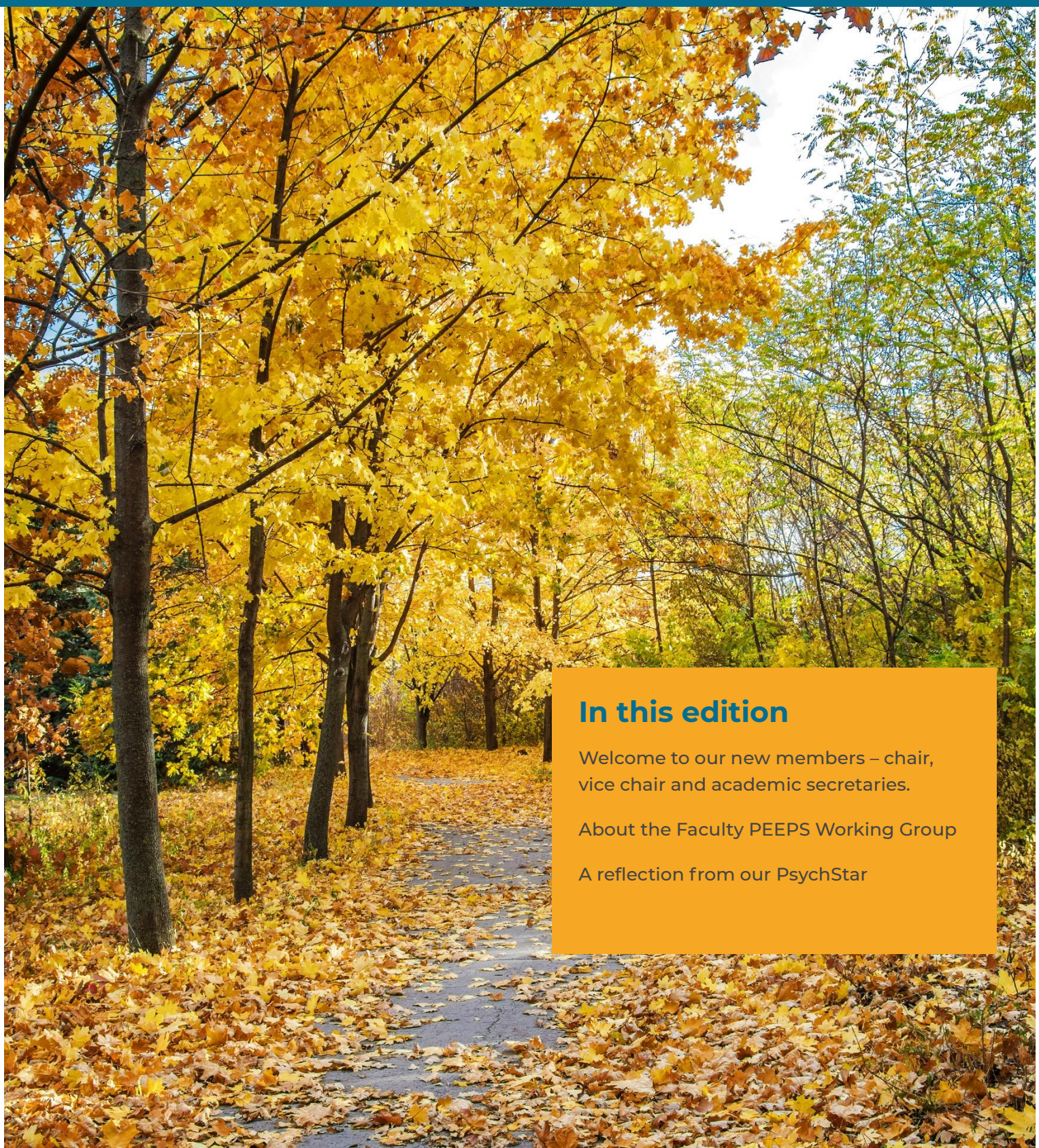
Faculty of Medical Psychotherapy

Newsletter

Autumn 2026

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS



In this edition

Welcome to our new members – chair, vice chair and academic secretaries.

About the Faculty PEEPS Working Group

A reflection from our PsychStar

Contents

Editorial 3

Chairs Message 3

Vice Chair's message 5

Two days in the City of Dreaming Spires – The Annual Faculty Conference in Oxford 6

Medical Psychotherapy Research Day event 7

The Faculty PEEPS Working Group 9

NRCSA Position Statement August 2026– How did we get here? 10

Between Philosophy and Psychotherapy: a brief account of imagination in self-change 12

Trainee Voices 13

Book Review 20

Adverts, events and Call for submissions 22

Editorial



Welcome to the Autumn edition of the faculty newsletter.

Autumn is visibly a time of transition and change in nature and if we are lucky, we might see glorious scenes of autumnal trees as depicted in our cover photo. It can be a time that we tend to return to business as usual after the long light days of the Summer

This has might also reflect transitions in our own working lives like it does for me as this Autumn's newsletter is my very first in the role as editor.

This season's edition is also an introduction and warm welcome to new post holders within the Medical Psychotherapy faculty with messages from our new Chair, Jessica Yakeley and our Vice Chair, Vikram Luthra. There is also a section from our new Academic secretaries who will be organising events for the faculty for the next term.

We will look at some of the influential work of the faculty in articles by Jo Stubley and Maria Eyres on the NRCSA position statement and Katherine Coulthard on the PEEPS working group.

And finally, not to forget the voices of those of you out there in training– we are featuring an article from Filip, our Psych Star from last year with reflections of his experience, amongst other contributions. Penny Camping also gives us something to think about with her review of the much renowned book "Personally Speaking".

I hope you enjoy this edition with its wealth of material to keep you warm as the nights draw in. I look forward to bringing you more in the Spring!

Parveen Bains
Newsletter Editor

Chair's Message



I am delighted and honoured to be the incoming Chair of the Medical Psychotherapy Faculty. I have been a Consultant Medical and Forensic Psychotherapist for over 20 years, including working in both a secondary care psychotherapy service and a national specialist forensic psychotherapy service. Having previously being a member and then Vice Chair of the Medical Psychotherapy Faculty until four years ago, it is great to be back, although taking over from the outgoing Chair, Jo O'Reilly, feels quite daunting!

We have plenty of reasons to be proud of our specialty. Medical psychotherapy lies at the heart of psychiatry. As medical psychotherapists, we are triply trained as doctors, psychiatrists and psychotherapists. Thus, our expertise in the body, brain and mind enables us to integrate the physical and psychological, neuroscientific findings with psychological processes, and the evidence base of a range of psychological therapies with therapeutic patient contact. Promoting the central therapeutic value of relationships and a developmental perspective of mental health and illness we offer meaningful psychological interventions for the complexities and comorbidities of mental disorders. We hold a central role, not only in the training of all psychiatrists, but also in the delivery of psychological treatments; running Balint groups and other reflective practice interventions; offering consultations and formulations to teams and organisations; conducting research; and providing strategic leadership. But there is work to be done: psychological therapy and trauma services remain patchy across the UK in the face of increased patient need, there are too few medical psychotherapists, training in the specialty is sub-optimal in some regions, much of the mental health workforce is overstretched and demoralised, and the psychiatry profession

remains at risk of devaluing the psychosocial in favour of the biological.

Jo, together with her Vice Chair, Rachel Gibbons, and their colleagues on the Faculty Executive Committee, have achieved a huge amount to address these issues during the last four years. This has included working with other faculties in the College to produce guidance and teaching materials on biopsychosocial formulation in psychiatry; position statements on reflective practice, psychedelic and related substances, the impact of non-recent child sexual abuse on the mental health of adults, and the menopause; guidance on supporting psychiatrists affected by patient suicide and homicide; and contributing to the College's work on assisted dying. Judith Mirsky, Chair of the Specialty Advisory Committee (SAC), with Jo and other members of the SAC, has achieved a phenomenal output in matters of training, including developing specialty specific guidance for the portfolio route in medical psychotherapy, producing resident doctor psychotherapy capability guidance, rewriting the Paper B psychotherapy syllabus, updating exam questions and honing workplace-based assessments. Medical psychotherapy contributions to the field have been showcased and well received in the Annual Residential, Psychodynamic Psychiatry Day, Trainer and Trainee, and Research in Psychotherapy conferences respectively. Active working groups have been established in a range of key areas, including workforce, quality standards for psychotherapy services, adademic and research, conference planning, medical education, sustainability, artificial intellience, well-being, and PEEPS - partially represented, emerging, and evidence based psychotherapies. This latter working group was established to strengthen the representation of psychological therapies other than psychodynamic across the faculty, SAC, exams, curriculum, research, conferences, and faculty communication, and this is one of my priorities over the next four years.

