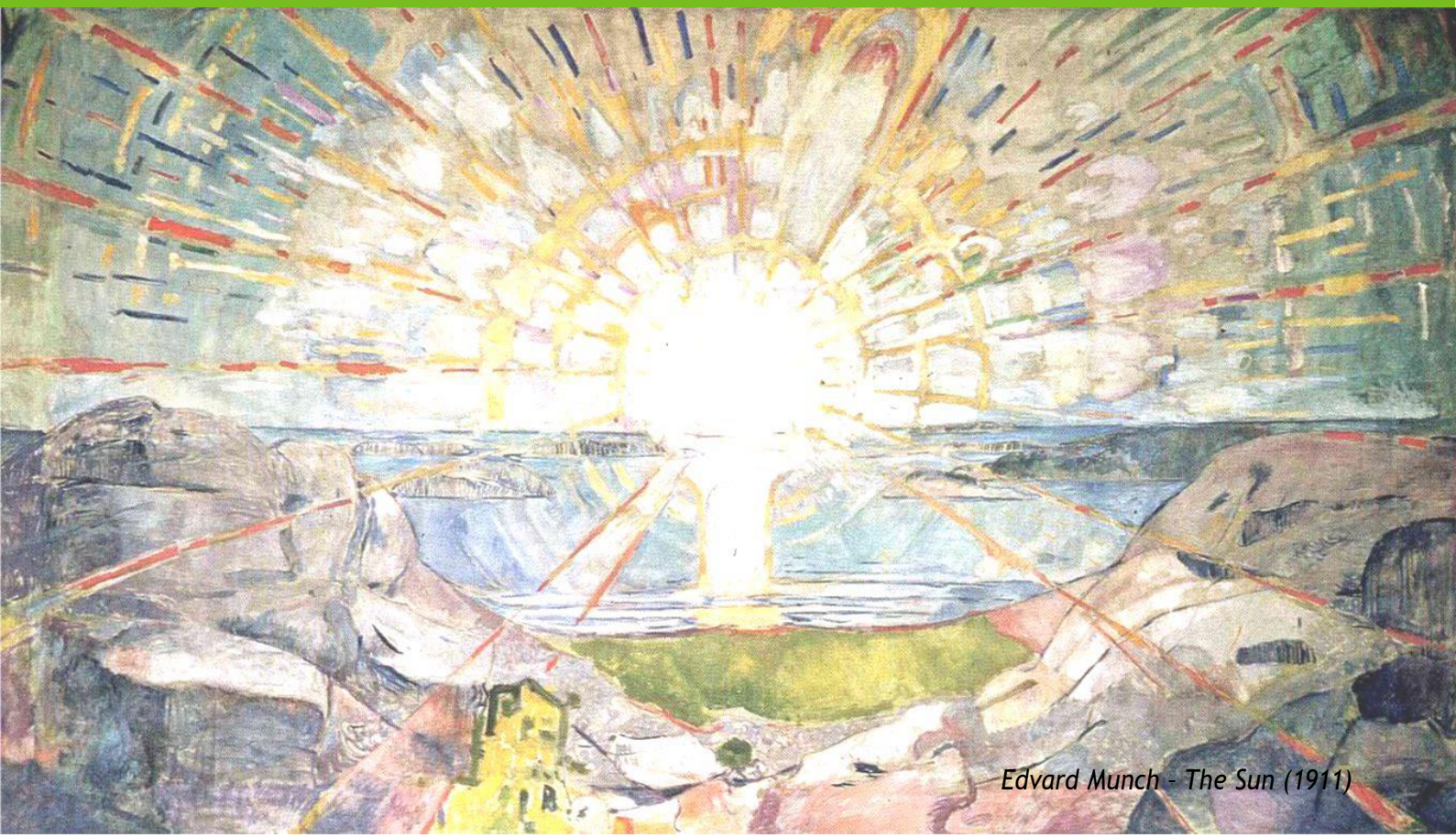
This year's conference, **Psychotherapy at Play**, is an invitation for us to explore the central role of play and creativity in psychotherapeutic work.

For booking and further details, click here: https://www.eventbrite.co.uk/e/psychotherapy-at-play-medical-psychotherapy-trainees-trainers-conference-tickets-539580047447

To contact the committee, email us: mptrainertrainee@gmail.com

A New Dawn: The World's First SUN Project Conference

Dr Thomas Dewhurst
On behalf of The Croydon and Lewisham SUN Project leads,
South London and Maudsley NHS Foundation Trust
RSVP: Trudi.Carmichael@slam.nhs.uk



Edvard Munch - The Sun (1911)

What is a SUN Project?

