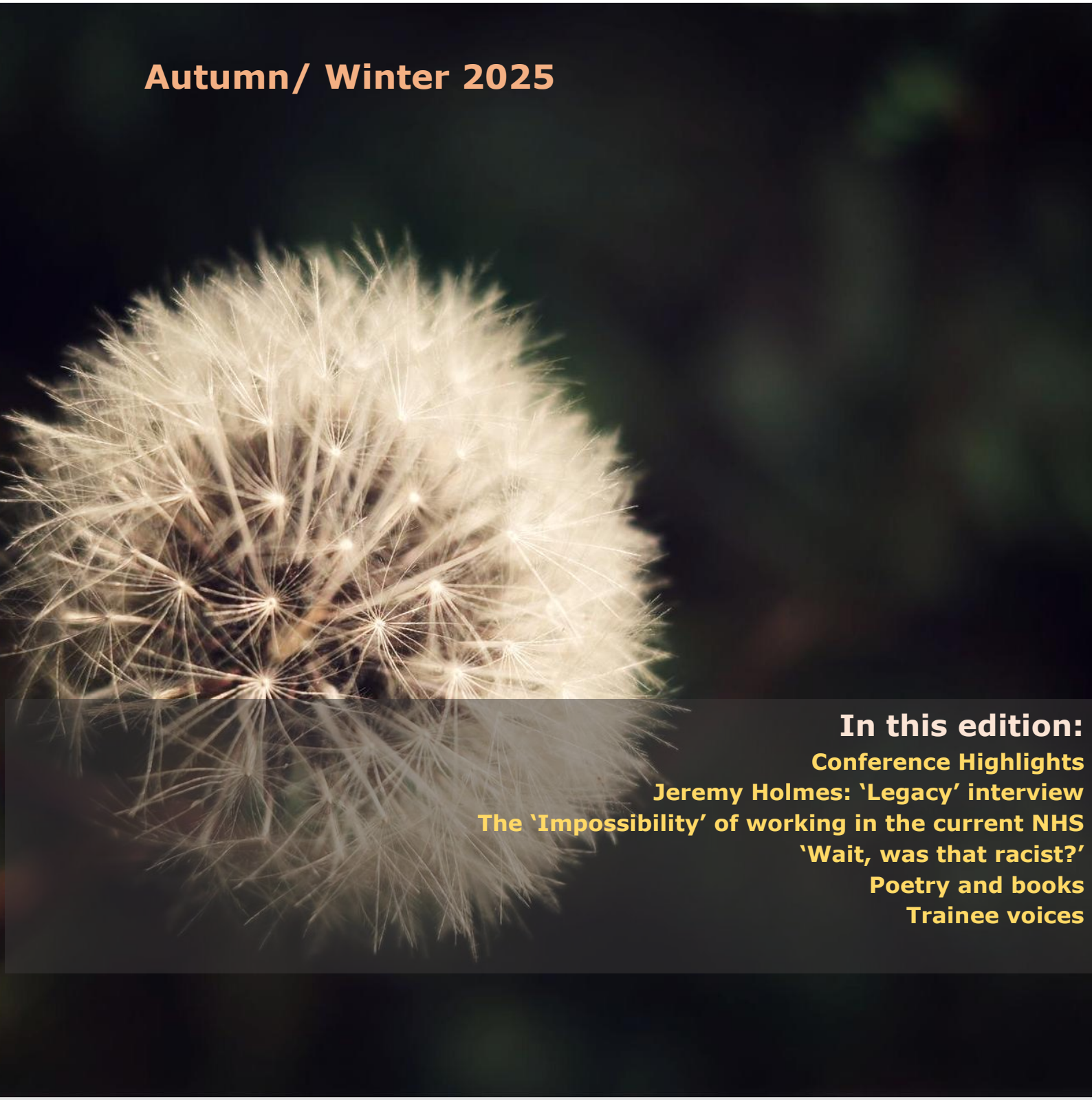
RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

NEWSLETTER

FACULTY OF MEDICAL PSYCHOTHERAPY



Autumn/ Winter 2025

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SAM BUCHANAN (sambuchananphotography.com)

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Editor's Welcome

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

Welcome to the autumn/ winter edition of the Medical Psychotherapy Faculty newsletter. This edition contains articles and reflections from the important conferences of the year. I hope you will enjoy reading the result!