Another key priority is workforce expansion - the urgent need to increase the number of consultant posts in medical psychotherapy, as well as resident doctors in the specialty. I have already had individual meetings with the College President, Subodh Dave, and the Registrar, Owen Bowden Jones, and Vikram, Judith and I are engaged in a series of meetings with the Dean, Nandini Chakraborty. All recognise the paucity of consultant medical psychotherapists across the UK, as well as lack of psychotherapeutic skills within the psychiatric workforce, but we must address these gaps without compromising the central place of consultant medical psychotherapists in training and service provsion, and thus any work on credentialling and other initiatives must be approached with caution.

The President is also keen that all faculties align their work with his seven priority areas for the College: clinical effectiveness, safer mental health services, applying research, early life mental health, wider determinants of mental health, physical activity and lifestyle determinants, and integrated care. I think that the areas of work that we have highlighted in our own faculty strategy will complement and contribute to the College's objectives nicely.

I am therefore excited to continue to address these issues over the next four years, working closely with the newly elected Vice Chair, Vikram Luthra, and the other members of the executive committee including the resident doctor, patient, and carer representatives, respectively. Medical psychotherapy may be one of the smallest psychiatric specialties in terms of numbers of consultant and trainee posts, but the faculty has one of the largest memberships of all the faculties, which is surely evidence of the huge interest and support for psychotherapetic, psychological and relational approaches to psychiatry.

Jessica Yakeley
Faculty Chair

Vice Chair's message



I am honoured to have been elected Vice-chair of the Medical Psychotherapy Faculty. I am a dual-trained Consultant Psychiatrist in Medical Psychotherapy and a trained Psychoanalyst, working in a large NHS Medical Psychotherapy service in Leeds. I previously worked as an inpatient consultant on a female acute ward. I am also Clinical Lead for a regional Doctors in Difficulty service in Yorkshire and Humber, Joint Training Programme Director for Medical Psychotherapy in the region and have recently stepped down as Joint President of the UK Balint Society. My clinical and leadership interests include doctors' wellbeing and the development of reflective practice across the medical workforce. I see both as central to the identity and contribution of medical psychotherapy.

Within the Faculty, I have co-organised six national conferences and served as Academic co-secretary, helping to ensure excellent academic content while developing new opportunities for engagement. It has been a great pleasure to work with Sophie Atwood, Parveen Bains and Anne Cooper, over my term. I now look forward to supporting the current secretaries, Haroula Konstantinidou and Pamela Peters; I am already aware they have exciting plans for the coming years.

While on the Faculty, I have also represented medical psychotherapy on the National Psychological Professions working group within NHS England, alongside several other Faculty workstreams, including redrafting the CR207 *Job Planning for Psychiatrists* document and developing the Medical Students website. Within the College, I am a CASC examiner and sit on the CASC writing panel. There has recently been a call for more medical psychotherapy representatives on the panel so please do consider applying. If we are to keep psychotherapy at the forefront of every psychiatrist's mind, we need robust representation across the College in various roles.

Having served on the Faculty Executive for six years, I have developed a strong understanding of our strategic priorities, current workstream and future projects that the previous Chair (Jo O'Reilly) and Vice-chair (Rachel Gibbons) worked phenomenally hard to establish. I would like to also thank them for them support, advice and guidance during my term on the Faculty executive.

Over our term as Chair and Vice-chair, I hope we can maintain and strengthen the five strategic pillars: patient care; workforce; education and training; academic and research; and communication and influence. I would encourage everyone to read these in detail. There is much work to do, and we will need colleagues' help, whether on the Executive, the SAC or across the wider Faculty.

Finally, I look forward to working with and supporting our Chair, Jessica Yakeley, over the next four years. I know that Jessica and I are proud to serve the Faculty and will continue to work hard on your behalf.

Vikram Luthra
Vice Chair

Two days in the City of Dreaming Spires – The Annual Faculty Conference in Oxford

by Parveen Bains, Sophie Attwood, Vikram Luthra and Anne Cooper (outgoing academic secretaries)

This year's conference took place on 3rd to 4th September at Lady Margaret Hall College in Oxford on the theme of Body Mind Integration. The venue was a welcome change from the more corporate feel of the College building lending the event a warmer, more collegiate atmosphere.



This was reflected in the sense of togetherness felt throughout the two days supported by the reflective large groups which were deftly facilitated by Alasdair Forrest, and compassion workshops led by Beena Rajkumar and Graeme Whitfield

There were talks from a wide range of speakers based in the Thames Valley region and beyond. We kicked off with a controversial but contemporary topic around the juxtaposition of the use of psychotherapy alongside psychedelics in the treatment of depression, with contributions from Guy Goodwin and Jonny Martell, leaders on both sides of the debate, and from a service user who had completed a course. As usual we would have liked more time to discuss! But we had more stimulating talks that morning from both Gwen Adshead and Anna Motz looking at female offenders and the childhood adversity underlying this, from two different angles.

There was also a retelling of the tale of how a local service for Medically Unexplained symptoms was decommissioned by Alexis Economou and Phil Davidson. This was creatively presented in the format of Greek Theatre.

After a fantastic barbecue social in the college gardens- luckily the weather remained dry amongst a rare wet patch this summer- we were back the next morning for our AGM, led by our new Chair Jessica, before moving on to more presentations.

We loved hearing the perspective of Rageshri, a sexual health doctor who has published a book about her experience of being unheard, as a female and Southeast Asian woman. But perhaps the highlight for most was the incredibly moving talk by Susan, a Group Analyst, with a visible physical disability, who talked with warmth and humour of some of the lifelong hardships she has faced.



After an active four years, we, the previous Academic Secretaries, Parveen, Vikram, Sophie and Anne (main picture) finished our term with a flourish. We enjoyed working this year alongside our excellent trainee representative, Georgina Corbett Burcher (pictured above) to deliver our final conference for the faculty. As we hang up our event organising hats and move on, it just remains for us to say goodbye from the four of us and...

Welcome to our new Academic Secretaries – Haroula Konstantinidou and Pamela Peters

Haroula: I remember as a core trainee attending the medical psychotherapy conferences. They were a significant milestone event of the year. I felt inspired and mesmerised by the presentations mostly as they enabled me to find meaning in my work, making me a better clinician.



I equally enjoyed the networking and social spaces where I got a better insight into the secret lives of my trainers! The laughs, the creativity, the ideas, the inspiration. I felt a sense of family and belonging.

I am therefore really excited to take over hosting the faculty's events and I would love to recreate this sense of family and belonging which nurtures us throughout the year.

Pam: I too am very excited to take up the opportunity of Academic Secretary of our faculty together with Haroula. Like her, I have a long history in the faculty from the early days of training and love the buzz and the sense of nourishment I get from our conferences. Meeting colleagues and peers, including the newer faculty members and trainees, as well as our patient and carer reps, other interested individuals and speakers, is a deeply fulfilling and fun experience. Being part of the committee creating this space is such a privilege.

We are grateful to Vikram, Parveen, Sophie and Anne for their hard work and the handover: we could say "sit back and relax" but we may need your help from time to time!

For the conferences: you can expect a focus on clinical cases and a true integration of clinical material with research and science. You can

expect events on psychotherapeutic psychiatry and interdisciplinary dialogues, pushing our thinking outside of our own disciplines and tribes.