Service User Network (SUN) Projects have been rapidly expanding in recent years across England as a structured and boundaried way to offer peer support to people with mental health difficulties in crisis. SUN Groups provide a safe and non-judgemental space for members to give and receive support from other SUN members who may be going through similar struggles, including difficulties in managing emotions, and engagement in behaviours to manage this such as self-harm and suicidal ideation. SUN has therefore become an important intervention for people with a Personality Disorder diagnosis, but also those without a diagnosis who might find it difficult to access the usual avenues of support and treatment – i.e. those who 'fall between the cracks'. For that reason, SUN Groups are open access with no waiting list - the ethos of SUN is that everybody is welcome if they have urgent crisis and support needs.

SUN Groups run for 2.5 hours, online or in person, at least three times a week. SUN Groups are led by two mental health professionals, with up to 10 members invited to sign up to each group. Risk is the priority of every SUN Group and each member co-creates their personalised Crisis and Support Plan (CaSP) document with the group, which identifies what they can be like 'at their worst' and what they can do to help in a crisis. The CaSP is the cornerstone of SUN – a document that each member can take away, share with their GP and other mental health professionals, and use to keep themselves safe.

SUN theory is based on Therapeutic Community principals and the Appraisal Based Coping model, and requires a structured and active approach by the two group facilitators, with weekly Clinical Direction from a consultant psychiatrist, Training & Implementation from a service manager, and daily meetings to support the team and reflect on the process. This requires a close-knit multidisciplinary team of doctors, nurses, occupational therapists, psychologists and psychotherapists (and their trainees and assistants), plus peer support workers – anyone who is prepared to work with high risk and enthusiastic about supporting patients in crisis.

What is the SUN Project Conference?

If you are currently running, or interested in setting up, a SUN Project for your local area, you are warmly invited to attend the world's first SUN Project Conference on Wednesday 19th July 2023 at the ORTUS Conferencing and Events Venue, Denmark Hill, South London, SE5 8SN.

Like our SUN groups, we want everyone to feel welcome to the conference – staff and service users alike. Please save the date and spread the word within your services.

We are now calling for briefs or abstracts for posters or talks you would like to present on the day. We want to hear about your SUN projects and where you see SUN going in the future.

More details including a programme of events will follow in due course. Please save the date and we look forward to seeing you in July.

Taking a moment: East of England trainees' reflective day on the impact of patient suicide and the coroner's court

Lawrence Congdon and Orestis Kanter Bax
Senior Trainees in Adult Psychiatry & Medical Psychotherapy, Essex Partnership NHS Trust

We were very pleased to attend a HEE Eastern Deanery School of Psychiatry reflective day for Eastern region Core and Higher Specialty trainees on 21st December 2022 at the Royal College of Psychiatrists. Being in the room with colleagues at the College, some of whom we had not seen in person for more than two years, was refreshing. Perhaps then, it is not surprising that getting together, with physical bodies in a shared room, allowed for the development of connectedness of feeling too, through sharing of experiences in this full day event.

Dr William Burbridge-James, Training Programme Director for the Higher Medical Psychotherapy training of the Eastern Deanery and psychotherapy tutor, introduced the day's programme – the topic: *'The impact of suicide and deaths of patients on trainees in a time of Covid, and the after effects, including the SI investigation and attending the coroner's court'*. He voiced the shared feeling that there had been a need for such a space for the trainees for some time now. We were offered the space to individually introduce ourselves to each other and it was nice to see a mixture of colleagues from the different counties of the east of England and also a variety of doctors from different levels of training, including some consultant colleagues.

The first session of the day was a dialogue between Dr Elizabeth Venables, Consultant Psychiatrist and Medical Psychotherapist and Dr Lynsey McAlpine, Specialist Registrar in East London NHS Foundation Trust, on *Suicide and its Emotional Impact*, very much grounded in their personal experiences of losing a number of patients to suicide and the aftermath of this. The candid and lively conversation between the two, was followed by a discussion with the attendees. A number of colleagues were actively engaged in negotiating the impact of patient suicide both emotionally and also in the practical aspects of lengthy Serious Incident Review processes and coroner's court hearings, which sometimes took place after years had passed since the last time patient and clinician had met. Complicated feelings such as anxiety, guilt, shame, anger, inadequacy, blame and depression were named and discussed. Colleagues were able to speak about the resources that they had to rely on, both internal (emotional) as well as interpersonal and systemic, in order to survive the traumatic impact that losing a patient to suicide had had on them.

Dr McAlpine, drawing on her special interest work on patient safety, spoke about *'Facing the Coroner'*; this allowed for a pragmatic and meaningful approach to the task of giving evidence through written and oral reports to the Coroner's Court: a delicate and complex balance between working through the experience (with clinicians and families both in mind) while also attending to the professional requirements of this quite stressful process. Attendees shared mixed experiences of feeling both supported and less so, when faced with this task, and a sense of isolation exacerbated by the disconnection the pandemic brought to working relationships. Resources discussed included talking to colleagues, supervisors' support, meeting with the Trust's solicitor, professional support organisations - in summary, facing the task "together".