As we enjoy the beauty of autumn, the fading warmth and light herald a more reflective internal space and cosying up with others. I am ever more mindful of the millions of people struggling at this time, facing the direct impact of catastrophic world events. Even in our backyard, levels of poverty and mental health crises are escalating, let alone the places devastated by war and famine. Working in the NHS is becoming harder too, as economic constraints start to bite, and clinicians are more exposed to scrutiny and blame alongside impossible demands. It can be difficult to fully appreciate, and to articulate, the meaning of what is going on in the wider world and within each one of us.

Our authors in this edition are grappling with some of these issues in ways that help us make sense of some of these events. Dr Rachel Gibbons has written about dysfunctional organisational dynamics within the NHS and their impact on clinical staff. From the Medical Psychotherapy Faculty conference, we have an article from Dr Cissy Atwine on the subject of racism and microaggressions. This was a very popular talk and many of the audience members, myself included, identified with the themes of Cissy's talk. We have 2 articles on personality disorder, exploring autonomy and a TFP approach. We also have reflections arising from the year's conferences and feedback from the climate workshop run by members of the Climate action working group.

We are privileged to have Prof Jeremy Holmes following up his article of last autumn with a fascinating 'Legacy' interview, looking back at his distinguished career. With warmth, humility and humour, he gives an account of the development of his thinking, his writing, and of all the people and movements that have shaped this. It is a wonderful account from one of the 'giants' of our Faculty.

We also have articles by trainees, beautiful poetry and events for your calendar. I want to highlight the request from the Exec committee regarding a survey on EDI soon to be sent to Faculty members.

I am very sad to be stepping down as Editor after this issue. I have absolutely loved the role!

Please continue to send in your wonderful articles, reflections and art for the spring/ summer edition, to Hayley Shaw Hayley.Shaw@rcpsych.ac.uk. The deadline for submissions is 27th February 2026.

Message from the Faculty Chair

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

Warm wishes to you all and welcome to the autumn/ winter edition of the Medical Psychotherapy Faculty Newsletter. We enjoyed our annual residential conference earlier this year. Themed around issues of inclusion, exclusion, stigma and discrimination, the program included moving talks and discussions. The speakers had a wide range of experience and expertise, addressing the difficult challenges we face as citizens, colleagues, and clinicians. Talks about racism, homophobia, climate change, sexual abuse, organisational dynamics, diagnosis and discrimination were interspersed with workshops and large groups to deepen and process our responses together. I had the pleasure of chairing the somewhat unruly pairing of Horatio Clare and Femi Oyebode from the Radio 4 Series "Is Psychiatry Working?"; it was a very enjoyable and lively conversation with these former neighbours who generously shared their experiences and wisdom from different sides of the patient/psychiatrist relationship. Many thanks to our academic secretaries and everyone else who was involved in creating this very successful conference.

We had the last annual Psychodynamic Psychiatry Day on 14th November 2025 in which we looked at the central role of mourning in mental health. Titled "If grief is the sea we swim in what does this mean for psychiatry?" we explored the emotional work of coming to terms with loss as a lifelong task, and how defences against this may lead to mental health difficulties across all diagnostic groups. We explored how we as psychiatrists can support a healthy mourning process as integral to mental health and recovery from illness. The day was supported by the charity Health Pitch, who performed arias from operas about loss during the day and had us all singing together by the end of the closing group, which was moving, uplifting and possibly a first at the RCPsych!

I also presented at the annual Medical students' conference in Leeds, PTC conference in Birmingham, NW Division conference in Manchester and academic program for psychiatrists in Brisbane. I've really enjoyed meeting the psychiatrists of the future and other colleagues working in different places and discussing the importance of psychological thinking and relational and psychotherapeutic skills across psychiatry with them.

In our executive committee meetings, we have been discussing the importance of psychiatrists being represented in the workforce for the wide range of psychological therapies needed across mental health services. This is something we are actively campaigning for and we hope that all psychiatrists trained or interested in training in psychological therapies beyond their core competencies will feel they have a home in our faculty. We have formed two new working groups: one focussing on diversity within our specialism and the other an academic and research working group to strengthen our capacity to generate data and evidence for service development.
I hope you enjoy the newsletter brought together by our brilliant and creative editor Pamela Peters.

Update from the Academic Secretaries

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

Medical Psychotherapy Annual Faculty Conference, Wednesday 30th April to Friday 2nd May 2025: "Inclusivity/Exclusivity; Medical Psychotherapy, labels and stigma"
We are pleased to report that the annual conference which took place in April/May 2025 was a huge success. This was reflected in the attendance, feedback and overall income generation for the Medical Psychotherapy Faculty. We received approximately 225 delegates from a variety of backgrounds at the Royal College of Psychiatrists; the highest number we have had since returning to face-to-face events post-Covid.