We have almost finalised the programme for the April 2027 conference, and we are lucky to be joined by faculty exec members Katharine Coulthard, Consultant Medical Psychotherapist in CBT and Zainab Hameed, dual trainee and trainee rep. The first day of the conference will open with a very impactful account of a clinician and his ex-patient, describing the vicissitudes of their long-term relationship. We will examine the varied aspects of the therapeutic relationship, focusing on ruptures and repairs and we will learn how different therapy modalities address conflict within and outside of the consulting room. The programme will be finalised shortly but for now SAVE THE DATES: an evening lecture on the 14th of April and two full days on the 15TH AND 16TH OF April 2027 at the college.

We look forward to seeing you there!

Haroula Konstantinidou and Pamela Peters

Academic Secretaries

The Medical Psychotherapy Conference 14th to 16th April 2027, London

Faculty of Medical Psychotherapy Annual Conference 2027

Medical Psychotherapy Research Day event, 13th July 2026

by Giles Story and Vikram Luthra

We were pleased to host the inaugural Medical Psychotherapy Research Day on 13 July, held at the College premises. The event was titled 'Psychotherapy Research: Evidence and its Discontents'. It attracted a diverse range of attendees, including psychiatry residents and consultants, alongside non-medical therapists, academics and representatives from governing bodies.

An opening keynote by Farhad Dalal, group analyst and author, critiqued the claims of outcome statistics and the way in which "success" can be presented in research, with reference to CBT research. He questioned whether objective measurement is even possible in psychotherapy. This was followed by an engaging conversational session with Liz

Allison, Director of the UCL Psychoanalysis Unit, and Emma Hotopf, Clinical Lead of the Maudsley Self-Harm Service, who discussed the epistemology of psychoanalysis and the merits of outcome data based on functioning rather than symptoms. The session concluded with a case study from the Self-Harm Outpatient Service. Tobias Nolte (UCL) closed the morning's talks with an overview of the concept of mentalising, drawing on three decades of research and clinical practice to consider its implications for psychotherapy, assessment and future research. The morning session ended with a lively panel discussion involving all the speakers.

Jessica Yakeley, Faculty Chair and Clinical Lead of the Portman Clinic, opened the afternoon session with an account of her journey into research, highlighting her national work on MBT for antisocial personality disorder in male offenders. Florian Ruths, consultant psychiatrist leading the Maudsley Schema Therapy Service, presented a case for empiricism in therapy research, with reference to his own research in mindfulness-based cognitive therapy.

Jennifer Dunn, Faculty Core Trainee Representative, presented her research on attitudes to personal therapy among 1,100 psychiatrists nationally, stressing the importance of space to maintain both wellbeing and clinical practice. Her talk concluded with tips for doctors starting out in research.

Subsequent panel discussion included reflections on the art of interpolating between individual and group-level data. The day ended with a well-attended experiential large group; an opportunity for delegates to reflect on the rich perspectives that emerged during the event.

We are grateful to the events team for their support in ensuring the smooth running of the day.

We hope that the research event will return in the future.

Giles Story
Academic Working Group Lead

Vikram Luthra

Vice-Chair of the Faculty

The Faculty PEEPS Working Group

By Katharine Coulthard



The PEEPS (partially represented evidence based and emerging psychotherapies) working group has been set up.

There is currently a significant imbalance in the representation of psychotherapeutic modalities within the RCPsych psychotherapy faculty committee and the medical psychotherapy workforce. In July 2026 out of 30 committee members only 3 had CBT as their major modality, and 1 had a systemic training. Within the medical psychotherapy work force out of approximately 140 medical psychotherapy posts within the UK, around 13 have CBT as a major modality, and none have systemic. There are only 5 current CBT major modality higher training posts in psychotherapy and 2 in systemic, a small proportion of the overall number.

This position contrasts starkly with the relative balance of recommendations for psychological input within clinical guidelines such as NICE. Given the lack of systemic representation on the faculty, it is likely there is an absence of children and family perspectives being heard. There is a substantial population need and limited public resources. Therefore, it is particularly important that cost effective and evidence-based interventions are adequately represented within the psychiatric and medical psychotherapy communities.

Outcomes for service users will be improved if psychiatrists are psychologically skilled professionals, who can provide holistic care. This involves integrating an understanding of biological, psychological and social issues, the ability to provide and signpost to evidence based and up to date psychological therapies, as well as being able to use the most relevant therapeutic techniques and types of formulation.

Psychiatrists will be more effective working within and leading teams if they have a good understanding of a diverse and evidence-based range of psychotherapeutic modalities.

Currently a proportion of resident doctors at core and speciality level are having difficulties accessing training experiences and supervision to meet curriculum requirements. Given pressures on other professionals within the NHS it is important that delivery is supported by a balanced medical psychotherapy workforce.

For some areas of medical psychotherapy (CBT and systemic) this is an existential issue. Based on the estimated workforce numbers there is no mechanism within the current system by which this situation can be sufficiently changed.

The working group is advocating for a balanced representation of psychotherapeutic modalities, particularly those with a strong evidence base, within the Royal College broadly, including RCPsych medical psychotherapy committee membership, training events, working groups and within the workforce of medical psychotherapists. We will be exploring all options to try and achieve this, including working more closely with other college faculties, alternative higher training options and promoting the SSG route. There is a planned survey of resident doctors training experiences. If you are interested in joining the working group, particularly if you are a resident doctor or member of another faculty please contact me.

Author details

Katharine Coulthard
Consultant Psychiatrist in Medical Psychotherapy, Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust

Lead for PEEPS working group, Medical Psychotherapy Faculty

Email katharine.coulthard1@cntw.nhs.uk.

NRCSA Position Statement August 2026– How did we get here?

By Jo Stubley and Maria Eyres

Giving Victims a Voice in 2013 was the official response to the Jimmy Savile scandal, detailing the findings of Operation Yewtree and written in partnership with the NSPCC. The aftermath of



the uncovering of the unprecedented and horrific scale of child sexual abuse committed over 50 years and likely involving over 400 victims was interesting. This "national treasure" had hidden in plain sight within the highest reaches of celebrity and power and yet so many people repeatedly described how, of course, everyone knew. This level of disavowal – a knowing and not-knowing – at a national and societal level reflects a common dynamic related to child sexual abuse, linked perhaps to the human response of wishing to turn away from the reality of this atrocity and violation of human rights. Numerous other police investigations followed, including those addressing decades of child sexual exploitation.

At the time, we were both on the executive of the psychotherapy faculty of the college. The faculty chair was setting up several task groups. Despite the media attention directed to the topic of child sexual abuse, it was noticeable that the college did not appear to be contributing to this discussion in any meaningful way. We therefore pushed to set up a task group on this subject. From 2014 until the publication of this position statement, we have journeyed together to attempt to bring a spotlight on NRCSA.

We began with various education activities, joined by some interested colleagues. A literature review addressing the prevalence of NRCSA in many mental health diagnoses ultimately served as the basis for the review in the publication of the position statement. Our experience of knocking on college doors to garner support during the early years was often painful. Inevitably the shame, stigma and silencing were felt to be located within us – these two women who were bringing this unpalatable subject that was of course known and acknowledged within mental health, but why did we need to bring it to the fore?

There was a gradually increasing interest in trauma in the wider field with the development of trauma-informed care, the impending addition of Complex PTSD in ICD 11 and a growing body of trauma research to draw on. The Independent inquiry into child sexual abuse (IICSA) began in 2015. IICSA's journey over the seven years until its final publications in 2022 highlighted to us the complex dynamics that may come into play when attempting to address this issue. The leadership crises, procedural breakdowns and internal politics might all be seen to mirror the institutional dynamics it was tasked with investigating.

One frequent response we would get from those in some position of authority and power was to ask – but what about false allegations? Not only did this serve to highlight serious failings in understanding the current literature, but it also emphasized the wish to turn away, to disavow.