Dr Burbridge-James, in a brief theoretical section about a psychoanalytic understanding of suicide brought together different strands of theory about unconscious processes concerning suicide: from Freud's work on Mourning and Melancholia, to Melanie Klein's theory of the paranoid-schizoid and depressive positions, to the more recent contributions by Rachel Gibbons and the RCPsych's Patient Safety Group and Working Group on the Effect of Suicide and Homicide, as well as Hale and Campbell's work on suicidal states of mind. The need for openness to receiving the distress signals patients send in such states, while also recognising the dangers of our

own omnipotence, very much resonated with discussions in groups. Both about limitations of our clinical capacities and also about our own susceptibility to experiencing or acting within the working relationship under the influence of unconscious processes that may have meaning for our patients' personal histories and vulnerabilities.

Medical psychotherapist colleagues facilitated five small reflective groups. The words of the *Chaplain of Beachy Head* resonated with the discussions in the groups: *'To help a truly suicidal person, you have to approach them with an open heart … If you are worried about the risk their action poses to you, they are more likely to jump'*. The reflective groups felt like spaces for the recognition of each other in our lived experience of losing a patient. Much like the practice mentioned in one of the groups, where some cultures during the period of mourning display in public a piece of cloth as symbolic of the deceased and the loss suffered, trainees came together to share their experiences in recognition of each other's losses. In another small group it was discussed that although many of the clinicians had never physically been to the coroner's court, we had all been there in our minds and it was in fact a mental space that loomed large in difficult encounters with patients. There was a discussion about how risk assessments can function as a sadomasochistic exercise when the clinician approaches the patient with a closed heart.

The highlight of the day was *the large reflective group*, facilitated by Mr Kannan Navaratnem, psychoanalyst and fellow of the British Psychoanalytical Society and the Squiggle Foundation (Winnicott Trust), where a case of patient suicide was generously presented for reflection by a trainee colleague, with moving contributions from both junior and senior colleagues. A discussion ensued about how the patient through their conscious and unconscious communication had given the clinician a powerful experience of their own internal world and object relations. The group was able to help make sense of some of the patient's experience retrospectively and how the contact with the clinician had been helpful. It was a moving account of how patient contact in times of the coronavirus pandemic was often disembodied and posed its own challenges in the transference and countertransference: there was a strong sense of loss that the group was unable to hear from the clinician what the patient looked like. The work of mourning was in the air and it was moving to see how a thoughtful clinician could use a reflective space as a way of working through such a traumatic event in their clinical life.

The conference-demon, a distant cousin of the demon-of-the-press that sometimes makes its presence known in this newsletter (and close relative to the zoom-demon that has been interfering with our remote meetings during the pandemic), made it so that we could not watch together the RCPsych video, 'Working helpfully with families after a patient dies by suicide' in the Creative Conversations about Suicide video series. Perhaps in a less persecuted state than talking about demons suggests, we were able to make something out of this loss. The day closed with an opportunity to continue the large group reflection instead, and it was there that the suggestion was generated that perhaps this event may become an annual opportunity for trainees to reflect. A task we would like to take forward.

General reflections on the day

There was a powerful feeling of connectedness created by the experience of meeting as a group, something that has been sorely missed during the times of Covid. For some of the attendees it was their first time visiting the Royal College of Psychiatrists and for many others it was the first time returning since the outbreak of the pandemic. As we reflected on the impact of Covid during recent years and the experience of fragmentation and loss, the experience of physical bodies in the room was a special emotional experience, which was warmly welcomed.

The topic of the day was by no means an easy one and carries a particular weight and heaviness for our profession. Something that stayed with us was the importance of having a space with others to reflect on suicide and patient death including experiences at the Coroner's Court. It is a terrain rich in persecutory anxiety and aloneness. Hearing others' experiences and feeling connected with our colleagues was enormously containing. There was also something quite refreshing about having a reflective space to think about patient deaths with an open heart and mind. It was also great to hear about work done by the Royal College of Psychiatrists in this area and the work of Dr Rachel Gibbons. Dr Gibbons will be talking to Essex Partnership University Trust MSC on the 16th of

February in relation to suicide and the Coroner's Court. For those interested, further information can be found in the references and further reading section below.

We would like to conclude this piece with a heartfelt thank you to Dr Burbridge-James for organising such an important event and to all the speakers who provided much food for thought. We would also like to thank all the delegates for attending and participating in the lively discussions. The value of reflective spaces can be easily overlooked in the current climate of ever-increasing workloads. However, we think that this reflective space was immensely valuable to those who attended.