On Wednesday 30th April, Dr Jo O'Reilly (Chair of our faculty) opened conference proceedings by facilitating an intimate conversation with Horatio Clare and Professor Femi Oyebode on: "Is Psychiatry working? What is the place of psychotherapy in psychiatry?" The conversation covered a variety of topics from a professional, patient and personal point of view.

On Thursday 1st May, we held our AGM for the faculty. The AGM included the annual update from our chair and treasurer, along with informative presentations from our service user and carer reps. During the remainder of the morning session, Dr Dan Beales gave a thought-provoking talk on the place of diagnosis in Medical Psychotherapy highlighting a detailed and balanced view of the subject. This was followed by Professor Russell Razzaque who shared his thoughts on the practice of open dialogue, the potential benefits of this within psychiatry and the ongoing ODDESSI trial. Dr Cissy Atwine then delivered a moving presentation about racism followed by Dr Graeme Whitfield who, through the medium of a music video, offered a creative and poignant talk on sexuality and stigma within psychiatry.

After lunch (which included poster viewing time), we returned to two parallel group sessions: 1) Self-care using compassion and 2) Large experiential group. Both groups offered space in a busy programme to reflect on the conference theme from different vantage points. This was followed by three different workshops on: Service User Network, Climate Action, and Yoga, all of which were well-received and gained excellent feedback. We then had our annual

conference dinner at Cinnamon Kitchen, which was the much-appreciated social gathering of our conference along with a culinary feast.

On the final day of the conference, we heard from Drs Jo Stubley, Maria Eyres and Caroline Thompson openly detailing their experiences in developing the crucial RCPsych position statement on the Impact of Non-Recent Child Sexual Abuse on Mental Health and its application in our work (*see reference links below*). This was followed by Dr Beena Rajkumar who presented a helpful and understandable talk on CBT for Complex PTSD. The Friday morning session closed with Tom Ayres, Mary Ryan, Dr Oliver Dale and Chris Young speaking candidly about their work on Personality Disorder, Prejudice and Discrimination.

Friday afternoon closed with the poster competition prize. Individuals gave a short presentation of their posters, demonstrating their passion in their associated subject matter. After much deliberation by the judges due to the calibre of work produced, the prize was awarded to Dr Burak Cardak for his poster on Balint groups for medical students.

We are very grateful to all the speakers and group leaders who were generous with their time, offering a variety of talks and workshops which stimulated lively discussions throughout the conference.

We hope to see you all in April 2026 in Oxford, for the last conference led by the current academic secretary team who will be stepping down next summer. We encourage anyone from the faculty to think about taking on the role which can be done as an individual or jointly, and we would be more than happy to discuss it further with any interested parties.
We would also like to thank Catherine Ayres and the CALC team for their support in the organisation of the conference.

Reference links below relating to Jo Stubley's talk on the RCPsych position statement on the Impact of Non-Recent Child Sexual Abuse on Mental Health:
Breaking Silences zine
Child sexual abuse disclosure: how to support adult survivors (DAA019) - Tavistock Training

Medical Student Essay Prize and Small Projects Grant update
We would like to draw your attention to the Medical Student Essay prize which will be opening for entries in the Autumn. The title will reflect the next conference theme and will be announced on the Faculty website in September. As usual, winners will have their essay published in the Faculty Newsletter and on the Medical Psychotherapy part of the college website.
Finally, we would also like to mention the Small Projects Grant which is currently being revamped for 2026. There is a monetary prize of up to £2000 which is awarded for original research in the field of Medical Psychotherapy. This will again be opening in September so please keep an eye out on the Faculty website for details.

Date for your diary: November 14th, 2025. Psychodynamic Psychiatry Day: "If grief is the sea we swim in, what does that mean for psychiatry."

Feature Articles

'Legacy' interview: Looking Back in ...Bemusement

Dr Jeremy Holmes MD FRCPsych
Former Chair, Medical Psychotherapy Faculty & Honorary Professor, University of Exeter

Introduction

My perhaps ironic starting point is that the term 'legacy' might be a misnomer. If there is one, my legacy is modest in the extreme. I once described my contribution to attachment theory, as a 'footnote to a footnote'. However, I have to admit that contained within that narcissistic negative lurks a continuing passive/ aggressive bid for reassurance and recognition.