By 2019 the college Policy and Public Affairs Committee had agreed to set up an Expert Reference Group (ERG), a commitment to funding that was an important step forward. Following due process for college ERGs brought us back to painful institutional dynamics around power imbalances as we watched a male psychiatrist with no expertise in NRCSA be given the chair. Representation from various faculties within the college was on a voluntary basis but this left the ERG with some enthusiasm for

learning but little expertise. Of particular concern was the usual process for gathering testimony from experts by experience. Survivors found themselves in a virtual room with strangers, being asked to give voice to their darkest moments, with little preparation or support.

All of this is not to criticise the college but to describe a recognition that at this time processes were not trauma informed. We found ourselves in the position of bystanders, knowing something is not right but, due to the power dynamics, struggling to find a voice. Recognizing that the ERG was not the right process for this work was aided by the college agreeing to additional representation from Survivors Voices – a non-profit, survivor-led charitable organization. The ERG was disbanded and a smaller working group was established.

The expertise, and personal and professional experience, of the survivors and professionals in the Working Group enabled us to appreciate together the impact and consequences of NRCSA at a deeper level, and to work towards more authentic co-pro-duction.

There were many times we thought the project had irreversibly stalled or that we could no longer give so much of our free time to something so painful and problematic. The dynamic interplay between the college representation, the survivors and we as the co-chairs would often seem to replay various traumatic scenarios of victim/ perpetrator/ bystander and rescuer. The Working Group needed additional time to address the complex dynamics that this topic inevitably generated, including engaging with external facilitation by an organisational consultant for a short period. The impact of the COVID-19 pandemic also played a role in the complexity of this work.

In 2024, after the Working Group developed a substantive draft of the position statement, there was an extensive process to seek views from across the College, as well as engaging with some external stakeholders. The Working Group received 290 comments, which were overwhelmingly positive and constructive. The Working Group spent time considering the feedback and making further revisions before a version was submitted for sign-off and approval for publication by the College.

We are grateful to the college for its courage and perseverance in seeing this project through, for learning and experiencing with us along the way. We would particularly like to thank George Roycroft who was with us throughout these long years and who opened himself to the emotional impact of the work whilst maintaining a steady, thoughtful presence. This project would not have been possible without the survivors who worked alongside us, challenging us and the college to get this right, holding the importance of an acknowledgement of harms within the mental health field for all survivors.

Author details

Maria Eyres

Consultant Medical Psychotherapist
Psychoanalytic Psychotherapist

DocHealth Independent

Jo Stubley

Consultant Medical Psychotherapist at the Tavistock and Portman NHS Trust.

Between Philosophy and Psychotherapy: a brief account of imagination in self-change

by Catia Guerra

This article is a brief reflection about the role of imagination in psychotherapy bringing together two main areas of knowledge—philosophy and psychoanalysis. For the philosopher L. A. Paul (2014), transformative experiences have two dimensions: epistemic and personal. An epistemically transformative experience teaches us something that we could not have learned before going through it. A personal transformative experience, by contrast, changes us at a deep and fundamental level—altering our core preferences, our understanding of our desires, or the kind of person we take ourselves to be. Therefore, a fully transformative experience is both epistemically and personally transformative. This distinction maps onto two functions of psychotherapy: knowing and becoming. Thomas Ogden (2019) distinguishes between what he calls an epistemic psychoanalysis, whose primary aim is to know and understand, and an ontological psychoanalysis, concerned with being and becoming. The two modes, however, are not alternatives. They coexist in a mutually enriching relationship. Considering psychotherapy, a transformative experience immediately raises a question: how, in adulthood, can someone willingly submit to a process that may transform them when they cannot know whether they will like the person they become? Although in the clinical setting this question can show up as resistance to therapy, it may also be an accurate description of a genuine epistemic problem: the patient cannot know what it would be like to be someone else without, in some sense, becoming someone else.

In philosophy, imagination has been conceptualised in various ways: as a skill, as a cognitive process or family of processes, or as an outcome. Contemporary philosophy has developed increasingly sophisticated accounts of imagination (Kind, 2016); however, these frameworks have rarely been brought into direct dialogue with psychotherapy. In Playing and Reality (1971), Donald Winnicott highlights both the problems of imagination describing a patient who is stuck in daydreaming, but also the potential of imagination and play as a resource for communication and growth. His idea of potential space - the intermediate area of experiencing that lies between fantasy and reality - allows precisely a space where play and imagination become possible. This concept can be understood as a state of mind constituted through a series of dialectical relationships—between fantasy and reality, me and not-me, symbol and symbolised—in which each pole creates, informs, and limits the other (Ogden, 1985). Imagination, on this account, depends upon the capacity to sustain a productive tension between what is and what might be.

Psychotherapy can be heavily cognitively loaded—weighted towards interpretation, explanation, and knowledge. But self-change may also require something different. An area that may help work through certain therapeutic stalemates is precisely the use of imagination—not simply as a technique for gaining insight, but as a space in which transformation can first be experienced experimentally, tentatively, and without commitment. Bringing psychotherapy and philosophy into dialogue offers fruitful ways of developing this idea.

Author details

Catia Guerra

Consultant Psychiatrist, PhD in Philosophy, Trainee in Psychodynamic psychotherapy

Cambridgeshire and Peterborough Foundation Trust

Trainee Voices

Reflections on my PsychStar year: the frontiers of relational care.

Dr Filip Trojan (MBBS BSc, iBSc Psychology)



Over the last year, I joined the PsychStar Scheme under the Medical Psychotherapy Faculty. I felt privileged to have a personality disorders (PD) specialist as my mentor for the programme, considering undergraduate teaching in this area is often sparse and outdated, and the topic tends to carry an aura of pessimism and stigma. I used the scheme to deepen my understanding of PD through conceptual and practical opportunities, notably by shadowing a modern PD service.

In this article, I would like to gather my thoughts on some opportunities that arose through the scheme, including my first-person impressions of the Service User Network (SUN),

The SUN

The SUN Project was established under SLaM over a decade ago and intends to increase access to support for PD patients in the community. Members self-refer, do not need a specific diagnosis, can come as often as they like, and there is no waiting list. Groups take place in person or online and are facilitated by two health professionals and often a Peer Support Worker with lived experience. As SUN is promoted for those with complex emotional needs and/or requiring support during crisis, it attracts almost exclusively individuals struggling with PD.

Group interventions can be particularly advantageous for PD patients as they can employ the specific aspects of relational functioning that disrupt their everyday lives. [1,2] An interview study of experiences of peer support among patients diagnosed with borderline personality disorder explored why peer support matters to individuals with PD.[3] What they found healing was the chance to use the community to achieve personal change, build connections based on relatedness and create a space that feels safe.

There are concrete ways I observed the above manifest in the SUN context. By participating in the co-production of the treatment, patients get a chance to restore their sense of self-determination.[4] The service users not only helped to establish SUN, but each session they are invited to express what worked well and what needed improvement. When I joined the group, there was a palpable sense in the room that the members felt responsible for the space.

Symbolically, it is a service user volunteer, not a facilitator, who presents the rules and proceedings of the session at the very start. Even after a volunteer was nominated, other users remained involved, immediately ready to assist if a volunteer struggled. By granting PD individuals responsibility, we give the healthy parts of their personality a chance to emerge.[5]

As the treatment fits in their everyday context, service-users have a chance to access support whilst remaining connected to their real social world. Compared to residential treatment, it may positively affect their mentalising ability [6] and help maintain coherence of the self between the treatment environment and the external world.[7]

Having a chance to support others can be fundamental in fostering self-value[5], which frequently remains a challenge for patients with PD.[8] Hence, at the check-in part of each session, SUN members can state whether they are here to give support, receive it or do both. Exploring relatedness, nonetheless, remains a complicated subject for PD individuals, even in the dedicated space. In a moving discussion about finding understanding among other PD individuals, one service user expressed how such connections always felt risky. They explained it was important to feel understood, but bringing two people with relational difficulties together often proved challenging. I found this perfectly captured a central conflict in PD we tend to re-enact systemically – the relational support is

fundamental for recovery in PD, but that's exactly where PD patients become most vulnerable.