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Support

We would like to signpost clinicians to the following resources if they feel they need additional support following the loss of a patient by suicide:

- The Practitioner Health Programme
- The Psychiatrists Support Service

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

Book Reviews

BOOK: Open Dialogue for Psychosis: Organising Mental Health Services to Prioritise Dialogue, Relationship and Meaning.

Putman, N Martindale, B. 2022. Routledge

A dialogue between Dr Richard Duggins, Consultant Psychiatrist in Psychotherapy, Newcastle upon Tyne, and Dr Brian Martindale, Psychoanalyst and retired Consultant Psychiatrist, co-editor of the book, Hon President of EFPP and former President of ISPS

What led you to be interested in Open Dialogue for Psychosis as a psychiatrist and psychotherapist?

When I first became a Consultant Psychiatrist in Psychotherapy in an outpatient service back in 1983, we could easily have had a notice on the door that said something like '*No psychosis here*'. This was in the days in the UK that, broadly speaking, general psychiatrists saw people with 'severe' mental illness and psychotherapy services saw people with 'neuroses'. However, the scales came from my eyes when in 1991, I went to Stockholm for an international conference of the ISPS (now called the International Society for the Psychological and Social Approaches to Psychosis). I heard multiple presentations of psychological and family interventions for people experiencing psychosis.

To keep my response to your question relatively short, from then I became more and more clinically and theoretically interested in the whole area of psychosis such that, when Early Intervention in Psychosis teams were introduced in the UK in the late 1990s, I was successful in becoming the general psychiatrist to an EIP service and one could say that there was from then a notice on our door saying '*Only people experiencing psychosis welcome here'*!! This reflected a complete transformation in my mind set.

Central to my capacity to function in this team was my clinical familiarity with the need-adapted approach to 'schizophrenia' as espoused by the late Professor Yrjö Alanen (Alanen, 1997), who was professor of psychiatry in Turku, Finland and a psychoanalyst. He led the transformation of Finnish psychosis services and went on to get the World Psychiatric Association Pinel Prize for Psychiatry for the Person. He became a good friend as was Professor Johan Cullberg who led the well-known Swedish Parachute Project, a researched clinical approach for early intervention in psychosis (Svedberg et al. 2001) He also wrote a very important and useful book. Psychosis: An Integrative Approach (Cullberg, 2006).

Coming to the end of your question, a key aspect of these approaches was their family orientation. The research outcomes were very favourable and one of Alanen's pupils Professor Jukka Aaltonen went on to supervise what became known as the Open Dialogue project in Western Lapland which was a development of Alanen and Cullberg's work. The Open Dialogue approach has had remarkably good outcomes (Seikkula et al, 2006) with follow ups now lasting 19 years (Bergstrom et al. 2018). There is a great reduction in both hospitalisation and need for neuroleptics and most importantly a striking return to work and studying, counteracting the usual widespread pessimism towards long term outcomes in psychosis.

Why do you think Consultant Medical Psychotherapists might wish to read this book?

I think one of the worrying things for me about many psychotherapy trainings was the lack of enough experience and confidence in working with more than one person in a room. So, I think this book will appeal to anyone who is even the slightest interested in working with families and with psychosis and with supporting psychiatric teams.

I was more fortunate than many to have had plenty of experience of working with families from the beginning of my psychiatric training and I had some excellent supervision later in my work with psychosis, continuing well after I became a consultant psychotherapist. It may be of value to readers that I gradually increased my experience of psychosis whilst still working in a traditional psychotherapy service. I ran a group for many years for day hospital patients and regularly saw an individual patient with psychosis and prior, to being appointed to the early intervention service, worked with several families where a member was experiencing psychosis. So, I think this book, with its detailed clinical example of the Open Dialogue approach, and its careful spelling out of the core principles will be most encouraging.

Who else might find the book helpful?

I think any one working in UK mental health services will find this book eye opening. Perhaps it is a good book to be read by teams who are wanting to shift their work to a more family inclusive approach. A key point of an Open Dialogue service is that the very first meeting involves the social network of the person about whom there is concern. This eliminates any concerns about confidentiality that can be are used as a reason for not involving families; furthermore good work with a family better supports later individual work if needed. Family members are very welcoming of this book as are people with lived experience. In fact a number of those chapters that describe the experience of OD are co-authored by such persons.

In Italy a national OD project is underway and in the feasibility studies managers were key persons in the initial training, so managers who are hearing about OD in the UK will benefit from reading the book and come to understand the purpose of the approach and read about its introduction in different ways in different countries and they can read the section on research outcomes.

An important point to bear in mind is that Open Dialogue is not just an approach for psychosis. In Western Lapland the whole psychiatric service is based on Open Dialogue principles. It just happens that it is the group of people who experience psychosis whose outcomes have been so thoroughly researched

What are the opportunities for Open Dialogue for Psychosis in the UK and what are the barriers in your opinion?