Let's admit that while I'm not, and do not claim to be, an original thinker, scholar, or researcher, my work hasn't been entirely negligible. I would summarise my contributions, such as they are, as follows:

a) Translating complex ideas, especially the broad sweep of attachment theory and research, into accessible and readable forms.
b) Showing how attachment theory can help the day-to-day work of the therapist in her consulting room.
c) Championing a multidisciplinary psychotherapeutic approach alongside my own preferred modality of psychoanalytic psychotherapy.
d) Emphasising the scientific basis of common factors in psychotherapy as antidote to the belief that one's own approach is uniquely effective.
e) Within my profession of psychiatry, advocating humane and psychotherapeutically-informed approaches to the treatment of mental illness.
f) Initiating a flourishing training centre in a 'periphery of excellence' away from the metropolis.
g) In my recent book "The Spirit of Psychotherapy: a Hidden Dimension (Karnac 2024)", arguing the case for psychotherapy as the secular successor to religion, and guardian of the inner world, with the consulting room as a 'sacred space' in an increasingly instrumentalist and superficial culture.
h) Attempting to bring freshness to the above via a vivid (albeit ephemeral) lecturing style.

I am hugely grateful to my triple professions of medicine, psychiatry and psychotherapy. Whether I chose them, or they me is debatable. What I would have done without them occasionally intrigues me – perhaps secondary school English teacher, or publisher. I've been lucky too in that my generation of psychiatrists pre-dated the ravages of NHS underfunding, endless management tinkering, bureaucratic interference, and DSM straightjacketing. Although painful at times, I have almost always enjoyed my work, and it has been a relatively straightforward and, on the whole 'successful', part of my life. This contrasts with an inner sense of 'failure' with which I continue to struggle and perhaps explains why even in my 80s I'm still working.

1943-1960: Post-war London

A GP friend once described my writing as 'wildly eclectic', and it is true that, when writing, I try, magpie-like, to bring together science, literature and consulting room praxis. At best this can perhaps be a form of 'hybrid vigour'; at worst a horrible mish-mash. Which brings me to my quite hybrid origins. My mother came from an urban Jewish American background; my father, an actor, poet, and BBC presenter, from Anglo-Scottish farming and brewing stock. They met and married in what I suspect was a *coup de foudre* at University, my mother never quite forgiven by her parents for marrying 'out'. Then came the war, my birth and the accompanying role of trauma. My father was, we were told, 'blown up' by a post D-day German landmine in France, sustaining a serious head injury from which he never fully recovered and which put an end to his acting career. Nevertheless he showed remarkable resilience and, with my mother's help, powers of recovery. I summarise this by reversing Spike Milligan's title: 'Hitler, his part in Dad's – and my - downfall'.

Childhood was in post-war West London, middle class, mildly bohemian. Mother was a social worker for the LCC 'care committee', early advocate of adventure playgrounds, Labour counsellor and Magistrate. My father did the Times crossword each morning, and, during holidays in Wiltshire and Devon, returned to his childhood loves of birdwatching and fishing. Although somewhat remote and irritable, he instilled in me a life-long love of poetry.

Freud's *Introductory Lectures* were on my parent's bookshelf. Although I 'passed' the 11+ ("in case Daddy dies") and was offered a place in a direct grant school, I and my two younger sisters were sent to posh London day schools - no 'boarding school syndrome' for us. I was 'good' at English, but under the influence of a brilliant physics teacher, fell in love with science (about which neither of my parents knew much). Aged 14, I decided I could always read novels in my spare time (which I continue to do 70 years on), and so went into the then unfashionable 'science side'. I had a relatively undistinguished time at school, although used regularly to win prizes for essay-writing and poetry recitation. I left aged 17 vowing never to set foot in that bastion of privilege ever again, a vow which I kept until my 70s when asked by the school counsellor to give a talk to parents about attachment theory.

1960-1970: Cambridge and beyond

Fast forward to University. There three main influences pointed – with hindsight - towards a career in medicine and psychiatry. First was 'Cambridge science' itself with an absolute respect, which I hold to this day, for evidence, experiment and creative hypothesis. The disciplines of Experimental Psychology and Immunology awakened me, respectively, to the mind as a suitable subject for investigation, and to the indispensability of defence mechanisms for survival and the integrity of the self.

Second was the meteoric advent of RD Laing, and his influence on a generation of future psychiatrists. I was bowled over by *The Divided Self* and would thereafter queue outside Foyles for his latest books. After reading it, I immediately switched from studying natural sciences to medicine. I now wanted to be a doctor – one of the few really significant positive decisions I've made in my life.