Safety and relationality

The same conflict is reflected in our approaches to safety in PD. It is necessary when designing any interventions for PD to account for the risk of suicide and self-harm, as these are distinctly common in PD patients.[9]

Considering that, SUN's model of risk management seems rather progressive. Staff are trained in risk management and can utilise a dedicated protocol for escalating concerns; however, during the group, it mostly comes to exploring whether a service user feels safe at the check-in and check-out. Every new member also completes their crisis management plan at their first session.

PsychStars get to join the International Congress of Psychiatry, where I attended a panel on managing risk without restrictions in complex emotional needs. Clinicians representing local (The Cassel Hospital and Springbank Ward) and overseas PD services shared how adapting a less restrictive and more relational risk management strategy helped their services reduce dangerous incidents and promote patients' autonomy. A recent study at Springbank Ward examined incidence frequency along with patient and staff attitudes after a risk assessment checklist was replaced with an optional conversation with staff. [10] Although a moderate fall in incident frequency was not statistically significant, the interview analysis revealed that patients felt the new framework strengthened their sense of responsibility and reassured them about returning to the community, in an atmosphere of 'positive risk taking'. Staff were also more satisfied with the new protocol and viewed it as efficient, allowing them to exercise their skills and focus on relational care.

A crucial caveat to this model is that it requires a dedicated strategy and work culture to help staff tolerate uncertainty. ***This entails providing enough reflective space to collectively contain the anxiety of responsibility transfer from the clinicians to the patient.***[6]

At SUN, staff reflective practice is built into the weekly timetable to allow for peer discussion and support regarding risk. As part of the programme, I got to participate in the Maudsley Lectures in Psychoanalysis on human destructiveness. We discussed how questioning traditional methods of risk management confronts us with a false omnipotent notion: that as clinicians we can continue to keep patients safe from the destructiveness of their own minds.[11] We reflected on how we employ more controlling measures partially to soothe some of our human yet misleading aspirations.

In current NHS culture, where we tend to prioritise safety over other clinical outcomes, it becomes easier to overlook breakdowns in patient-clinician alliance if we concentrate on avoiding incidents. This philosophy predictably creates a discouraging landscape for individuals with PD, where cracks in the therapeutic relationship are particularly distressing.[12] In the context of PD, dogmas of safe practice need to remain flexible as relational continuity may be a key transformative force in recovery in this patient group.[13] SUN's way of risk management is perhaps counter-cultural, but it opens the way for trust.

Responsibility renowned

In this article, I hoped to convey some of the growing optimism around the paradigm shift in supporting patients with PD on more trust-based terms. Varied experiences during the PsychStar programme helped me recognise that in PD, a key task is helping patients reconnect with their sense of responsibility. I am grateful to all the teams who shared their insights with me on many occasions and to my mentor for invaluable support.

References

1. Koppers, David, Henricus Van, Jaap Peen, and Jack J.M. Dekker. "Psychological Symptoms, Early Maladaptive Schemas and Schema Modes: Predictors of the Outcome of Group Schema Therapy in Patients With Personality Disorders." Psychotherapy Research 31, no. 7 (December 3, 2020): 831–42. https://doi.org/10.1080/10503307.2020.1852482.

2. Kvarstein, Elfrida Hartveit, Ola Nordviste, Lone Dragland, and Theresa Wilberg. “Outpatient Psychodynamic Group Psychotherapy – Outcomes Related to Personality Disorder, Severity, Age and Gender.” Personality and Mental Health11, no. 1 (October 21, 2016): 37–50. https://doi.org/10.1002/pmh.1352.3.
3. Dahlenburg, Sophie C., Dianna R. Bartsch, Jessica A. Giles, Kristy A. Koehne, and Judy O’Sullivan. “Experiences of a Peer Group for People Diagnosed With Borderline Personality Disorder: A Qualitative Interview Study.” Personality and Mental Health 18, no. 2 (February 4, 2024): 166–76. https://doi.org/10.1002/pmh.1604.
4. Turner, Brianna J., Baylie McKnight, Carolyn E. Helps, Si-Ning Yeo, and Skye Barbic. “Peer Support for Borderline Personality Disorder: A Critical Review of Its Feasibility, Acceptability, and Alignment With Concepts of Recovery.” Personality Disorders Theory Research and Treatment 15, no. 6 (August 5, 2024): 425–35. https://doi.org/10.1037/per0000683.
5. Veale, David, Paul Gilbert, Jon Wheatley, and Iona Naismith. “A New Therapeutic Community: Development of a Compassion-Focussed and Contextual Behavioural Environment.” Clinical Psychology & Psychotherapy 22, no. 4 (April 14, 2014): 285–303. https://doi.org/10.1002/cpp.1897.
6. Chiesa, Marco, Patrick Luyten, and Peter Fonagy. “Two-year Follow-up and Changes in Reflective Functioning in Specialist and Nonspecialist Treatment Models for Personality Disorder.” Personality Disorders Theory Research and Treatment 12, no. 3 (October 8, 2020): 249–60. https://doi.org/10.1037/per0000464.
7. Miell, Sarah, and Simmi Protab. “Out of Sight, Out of Mind? Working With Separation and Risk When Patients Are Away From the Hospital.” British Journal of Psychotherapy, June 16, 2025. https://doi.org/10.1111/bjp.12969.
8. Tyrer, Peter, and Roger Mulder. Personality Disorder. Cambridge University Press eBooks, 2022. https://doi.org/10.1017/9781108951685.
9. Krysinska, Karolina, Travis S Heller, and Diego De Leo. “Suicide and Deliberate Self-harm in Personality Disorders.” Current Opinion in Psychiatry 19, no. 1 (December 2, 2005): 95–101. https://doi.org/10.1097/01.yco.0000191498.69281.5e.
10. Yue, Adelaide C, Alasdair W Philbey, Owen A Crawford, and Jorge Zimbron. “The Impact of Stopping Risk Assessment Checklists at a Specialist Personality Disorder Unit.” Cureus 15, no. 1 (January 18, 2023): e33935. https://doi.org/10.7759/cureus.33935.
11. Gibbons, Rachel. “Scapegoating in Healthcare: A Primitive Response to Tragedy.” International Journal of Social Psychiatry, December 26, 2025, 207640251398277. https://doi.org/10.1177/00207640251398277.
12. Woodbridge, Jane, Michelle L. Townsend, Samantha L. Reis, and Brin F. S. Grenyer. “Patient Perspectives on Non-response to Psychotherapy for Borderline Personality Disorder: A Qualitative Study.” Borderline Personality Disorder and Emotion Dysregulation 10, no. 1 (April 18, 2023): 13. https://doi.org/10.1186/s40479-023-00219-y.
13. De Salve, Francesca, Chiara Rossi, Elena Gioacchini, Irene Messina, and Osmano Oasi. “Dropout in Psychotherapy for Personality Disorders: A Systematic Review of Predictors.” Clinical Psychology & Psychotherapy 32, no. 3 (May 1, 2025): e70080. https://doi.org/10.1002/cpp.70080.

Author details

Filip Trojan

Royal United Hospitals Bath NHS Foundation Trust.

Graduated from UCL Medical School

When the Body Remembers: Trauma and Chronic Pain in Liaison Psychiatry

By Mohammed Wajahat Shabir

In liaison psychiatry, we often meet patients living with chronic pain: pain that persists beyond the expected period of tissue healing or continues despite repeated investigation and treatment. Too easily, the clinical conversation becomes organised around a false choice: is the pain “physical” or “psychological”?

A psychotherapeutic perspective offers another way of understanding this. Pain is not simply a direct read-out of tissue damage. It is a perception shaped by biological signals, nervous-system processing, attention, expectation, memory, emotion and meaning. The biological and psychological are therefore not competing explanations but interacting parts of the same embodied experience.

A cut may heal, yet pain can remain. The tissue has repaired, but the nervous system may continue to anticipate threat. Previous pain can

create conditioned threat: movement, touch or bodily sensations themselves may become associated with danger. Hypervigilance and heightened attention to internal sensations can then amplify what is noticed and how threatening it feels. For some patients, trauma or chronic adversity may further sensitise this system, leaving the body organised around an expectation of threat even when immediate danger has passed.