I think the key thing is to learn from the mistakes of the past when family approaches have been espoused. The evidence for the benefits of family approaches in psychosis has been available in the UK for more than four decades and the late Professor Julian Leff was especially responsible for some of the best evidence. However, making a service family orientated needs systemic changes. We know that there is little point in sending a couple of people away to do a family training and then making no reorganisations to allow this to be properly practised in terms of working hours, working place and ongoing supervision. This goes back to the leadership of teams. If those in charge have no good depth experience of family work and are at worst antipathetic to families, other team members so trained will soon become disillusioned.

As Open Dialogue is becoming better known, there is considerable clamour for it. Professor Russell Razzaque (2022) is leading a very large research project into Open Dialogue involving several trusts using a cluster approach (in which whole teams are randomly allocated and the experimental team trained). People involved in Nice Guidance are behind some of the research design. If the results are favourable then there should be much greater opportunities for Open Dialogue to be rolled out. But I cannot emphasise how much the state of mind and experience of leaders is in determining the kind of service on offer.

I do think there are great opportunities here for psychiatrists who have done the dual training in general psychiatry and psychotherapy to offer themselves as leaders in community mental health and EIP teams and help shift the pendulum back to a psychosocial understanding of mental distress and OD is an excellent vehicle for that.

In the UK, one of the key systemic problems to introducing the full monty of OD is the division into psychosis and non-psychosis teams and also the finite length of time people remain in, for example, early intervention in psychosis teams. This is a problem in that one of the core principles of OD (that leads to its effectiveness) is psychological continuity of therapeutic relationships as long as needed. One person with an acute psychosis might be able to diminish contact after a few months, others may need something that helps them through developmental phases or repeated developmental challenges over some years.

Do you have any reservations about the Open Dialogue approach?

I do have a few concerns. My first concern is about training. There have been many promising psychological approaches that have fallen by the wayside. Working with psychosis and with families is sometimes very stressful and one has to manage a lot in oneself. So, the training has to be long enough and deep enough. Practitioners also need a support structure that allows ongoing peer reflection. Those that have done the training have greatly valued the opportunity to reflect on their own families of origin and how this influences them positively and problematically in their work. So, in my view, the selection for training needs to be careful and the training itself has to be of a good standard and not diluted.

My second concern is that Open Dialogue came out of applied psychoanalysis. I was concerned that some core concepts of psychoanalysis relevant to psychotic manifestations, such as familiarity with primary process thinking, are not part of the training. The rationale for this is that the overall function and skill of OD team workers is to support the members of the OD network develop their own expertise and to not be there offering themselves as experts, except as expert facilitators of dialogue. I think this can be carried too far and that, without familiarity with such phenomena as primary process logic, practitioners may be somewhat handicapped in that facilitation. Primary process logic is absolutely central to the formation of psychotic symptomatology (Martindale & Summers, 2013).

My final point is perhaps a general scepticism about our society that is too dominated by self-interest and short termism. In psychiatry, how hard it will be to shift the dominant paradigm in which the pharmaceutical industry readily feeds the need for diagnosis and medication for everything that squeaks. On that note perhaps it is better for me to stop now…

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8. Svedberg, B, et al (2001) First episode non-affective psychosis in a total urban population: A five-year follow-up. Social Psychiatry and Psychiatric Epidemiology: 36, 332-337.
doi: 10.1007/s001270170037.

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 looking for a medical psychotherapist or higher trainee in medical psychotherapy to review the book:

Don't Turn Away: Stories of Troubled Minds in Fractured Times

by Penelope Campling

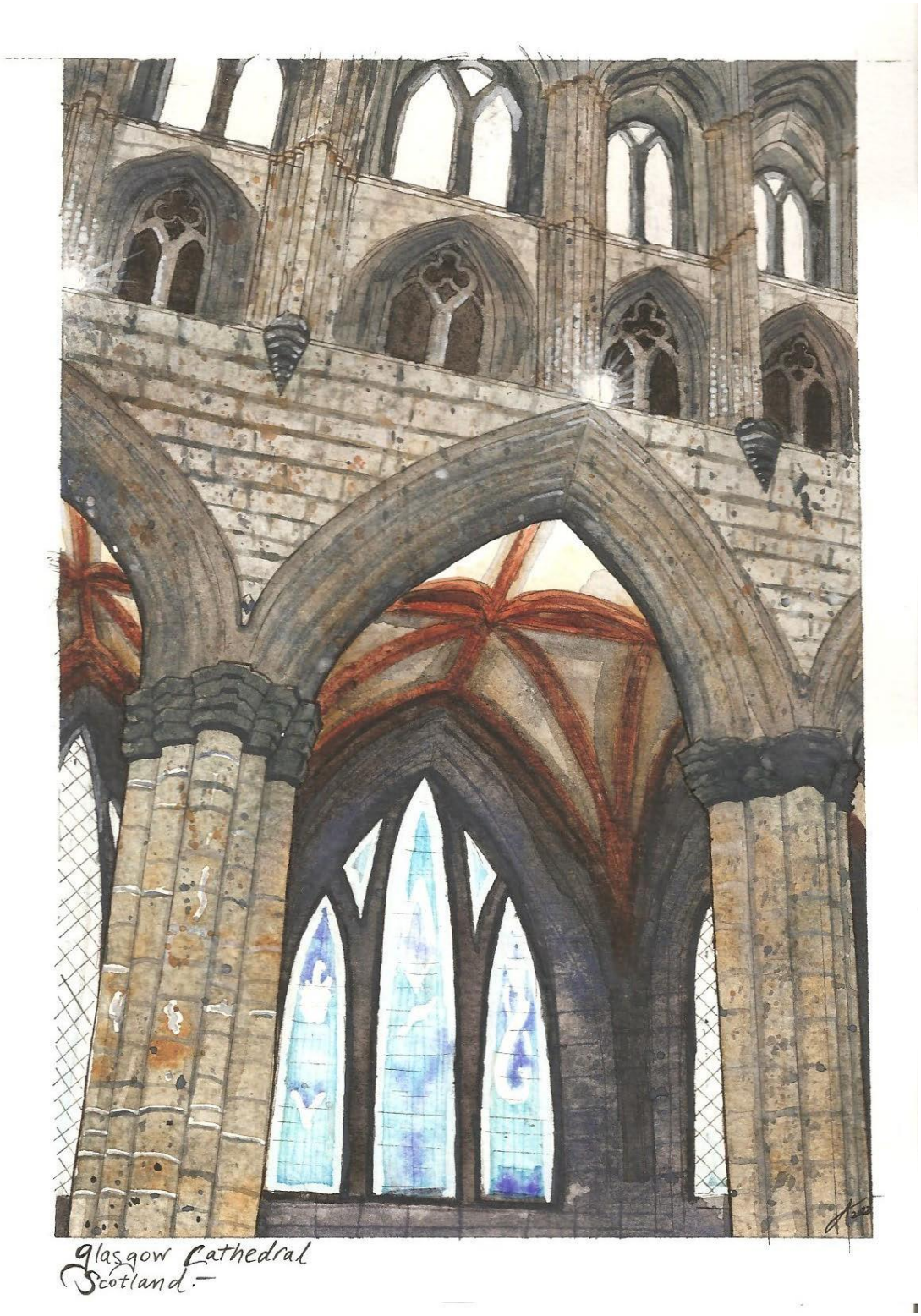
We are also keen to hear from you if you have an idea for a review, want to share books you wouldn't do without/ classics revisited/ hidden gems; a series for discussion or other contributions to make.

We are able to negotiate access to review copies of books in many cases. Please therefore, if this is something you are interested in helping to take forward, send an email to the Book review editors Dan Beales and Andrew Shepherd, via Hayley Shaw Hayley.Shaw@rcpsych.ac.uk or Pamela Peters pamela.peters@cpft.nhs.uk.

Poetry/Art contributions

Glasgow cathedral (watercolour)

Dr Amarenna Guevara Celsi
CT3 Psychiatry, NHS Greater Glasgow & Clyde, Scotland



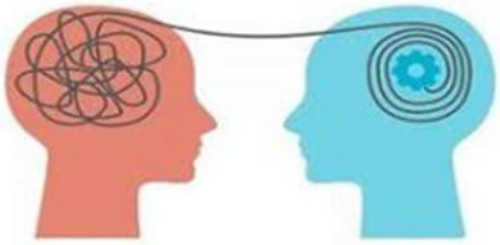
Poem

Dr Anna Crozier
ST7 dual trainee in Adult Psychiatry & Medical Psychotherapy, EPUT

Dear Miomir

Dear Miomir, where do I start?
You have been such a very large part
of my life. In a way
It is hard to convey
The place that you hold in my heart

You supported me in my career
When beset with irrational fears
You interpreted doubts
Believed in my clout
Your faith in me's why I'm still here



"Have therapy" you said. You weren't wrong
My children *will* gain their lives long
And despite my concern
You'll be happy to learn
My marriage is still going strong!