In retrospect we know that Laing was just plain wrong. There's no such thing as a schizophrenogenic mother. Communication abnormalities are no more common in families with a psychotic member than those without one, (although high 'expressed emotion' does

presage a worse prognosis). Laing is now largely forgotten by psychiatrists. I see him as a poet and a prophet, a flawed guru-figure who helped to bring mental illness and its treatment into the mainstream and understand the social determinants of mental ill health.

The third, related, influence – this was the 1960s era of nuclear threat, the Cuban missile crisis, Kennedy assassination, Harold Wilson's Labour government, the Civil rights movement - radical politics. Here Laing helped because he maintained that mental illness was a symptom of a wider sickness affecting capitalist society as a whole. Self-sustaining communities were needed if a new society was to be born in the ashes of the old.

Naïve though it sounds, all this strongly shaped my choices and subsequent career. I spent a summer working in Laing's colleague anti-psychiatrist David Cooper's 'no-drugs mentally-ill-are-saner-than-so-called-sane' unit at Shenley hospital, Villa 21, and devotedly attended Laing's seminars in his Kingsley Hall community. There I learned, not without a struggle, as opposed to the 'doing to' ethos of mainstream medicine, the virtues of simply listening to and 'being with' people suffering from psychosis.

It's the mid-1960s. I'm now a clinical medical student at UCH. In psychiatry two outstanding teachers held sway, who also helped to inspire a generation of future psychiatrists into what was then a very low-status speciality within medicine: Heinz Wolff, a Winnicottian psychoanalytic psychotherapist, and psychoanalyst Michael Balint, a GP's son who wanted to spread psychoanalytic ideas into General Practice. Both were interested in what is now called liaison psychiatry, but in those days was psychological or psychosomatic medicine.

Balint set up groups for GPs to think about themselves in relation to their patients, and tried out a similar format for interested medical students. As 'Balint boys' (only 5 of the 50 students in my intake were women) talking about the psychological aspects of our medical patients, we developed a sense of role and conversational skills with our patients that counteracted the humiliations of learning clinical medicine.

In parallel, Heinz started the UCLH 'student psychotherapy scheme' where we took on patients under supervision for weekly therapy, thereby becoming nascent therapists. Two of my influential psychoanalytic supervisors were Dorothea Ball and Egle Laufer, both prepared to apply psychoanalytic thinking within the hurly burly of everyday psychiatry.

More fast forwarding. I'm now serving my time as surgical house officer. There, listening to my patients rather than cutting them open, and still under Balint's influence, I wrote my first published paper 'Varicose Veins – an optional illness' in which I suggested that opting for vein removal often denoted an un-punned vain hope for resolution of life crisis for the (mostly) female patients so afflicted – bereavement, divorce, depression - as compared with those with emergency hernia occlusions, whose life event incidence was no different to normal (the comparator group).

At this point I deviated away from psychiatry into internal medicine and neurology at Queen Square. This was a requirement for training at the Institute of Psychiatry where the doyen and terror-figure of Aubrey Lewis still held sway, insisting that psychiatrists be doubly qualified so as to counteract the prevailing view of them as either mad or dim - or both.

That in turn led to a further deviation when, after a year as a locum GP in Hampstead Garden Suburb, with my then wife and three children, I went to work as a university lecturer in medicine in Tanzania in East Africa. Tanzania was then only 5 years post-independence, led by President Julius Nyerere, described as a Christian Maoist, and guided by the principle of 'ujama' – community togetherness, which chimed with my residual infantile leftist aspirations. There I joined an international ex-pat community, learned about 'transfer neurosis' (a psychosomatic disorder prevalent in government employees posted into the far reaches away from the capital Dar Es Salaam); 'patient passports' closely guarded by patients instead of a chaotic administration and now discovered by the Labour Government of 2024; the role of associate physicians who do the work of doctors and yet cannot join the brain drain to the US and UK; and the importance of primary care in an equitable health care system.

1973-1986: Psychiatry

Two years later, having swung away from General Practice, I am now at the Maudsley Hospital learning to be a psychiatrist. Just as in politics there is an inescapable Left-Right divide, so psychiatry was then, and perhaps still is a never-the-twain-shall-meet fissure between the 'organic' and psychotherapeutic wings. I was immediately drawn to the latter, and in the psychotherapy department fell under the spell of the charismatic Kleinian analyst Henri Rey. Rey was notoriously reactionary and pro-colonial, so between supervision sessions we enjoyed fierce political debate. Although not much of an author himself Rey left his personal mark on a generation of psychoanalysts, including John Steiner, Michael Feldman and David Bell.