Yet pain is never experienced outside a story. The patient lives within a narrative of what happened, what the pain has meant, what has been lost, what was feared, and what the body has come to represent. At times, bodily distress may also communicate experiences that have been difficult to put into words. This does not mean that chronic pain is necessarily caused by trauma, nor that symptoms are "all psychological". It reminds us that bodily experience is shaped by the whole person and their history.

The healthcare system can itself become part of that narrative. Repeated investigations, admissions and conflicting explanations may increase uncertainty rather than resolve it. Language matters. Being told that "nothing is wrong" or feeling that pain is not believed because tests are reassuring, can be profoundly invalidating. Such encounters may heighten threat, increase monitoring of the body and contribute to repeated healthcare attendance. Conversely, careful language can itself be therapeutic: the pain is real, even if its mechanism is more complex than ongoing tissue damage.

This creates a familiar cycle in liaison settings: pain leads to fear and increased bodily attention; uncertainty prompts further investigation; normal or inconclusive results fail to resolve distress; and continuing pain then appears to confirm that something remains dangerously wrong. Neither endless medical escalation nor premature psychologisation is likely to help.

The therapeutic task is not to explain the pain away, but to help the patient develop a coherent account that can hold bodily reality, psychological experience and uncertainty together. Physical pathology must still be appropriately investigated, while recognising that nervous-system sensitisation, trauma, expectation, relationships, culture and previous healthcare experiences may all shape the final experience of pain.

Psychotherapy invites us to ask questions beyond "Where does it hurt?" What happened when the pain began? What did it come to mean? What does the patient fear will happen next? How have previous clinical encounters shaped their understanding of the body?

Perhaps the most important shift is in the question we ask. Rather than asking whether pain is physical or psychological, we might ask: what is maintaining this experience of pain, what meaning has become attached to it, and what might help the person feel safer in their body again?

Sometimes the wound has healed before the experience surrounding it has. In chronic pain, our task may be less about deciding which side of the mind–body divide the symptom belongs to, and more about helping the patient build a coherent story in which their pain is believed, their body is understood, and threat no longer has to speak so loudly.

Author details

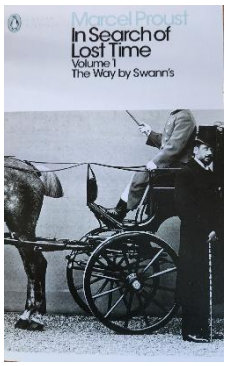
Dr Mohammed Wajahat Shabir

ST4 Old Age Psychiatry Trainee

NHS Tayside

The Madeleine Effect: Proust, Memory and the Mind

By Sinem Buse Tepe



Marcel Proust's Swann's Way is the first volume of In Search of Lost Time, his seven-part novel about memory, time, relationships and the experience of being human.

What makes Proust particularly interesting from a psychiatric perspective is his understanding of memory. He seems to recognise something we still see in clinical practice: memory is not simply a record of what happened. It is closely tied to emotion, sensation and meaning.

The most famous example is the madeleine scene. The narrator tastes a madeleine dipped in tea and is suddenly taken back to his childhood. He was not trying to remember it. The memory arrives unexpectedly through taste and sensation. Proust called this "involuntary memory".

This feels surprisingly familiar. A smell, a piece of music, a particular place or even a taste can sometimes bring back a memory that we have not thought about for years. The emotional quality of the memory can be just as important as the event itself.

Proust was also influenced by the philosopher Henri Bergson, who wrote about time as something we experience rather than simply measure. The past, in this sense, does not completely disappear. It continues to exist within our present experience.

There is an interesting psychiatric connection here. In 1905, following the death of his mother, Proust spent a short period at the clinic of Paul Sollier. Sollier, a pupil of Charcot, had a particular interest in memory and emotion. He described a process called "reviviscence", referring to the way emotional experiences could bring memories back to life. Some authors have suggested that Sollier's work influenced Proust's ideas about involuntary memory.[1]

Proust was writing at a time of major social and cultural change. His novels capture the world of the Belle Époque, including its class divisions, social aspirations, salons, music and art. His character Swann, for example, moves between aristocratic and bourgeois circles without ever completely belonging to either.

But what stays with me most is Proust's idea that our relationship with the past is not straightforward. We do not simply remember events as they happened. We remember them through how they felt, and sometimes the smallest sensory experience can bring an entire world back.

This is perhaps why Swann's Way still feels relevant to psychiatry and psychotherapy today. Proust was interested in the inner world long before we had much of the language, we now use to describe it. His writing reminds us that memories are not just facts stored away in the mind. They are connected to relationships, emotions, identity and the meaning we give to our experiences.

As Proust writes towards the end of the book:

"The places we knew in the past are not just part of the world of space where we locate them for convenience. They are a slice of time made up of impressions that once formed our life at that moment…"

Perhaps this is what makes Proust so interesting for psychiatrists. He reminds us that when we listen to someone's story, we are not simply hearing a sequence of past events. We are hearing how those events continue to live in the person's present.

References

1. Bogousslavsky, J., & Walusinski, O. (2009). Marcel Proust and Paul Sollier: The involuntary memory connection. Schweizer Archiv für Neurologie und Psychiatrie, 160(4), 130–136.

Author details

Sinem Buse Tepe

CT3 Psychiatry Trainee in NHS Tayside

The fledgling: a reflection on the daily occurrences in our gardens

By Tina Kenning



A female great tit tentatively peeps into our garden nest box. She has ventured into our garden with her partner, looking for a suitable place to raise a family. As the weeks go on, I get to know both their quirks. One wiggles their tail out from the nest box hole whilst feeding their babies, perching from the apple tree to a long strand of bamboo before hopping into the box. The other flies in from the opposite direction, oscillating in their flight path over the fences. Golden light from a spell of warm weather pours over the burgundy tipped grass bathing the busy new parents. Their physical efforts tremendous.

The following weeks become damper, the sky metamorphosing to an ashen grey. The shrills of the babies grow louder daily into a rambunctious crescendo over their final days in the nest. A heavy outpouring of rain starts. I see a fledgling take flight. The first clumsy wing beats into the outside world. They land in the rippling grass of the uncut lawn. Perched awkwardly, wet and bewildered on the edge of the fence. We are both unsure what comes next. They chirp for their parents. Timid and fragile. Lemon hued body. Momentarily safe in the shelter of the greenery of the garden.

They hop through a gap to the other side; an open footpath. Within seconds two corvids descend. The fledgling's fragility exposed. They are ripped apart by beaks and taken in flight. Their freedom feels fleeting. I feel a deep sense of sadness for one being whilst still holding space for others; I remind myself they are a link in a chain. Their mother perpetually flits from fence post to post and calls - a call reminiscent of a hungry human infant about to latch on to a breast. I hear her calls into the night, increasingly becoming achingly frantic. I wonder the fate of the remaining fledglings.

Stillness in the garden; I'm met by the paradox of a new unfamiliar 'silence'. I'll miss the presence of this enthralling bird family I had grown so fond of. My anchor in the passing seasons. The next dewy early June morning a goldfinch perches for a few moments on the apple tree - the first I have seen visit our garden. I watch a trio of blackbirds eagerly search for earthworms. Meanwhile, several generations of a house martin family continue to diligently repair last year's mud nest in our eaves. Their playful chatty warbles and chortles to each other a welcome distraction.

I ponder our capacity for such connection to nature, and often, significant empathy towards other species. I've met countless psychiatric patients who are drawn to animals, unsurprisingly, given sadly too frequent traumatic experiences of other humans. I then wonder what the loss of, and subsequent detachment from, these connections does to us. I often feel our society is becoming increasingly estranged from the ecosystems we are part of, yet people tend to feel more peaceful when beside water, trees, animals or seasons. Nature often has a way of putting our 'human' experiences, no matter how painful, into perspective. What might we therefore learn from spending time within nature, and the affinity of these connections, for aiding recovery and staying well? I believe it is such an underutilised resource in our society's current models for caring for people. The contributory healing properties it can have for the mind can be transformative. Never underestimate the value of an activity as simple as a butterfly count. I am also reminded of the power in humble observation, the art of listening intently and the delicate skill of stopping to stand 'still' in our ever-evolving modern world. Some transferable thoughts we could all make use of within our roles helping those experiencing mental unrest. So, consider reconnecting with your childhood curiosity and lean into making 'fine feathered friends'[1] of the birds.