You taught me that life is to tend
To relations with family and friends
And emotional pain
For patients the same
Needs real understanding to mend

And you showed me there's nothing above
Feeling accepted and loved
Secure in oneself
Might achieve nothing else
Yet, to have this is more than enough

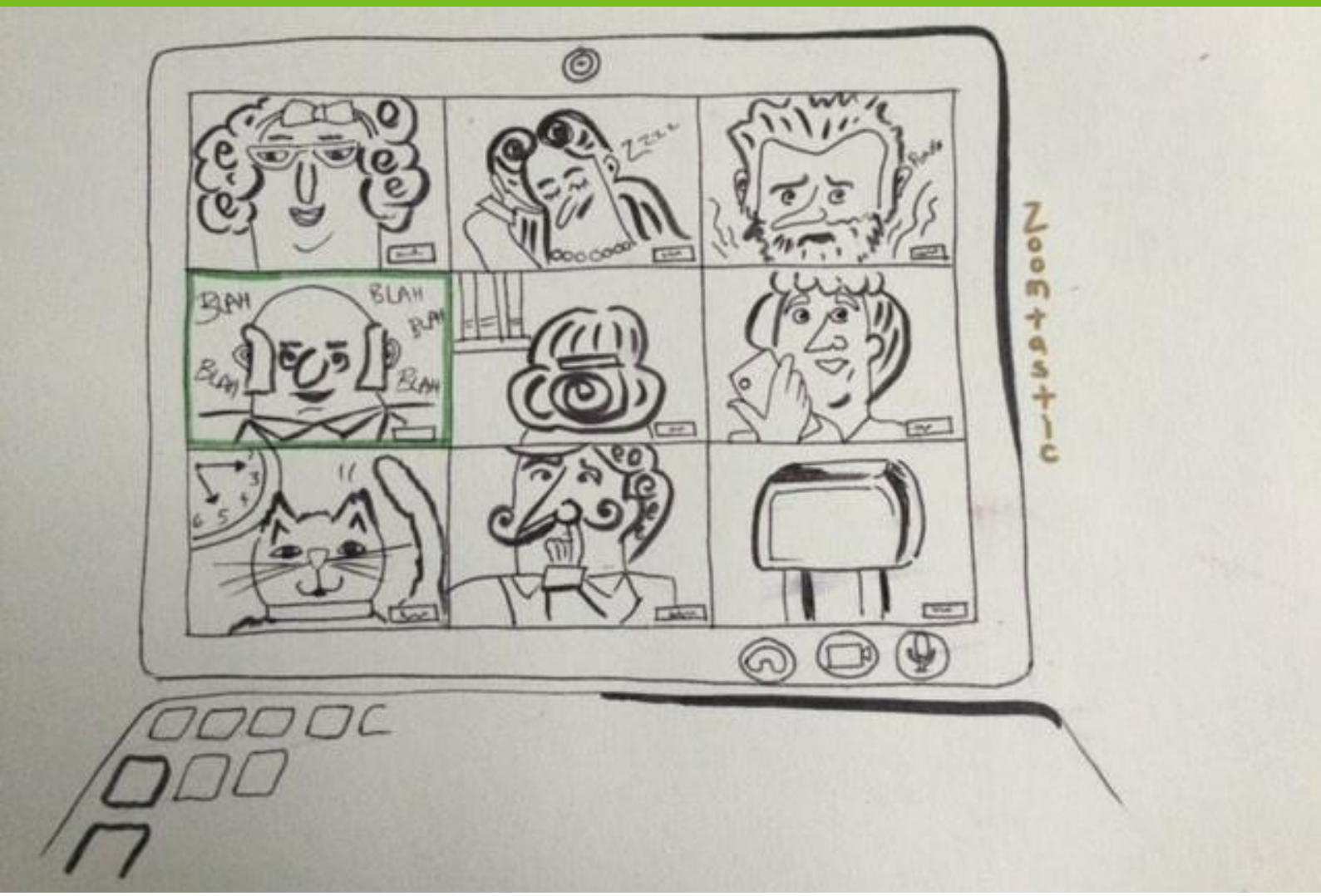
So goodbye to you Miomir
I'll miss you when you are not here
Don't want a new boss
Your leaving's a loss
But your legend will live on for years.....

Dr Anna Crozier, ST7 dual trainee in Adult Psychiatry & Medical Psychotherapy, EPUT.

For Dr Miomir Milovanovic, Consultant Psychiatrist & Psychoanalyst, who retired from EPUT in December 2022

Zoomtastic

Dr Jenissa Tanna
Consultant Psychiatrist in Medical Psychotherapy, South West London and St Georges University Hospital



Update: The Cassel Hospital

Dr Miriam Barret

The Cassel Hospital was founded in 1919 by Sir Ernest Cassel as a private psychiatric hospital to treat civilians who had been traumatised by the First World War. Today, more than 100 years on, The Cassel Hospital is a national NHS Tier 4 service in Richmond, Surrey, which has decades of experience in providing assessment and treatment for young people and adults with emerging and severe personality disorder, or complex needs, on an inpatient and outpatient basis.