Watching Rey in clinical action, my main take-home was not his abstruse theories, but his aphoristic capacity to challenge patients with such warmth that their defences crumbled into a species of regressed dependency, out of which new and more adaptive ways of living could emerge.

Meanwhile - very much for personal rather than training reasons - I found myself in analytic therapy. Charles Rycroft is an ambiguous figure in the history of psychoanalysis, his *Critical Dictionary* an indispensable account of psychoanalytic concepts untrammelled by Klein/Anna Freud/middle group allegiances, yet somehow detached and possibly rather superior in its tone.

Despite 6 years of therapy, I never felt quite intelligent, interesting or cultured enough for his liking – which, given that he was against transference interpretations (which he felt to be conventional and clunky), remained and perhaps remains unanalysed. In retrospect, I'd characterise his approach as more existential than analytic. His aim was *authenticity*, helping his patient (me) to discover what their true feelings were rather than conforming to (m)others' expectations, or repression (in the service of survival) of loss and pain. Later, I would reframe authenticity in an attachment context where secure-making care-givers are able to mentalise their children, similarly validating the authenticity of their charges' desires and projects.

My main debt to Rycroft therefore was that he liberated a creative side in me, hitherto latent, or as I would later in Bowlbian terms come to see it, suppressed in my avoidant attachment stance on life. Much of my subsequent writing has been within his orbit and aegis, my

collection of literary essays, *The Therapeutic Imagination*, most obviously so. In my therapeutic work today, his influence is still to be felt. My aim is to allow my authentic unconscious responses to my patients to surface. I try to get out of the way of my 'top down' theoretical and conscious self, and to allow thoughts and feelings to surface 'bottom up'. The job of my conscious self is merely to translate these intuitive responses into words in a genre and language which makes sense to the patient.

While I was seeing Rycroft I applied for admission to the Institute of Psychoanalysis but withdrew halfway through the process. Three things stopped me. First, my genial assessor said encouragingly – 'you're exactly the sort of person the Institute needs' and then told me how much he enjoyed being a therapist to the boys at Eton College. My Marxism - Karl and Groucho - still active, I would never join a club, especially an elite one, that would have me as its member. Second, while filling in my forms I realised that, as though applying for a job, I was selling myself rather than speaking truths about my lostness, confusion and depression.

Third, in retrospect, I think I was terrified of having to give up Rycroft on whom I was by now highly dependent and also frightened of having to submit myself to an arbitrary authority and admit to my weaknesses and inadequacies once again. The tough mother and firm father the Institute represented would have been new beginnings for me, probably just what I needed. Anyway, it didn't happen. My status in the therapy world might have been enhanced had I trained there; who knows whether my psyche and its choices would have benefitted. I certainly saved myself quite a lot of money. I was much later put up for associate membership, but turned down with the dismissive comment that 'Holmes has never been a friend to psychoanalysis'. I am told that some members resigned in protest against this decision. I eventually found a psychotherapeutic lodging (although not exactly a home, see below) in the Guild of Psychotherapists.

Training at the Institute of Psychiatry in the 1970s focussed mainly on diagnosis and phenomenology. There was a strong emphasis on research (e.g. Julian Leff's debunking of the Laingian theory of miscommunication as cause of schizophrenia, see above), while getting patients better was seen mainly in terms of medication, the passage of time, and/or intrinsic 'prognosis' of the disorder. In the face of this, my generation of rebellious trainees were keen to learn how to be therapists as well as diagnosticians/ physicians. We therefore set up our own alternative clandestine training in which we invited teachers in Gestalt, family therapy, systemic therapy, psychodrama and group analysis to share their wisdom with us, including visiting the still revered RD Laing himself (by now, like an aging rock star, a rather tipsy narcissist who continued to trot out his time-expired stories but played the piano beautifully). I was particularly drawn to psychodrama and family therapy. There were one or two outstanding exceptions to diagnosis/ research/ Harley Street culture amongst the Institute staff from whom I learned a great deal. Douglas Bennett ran a day hospital along group therapy lines, in which Robin Skynner ran an explosive staff group once a week and Chris Dare was a magnet for people interested in family therapy.