Mid-July, much to my delight, a female great tit reappears in our garden.

References

1. Blake Q (1992), Cockatoos. Jonathan Cape

Author details

Dr Tina Kenning

CT3 Psychiatry. Northern Ireland

Medical Student Essay Prize winner 2026

Eesa Farooqui

Huge Congratulations to Eesa who wrote the winning essay with the title:

What are your experiences of the integration of body and mind for patients and staff within the UK healthcare system? How has your training been influenced by this thinking?

You can read Eesa's full prize-winning essay here Read essay

Book Review

By Dr Penny Campling

Personally Speaking



Stories from Psychiatrists on Learning from Life's Experiences

gathered by Glenn Roberts

I recently attended the launch of a new book, 'Personally Speaking - Stories from Psychiatrists on Learning from Life's Experiences'. I'd been fortunate to be invited to contribute a chapter but was very much a member of the audience at this event. It was a convivial gathering at the College, unusual because of the degree of self-disclosure in the presentations – and indeed, the number of ex-presidents and College officials in the room!

Despite being out of the ordinary (and sadly, a project the College/CUP publishing department couldn't get their heads around) when Glenn Roberts, who edited the book, or as he prefers to put it, 'gathered the stories', first sounded me out with the idea, it immediately felt like a completely obvious and important project. The only questions in my mind: why hadn't it be done before - and why hadn't I thought of it first!

With warm commendations from Lade Smith (our president) Professor Dame Clare Gerada (past president Royal College of GPs) Caroline Elton (author of 'Also Human: the inner lives of doctors') – not to mention Sir Stephen Fry, it seems, there is a widespread agreement of the value in reminding readers of the ordinary personal struggles that can serve to deepen our human understanding and connection with patients.

Patients often assume that we have not had to struggle in the ways they have and there is much in the culture of healthcare that reinforces this view: mutual projections of the clinician as healthy, wise and holding all the answers in the face of the patient's helpless vulnerability.

A few of the authors mention how difficult it was to find a forum at work to talk about the problems they were facing and the explicit messages to maintain a brave face and keep personal problems separate from their professional lives. No denying that a brave face and professional persona can be important in some circumstances. But from these stories, it is clear that it is often an inner voice that maintains such a taboo. This silencing, judgemental voice has perhaps been internalised from our training or work environment, but also in some cases is the legacy of a childhood where key figures saw hard work and achievement as all important, with little recognition of vulnerability. Hard then to admit one is concerned about one's own mental health, desperately grieving over the illness or death of a loved one, finding it hard to adjust to a long-term condition in the family or struggling to come to terms with very difficult family histories and ongoing dynamics. Hard to admit one is the object of racism or misogyny or struggling to survive in a toxic work environment. Compared to the general population, we know that doctors are slow to admit they have a problem with their own mental health and continue to work long after they should have gone off sick. Some of the authors describe the experience of acute bereavement or trauma, where their lives are dramatically turned upside down. But another common narrative is of an invisible, isolated struggle, for a long period of time, then a break-through when the author can start to connect with others and share what they are experiencing.

This book reminds us that vulnerability and suffering is very much part of the human condition. We don't divide neatly into patients and clinicians, and our lives don't divide neatly into professional and personal. As psychiatrists, and particularly as psychotherapists, there is no escaping this. For all the progress in our understanding of neuroscience, we bring ourselves to our interactions with patients, and self-awareness is all important. Our experience then – duly reflected upon - can become part of our expertise.

Someone raised a question about suffering. He'd been surprised by the amount of distress described in the book, felt his own life had been relatively free of such pain, and wondered if suffering was necessary in the forging of a good psychiatrist. Although some of the writing made me cry, this book is not a collection of misery memoirs. Illness, death and severe distress are approached with a refreshing honesty, often beautifully described in intimate detail, but the emphasis is always on recovery, finding a way to live with a changed reality, and ultimately the comfort and privilege of being able to use our experience in our work with patients.

Alongside these experiences of loss and disillusionment, there are also chapters that focus more on professional endeavour, the personal impact of everyday work with patients and the cost of trying to bring about change. I should also tell you that the book is beautifully produced, with photos, pictures and poems enhancing the text.

Suffering, of course, can't be measured or compared. As Gwen Adshead pointed out, she has had a very ordinary life compared to the people she works with as a forensic psychiatrist. But she can use her experience and her imagination to be alongside them as they struggle to survive and find meaning in their lives.

Gwen was one of three speakers at the launch. She centred her talk (and her chapter) on setting up a therapy group for patients who'd killed their parents. Along the way she shared something of her own struggles with grief and unhappiness and how much therapies of different sorts have helped her. As usual she demonstrated an extraordinary capacity to get to the nub of things in a deeply compassionate way and brought home to us how much we have in common with even our most violent patients.

The second speaker was Chris Cook who is an ordained priest as well as a psychiatrist and is a past chair of the Spirituality & Psychiatry SIG at the College. He told the story, from many years past, of learning that his young wife, pregnant with their second child, had terminal Leukaemia. She died within a few months, leaving him bereft, with a new baby and a two-year-old. It is a story he has told before leading him to reflect on the impact it has had on his career and the way he is with patients, the fundamental importance of spirituality in his life and the way stories evolve as time moves on.

The final speaker was Dinesh Bhugra, one of four ex-presidents of the College (plus Lade) to contribute a chapter to the book. He spoke with energy and passion about his vision and frustration with the narrow perspectives that limit psychiatry; and with humility about his amazing career path, jumping from one presidential role to another - the World Psychiatric Association and BMA following his stint at the College. Dinesh is very open about the sense he has of himself as an outsider, the pain of this but also the advantages and the good that can come from it.

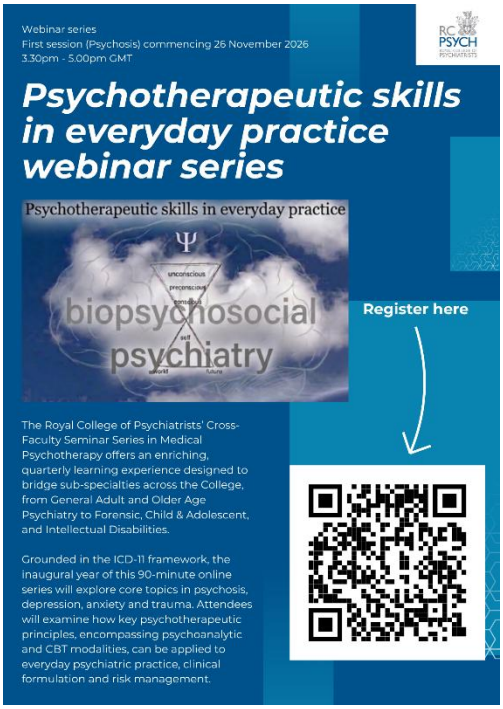
The three presentations were all excellent in their own way, different from each other, but complementary. As I drank it all in, it struck me the speakers embodied the fruits of personal development, relaxed around their vulnerability and so fully alive and quietly passionate that we attended to their every word.

And then there was Glenn Roberts, who dreamt up the project in the first place and has spent many hundreds of hours bringing it all together. Helped by Helen Smith, he facilitated the event, in a friendly, gentle manner, making sure everyone felt included, appreciated and listened to.

As Lade Smith says in her foreword, "psychiatrists must be the most human of doctors". I am hopeful this book might help us think about that and come up with some ideas on how to do better.

Adverts and Events

Psychotherapeutic Skills in Everyday Practice – webinar series



We are delighted to launch the Royal College of Psychiatrists' Cross-Faculty Seminar Series in Medical Psychotherapy. The series will offer an enriching, quarterly learning experience designed to bridge sub-specialties across the College, from General Adult and Older Age Psychiatry to Forensic, Child & Adolescent, and Intellectual Disabilities.