Importantly, as a national Tier 4 service, there is national funding for patients from England which may not be widely known. This means that local mental health services in England can refer patients for treatment, with no need to apply for funding and without costs to their local health budgets. We also accept patients from Wales, Scotland, Northern Ireland and the Republic of Ireland.

We offer the following to our patients:

- A stable and containing setting where patients' complex difficulties can be thought about in depth and made sense of together
- Providing formulations of our patients' troubles that include unconscious dynamics and inform treatment recommendations
- Knowing that there are healthy parts to all our patients which we actively support whilst working together on what ails them
- A living learning environment where patients are a vital part of their own and each other's treatment

- Providing hope and bringing about effective change in patients' relationships and social functioning
- A treatment that is evidence-based and nationally funded (for patients from England), plus 3 beds for patients from other parts of the UK and the Republic of Ireland (on a cost per case basis)

We welcome referrals from diverse backgrounds and are keen to ensure that our community is representative of the population at large.

Our revised referral criteria are as follows:

Inclusion Criteria

- Age 17.5 years and above at time of referral, 18 years by time of admission
- Diagnosis of Emerging or Severe Personality Disorder or Complex Emotional Needs
- Need for a Tier 4 service due to local mental health services being unable to meet the patient's needs
- The referral has the support of the local Consultant Psychiatrist and agreement from the regional NHS England specialist commissioner
- At point of admission the patient has a home where they can return to at weekends

Exclusion Criteria

- Active risk to others
- Acute substance addiction

Please feel free to contact us, if you would like to discuss a potential referral or are interested in coming for a half-day visit.

For further information please see Cassel Hospital :: West London NHS Trust

Dr Miriam Barrett, Consultant Psychiatrist & Medical Psychotherapist, Inpatient Service (Miriam.Barrett@westlondon.nhs.uk) and
Dr Kimberley Barlow, Clinical Lead and Consultant Psychiatrist, Outreach Service (Kimberley.Barlow@westlondon.nhs.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. We have recently released episodes focusing on psychotherapeutic concepts and technique and one where our guest discusses their experience of DBT.

These are the most recent episodes, and they are free to listen to on many different podcast platforms, Spotify links are provided:

Lived Experience #4: Anxiety, Depression, DBT and Navigating the Mental Health System
Our host, Alex, sits down with Katie to talk about her experiences getting treatment from the mental health system, including CBT, psychodynamic therapy, DBT, crisis visits to A & E and medication. They also discuss issues around diagnosis (including depression, anxiety, autism and emotionally unstable personality disorder). They talk about what helped Katie make deeper meaningful changes and how this has put her in a position where she can now help others.

All platforms:
https://podfollow.com/1466932169/episode/76d43577f4f691db5d7bf546f53145b3b9ececde/view
Spotify:
https://open.spotify.com/episode/2udbgEDQz5anP9l8s0Cu82?si=63141a4ce3a440d5

Interview #43: How Does Therapy Work? (with Dr Martha Stark)
This episode discusses psychotherapeutic/psychoanalytic theory and technique.

All platforms:
https://podfollow.com/1466932169/episode/e987de4d632887a6c45d6c7905737c1c20bd1167/view
Spotify: https://open.spotify.com/episode/59aq0e4fpg4yY9BOTz6Zkv?si=3d23f05912174ffc

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 last Thursday of the month at 5.30-7 pm. If you would like to join, please contact Hayley Shaw so that your email address can be passed to Mark Morris.

RCPsych library

Need access to online journals and other resources?
The College Library provides a wide range of library services to members, primarily OpenAthens accounts to help you access research online. The collection is built on member recommendations, so if you can't find something you need, just let us know and we can look into adding it to the collections.

Databases: the College provides access for members to Medline, PsychINFO and Embase.
Journals: some examples include: Lancet Psychiatry, the American Journal of Psychiatry and European Psychiatry.
Books: we have a physical library and members are welcome to borrow books, which we will send out in the post for free. We also provide access to online versions of the **BNF** and the **Maudsley Prescribing Guidelines**.

For any articles not available through our own subscriptions, we offer inter-library loans, finding what you need in another library and sending it out to you by email.

We also offer a free and unlimited literature searching service for those who do not have the time or confidence to search through the medical databases. This can also be combined with training for anyone who wants to refresh their skills.

You can find all these resources on the College website:
www.rcpsych.ac.uk/library
Or get in touch with us directly:
infoservices@rcpsych.ac.uk
020 8618 4099

Call for submissions

Many thanks to all who have contributed to this newsletter. Please continue to send in contributions over the next few months for the autumn edition. The deadline for submissions is **4 September 2023.**

Contributions or enquiries can be sent to me, Pamela Peters, at pamela.peters@cpft.nhs.uk
or to sub-editors via Hayley Shaw at Hayley.Shaw@rcpsych.ac.uk.