Let's move on. It's now the late 1970s. I'm now a Consultant Psychiatrist, back at my old medical school UCH. The department is unashamedly psychotherapeutic, still dominated by Heinz Wolff and his followers – including Anthony Bateman, Jane Garner, Peter Schoenberg, David Sturgeon, Mike Parsons – and me. My job was to inspire medical students with

Balintian psychological awareness, and to provide a range of community services to Camden. Prominent among the latter was a weekly 'shifted outpatients' clinic in the famous left-wing General Practice, Caversham Centre in Kentish Town. There I had a weekly lunch with the practice GPs and paramedics, including Iona Heath, later President of the RCGP, (who has remained a firm friend) and discussed cases. In the afternoon I saw patients referred by the team. When I moved to North Devon I continued with this model to my own and, I hope, my GP colleagues' enjoyment. However, I suspect it is one of the many casualties of Covid-19 that UK General Practice has reduced to the parlous state it finds itself in today.

1986-2003: North Devon

My UCH life lasted from 1977 to 1986. Then my wife Ros and I and our 3-year-old son Josh (now a child psychotherapist) moved from the familiar world of London (where I had lived for most of my life) to a rural backwater of North Devon in the West country, where we had spent idyllic summer holidays throughout the 1950s. Mental hospitals were closing and the resources tied up in the Exeter 'bins' were passed up to Barnstaple establishing the new post which I took up.

Barnstaple was culture shock. Everything slowed down. The working day was 9.10-5.00. We were initially just three adult psychiatrists, later 4, each responsible for the totality of our patients' psychiatric illnesses: sickness, health, in-patient, community. Community Psychiatric Nurses – like today's physician associates – were doing much of the work. Management interference was minimal. Psychotherapy almost non-existent.

I decided to set up a multidisciplinary psychotherapy team. I was fortunate in that I had known a local group analyst, Joy Thompson, from family therapy training in London. We found the money for her to join the team. There was a CBT-enthusiastic Clinical Psychologist who in turn encouraged a talented nurse therapist to go to the US to train with Aaron Beck. I represented analytic psychotherapy and family therapy. When Joy retired, my friend and colleague Nic Sarra, another group analyst, replaced her. Another later key team member was Clinical Psychologist Eugene Mullan (of whom more below). We discussed – and sometimes battled over – theory, did mutual supervision and saw clients. It was small scale but worked well. When I became Chair of the Royal College Psychotherapy Faculty and later at the Department of Health, I drew on this multidisciplinary model in the wider political sphere.

1990-now: Books, Attachment Theory etc

It's time I said something about my writing. In the days when case histories and unsystematic qualitative research were academically permissible, most of my papers had been stimulated by a clinical observation or experience which I wanted to understand better. Why do otherwise healthy people seek a surgical operation (as above)? What part does the sibling dynamic play in the inner world (sorry Juliet Mitchell, I reckon I got there first!)? Is anxiety about nuclear war, however realistic, predominantly a projection (ditto Hannah Segal)? What does it mean when a patient gives you Christmas cake and how should one respond? What are the main patterns of endings in therapy and which work best for which kinds of people?

It's quite difficult to get papers published. Inundated, 'top journal' editors' aim in life is to find reasons for not publishing. The opposite is true of books where publishers are under

pressure to produce a new 'list' in the hope of a JK Rowling jackpot. I used facetiously to say that everyone I knew was writing a book, and no one I knew was reading one. Thus a second thread in my writing and editing has been producing collaborative books: *Introduction to Psychoanalysis* (with Anthony Bateman); *Psychotherapy and General Practice* (Andrew Elder); *Oxford Textbook of Psychotherapy* (Gabbard and Beck), *Integration in Psychotherapy* (Anthony again), *Attachment in Therapeutic Practice* (Arietta Slade) and *The Art of Psychotherapy* (3rd and 4th editions, with Anthony Storr, posthumously).

Perhaps the most important of these collaborations was the first, with my brother-in-law Richard Lindley. Our co-authored *The Values of Psychotherapy* first appeared in 1991. The main purpose of the book was, somewhat ahead of its time, to consider some of the ethical issues that arise in relation to psychotherapy, especially those that arise out of the power imbalance between therapist and patient and how this may be used to exploit patients, financially, sexually and even morally in the sense of instilling false memories and invalidation. We discussed the need for regulation of the psychotherapy profession, comparable to that obtaining in medicine (all of which remain relevant today). We also wanted to capture what was the basis of psychotherapy that makes it distinct from medicine, social work or clinical psychology. Richard's previous book had been on the concept of autonomy, especially as developed in the philosophy of Kant and John Stewart Mill, which he saw as a fundamental human need, distinct from the utilitarian seeking of pleasure and avoidance of pain as advocated by Jeremy Bentham. We decided that psychoanalytic psychotherapy's (PP) values were informed by the valuation, validation and promotion of *autonomy.* This brackets PP off from say CBT which is essentially pragmatic and utilitarian. PP sees the need for freedom, self-determination and self-expression as goals in their own right, even if they entail painful facing up to trauma, loss and abuse.