Grounded in the ICD-11 framework, the inaugural year of this 90-minute online series will explore core topics in **psychosis, depression, anxiety, and trauma**. Attendees will examine how key psychotherapeutic principles, encompassing psychoanalytic and CBT modalities, can be applied to everyday psychiatric practice, clinical formulation and risk management.

Led by experienced national figures in medical psychotherapy, including Dr Jo O'Reilly, Dr Anne Cooper, Dr Jessica Yakeley, Dr Saju Padakkara, Dr Anuradha Menon, Dr Steve Moorhead, Dr Rachel Gibbons and Dr Beena Rajkumar, the series will deliver high-level expertise in an accessible and digestible format.

Alongside fostering cross-faculty collaboration, the series aims to update and deepen clinical knowledge through a biopsychosocial approach, supporting the development of the psychotherapeutic mind in psychiatry.

Who should attend?

Open to all RCPsych members and doctors at all training and non-training grades, these seasonal online sessions are ideal for clinicians seeking to enhance their psychotherapeutic understanding across diagnostic domains.

Format and Schedule

Each seminar runs on Thursdays from 3:30pm to 5:00 pm on the following dates:

26 November 2026 - Psychosis

25 February 2027 - Depression

20 May 2027 - Anxiety

30 September 2027 - Trauma

Every session will include:

A 60-minute talk by a medical psychotherapist representing psychoanalytic and CBT approaches

A 30-minute interactive group discussion, Q&A and live panel debate

We look forward to welcoming you to this enriching series.

The Nature of Group Attachment: Creative and Perverse Dynamics

50th Foulkes Lecture and Study Day

King's Fund, London, 14 - 15 May 2027

by Arturo Ezquerro

The Foulkes Lecture and Study Day is the most prestigious annual event in the calendar of the Group Analytic Society International, which was created in 1952. I am deeply honoured to have been invited to deliver the 50th Foulkes Lecture and to convene the Study Day over the weekend of 14 - 15 May 2027.

It will be a special privilege to honour S. H. Foulkes's legacy as the father of group analysis, coming in the wake of the fiftieth anniversary of his death, and, at the same time, to explore his contribution to the history from which our Medical Psychotherapy Faculty at the Royal College of Psychiatrists eventually emerged.

Foulkes founded group analysis in the crucible of the Second World War, when he established and developed group-based treatment for severely traumatised soldiers at Northfield Military Hospital, working alongside Tom Main, Harold Bridger and Pat de Maré. Foulkes would often begin a therapy session by saying, *while we remain in this group, we are not at war*. His work followed the remarkable and controversial group experiment pioneered there by Wilfred Bion and John Rickman, which ended abruptly after only six weeks.

Out of these extraordinary wartime beginnings grew an insight of enduring power: that we need one another not only to survive, but to form meaningful attachments, to make sense of our experience, and to grow.

At a time when our institutions and societies are once again being tested by fragmentation, division and conflict, this profoundly Foulkesian message feels especially urgent. I believe it is a message worth returning to with curiosity, humility and gratitude.

Born Siegmund Heinrich Fuchs in Karlsruhe, Germany, in 1898, into a middle-class Jewish family, Fuchs trained as a psychiatrist and Freudian psychoanalyst. During the First World War, he served in the German Army's telephone and telegraph corps in France, where he came to appreciate the central role of communication, not only to military effectiveness but to human survival itself. For him, particularly in times of conflict, it was essential to keep communication going. He became so convinced of its importance that, in his thinking, communication and psychotherapy ultimately came to be understood as one and the same thing.

After Hitler came to power, Fuchs was forced to flee Germany. At the invitation of Ernest Jones, then President of the British Psychoanalytical Society, he settled in England and became a British citizen in 1938. At this point, he changed his surname to the more Anglicised Foulkes: a change that can be understood both as an adaptation to his new country and as part of the story of integration and survival that marked his life.

It so happened that Foulkes was the analyst of my own training analyst; in both a symbolic and a very real sense, therefore, he is my analytic grandfather. Through this lineage, I inherited the intuition that the group is fundamental to human survival, an insight that led me to explore the evolutionary nature of group attachment.

Alongside this, I trained in child and adolescent psychiatry and in adult psychoanalytic psychotherapy at the Tavistock Clinic in London. There, John Bowlby, the pioneering architect of attachment theory, became my supervisor and my mentor during the final six years of his life, from 1984 to 1990.

It is against this background that I have sought to bring the attachment, psychoanalytic and group-analytic traditions into a fruitful dialogue with one another.

I would also like to use this occasion to recognise Foulkes's wider contribution to the

development of psychotherapy within British psychiatry and to the history of the Royal College of Psychiatrists.

In 1950, he was appointed Consultant Physician at the Bethlem Royal and Maudsley Hospitals, where he introduced group analysis and directed a pioneering group-psychotherapy service. There, he treated large numbers of patients and trained generations of psychiatrists and psychologists in the group-analytic approach. Under his direction, group psychotherapy became a substantial part of outpatient psychotherapy at the Maudsley. These significant achievements, it seems to me, have yet to receive the recognition they deserve.

Foulkes's contribution to the College's history was, likewise, distinctly direct. In 1964 and 1965, he served as Chair of the Psychotherapy and Social Psychiatry Section of the Royal Medico-Psychological Association. When the Association became the Royal College of Psychiatrists in 1971, a separate Psychotherapy Section was established within the new College. This subsequently became a Faculty and, later, the Faculty of Medical Psychotherapy. Foulkes himself was appointed a Foundation Fellow of the newly established College in 1971.

Thus, Foulkes played an important part not only in the development of group analysis and psychotherapy services within the NHS, but also in the wider history of psychotherapy within British psychiatry. His place in the genesis of our Faculty is therefore not simply a matter of historical association: he was himself an active participant in the professional structures from which the Faculty eventually emerged.

I trust that many members of our Faculty will participate in this event. The occasion offers a valuable opportunity to reclaim and celebrate an important part of the College's own history, whilst honouring Foulkes's enduring legacy and reflecting on the continuing relevance of his ideas to contemporary psychotherapeutic and psychiatric practice.

On Friday 14 May 2027, I shall deliver the Lecture in the evening at 6.00m, followed by a reception with drinks and canapés at 8.00 pm. On Saturday 15 May, from 9.00am to 5.30pm, we will have an opportunity to elaborate on the themes of the Lecture, *The Nature of Group Attachment: Creative and Perverse Dynamics*. Our Faculty will be represented on the panel during the first session, from 9.00 to 10.45am. This will be followed by three professionally led large groups, providing further opportunities for other members of the Faculty to contribute to the discussion from the historical and organisational perspective of the College.

The flyer with full details of the programme should be available soon. In the meantime, I hope this early announcement will enable you to put 14 and 15 May firmly in your 2027 diary. This event may, in turn, provide the impetus for a more specific Faculty initiative to explore its own history as an integral part of the institutional evolution of the Royal College of Psychiatrists.

I very much look forward to sharing this occasion with you, and to opening a conversation between Foulkes's pioneering vision, the history of our Faculty, and the challenges facing psychiatry and psychotherapy today.

Arturo Ezquerro, Consultant psychiatrist in psychotherapy and group analyst, serving as senior assessor and trainer at the Institute of Group Analysis. Former Head of NHS Medical Psychotherapy Services for Brent, London, and author of more than 250 publications in six languages, including nine books.

The College SAS doctors committee is currently looking for a Medical Psychotherapy representative

Further information here: SAS Psychiatrists Committee
Here is the link to the JDF: sas-committee-job-descriptions-april-2023.pdf

Prizes and Awards

The Medical Psychotherapy Faculty Medical Student Essay prize

The Medical Psychotherapy Research Small Projects Award

Now open for entries:

Medical psychotherapy faculty prizes and bursaries

Call for submissions

My huge thanks to all who have contributed to this newsletter. Please continue to send in contributions over the next few months for the spring/ summer edition. The deadline for submissions is 1st March 2027.

Please send your contributions to Hayley Shaw **Hayley.Shaw@rcpsych.ac.uk**.