This valuation on autonomy follows helpfully on from the Rycroftian emphasis on authenticity. I would argue it forms the lynchpin of the psychodynamic triad of *authenticity, autonomy* and *connectedness*. Fostering authenticity helps the patient to begin to know themselves and their desires and goals. Autonomy implies active subjects, agents in the world able to make their own choices, to know their mind and act on it. As I shall argue below, connectedness entails reaching out with one's autonomy into trusting relationships with others, leading to a sense of creativity and satisfaction.

The Values was a moderate success (reviewed in the Independent, 2nd edition 1999). Not long after its appearance I was contacted by Routledge who were planning a series, *Masters of Modern Psychotherapy*. Would I like to contribute? I could write about anyone I chose, Freud, Jung, anyone. Of course I said yes, but who could it be? I narrowed it down to the '3 B's': Balint; Bateson (the great anthropologist and author of the 'double bind hypothesis', taken up by Laing, and whom, as a medical student in 1967, I had driven from his hotel to the *Dialectics of Liberation* conference at London's Roundhouse); and John Bowlby. As it happened, I had met all three of them. My wife was having lunch with a social work friend at the time, and mentioned my dilemma – 'Oh,' said her friend, 'never heard of Balint or Bateson, but do know about Bowlby.'

So Bowlby it was. I was around 50 – mid career, and at this point had a very lucky break. I applied for and was awarded a nine-month Wellcome Fellowship to research and write the book which became *John Bowlby and Attachment Theory.* This was my mid-career sabbatical.

I continued with one day a week clinical and administrative work (I was Chair of the Hospital Medical Committee at the time), but the rest of the time I was free to study the whole of Bowlby's monumental oeuvre, try to master the huge variety of attachment research that had flowed from it, interview his family, friends and colleagues – and to write the book.

I think it's fair to say the book was a success. It's still in print 25 years on and has held its place on reading lists for social work, counselling and psychotherapy courses. It is part-Bowlby's personal and intellectual biography, part summary of Mary Ainsworth and her successors' research, and, to the extent that it was original, tried to show how the principles of attachment theory can inform psychotherapy practice.

Although I am, as I've said, by nature eclectic, and firmly believe in psychotherapy polyphony and the mutative role of common factors, I also acknowledge that every therapist needs a home, a starting point, a set of ideas and practices with which they can identify. In the course of writing the book, I had at last found my psychotherapeutic home – attachment-informed psychodynamic psychotherapy. And the concept of the secure base even gave a theoretical justification of the need for one and its specificity (when the attachment dynamic is active, 'only Mum will do').

Sarah Hrdy (another legacy interviewee) argues that what is unique about our species is collaborative child rearing. So finding a 'home' is not just a matter of acquiring a parent-figure or figures whoever they might be – Freud or Jung themselves, or Klein, Segal, Moreno, Perls, Hobson and Meares, Ryle, etc - in my case Bowlby, Ainsworth, & Main – but also a community of like-minded colleagues, who meet regularly at conferences for mutual support, discussion, disagreement etc. I was now firmly in the attachment club. I suddenly found I had a new group of attachment 'friends', mainly clustered around the Anna Freud Centre and the Psychoanalysis Unit at UCL, (some of whom became firm social friends as well): Arietta Slade (she too has been 'legacied'), Peter Fonagy, Mary Target, Miriam and Howard Steele, Jon Allen, Marinus van IJzendoorn, Juliet Hopkins, Evrinomy Avdi, and many others.

Thanks to the book, and further work in the attachment field that flowed from it, I now found myself on the lecturing 'circuit', going regularly to most European countries, as well as Hong Kong, Singapore, Australia, Canada and the US to spread the attachment word. Reciprocally, talented students and junior colleagues were drawn to work with or in our department with its combination of psychodynamic psychiatry and attachment-informed therapy; these included Glenn Roberts, Charles Montgomery, Saadia Muzaffar, Irene Kam, Samuel Cheng, Tobias Nolte.

So what is the 'attachment word'? Summarising very briefly, I would include the following:

a) Evidence based account of caregiver-child relationship and its long-term sequelae, rather than putative reconstructions from the couch
b) Observation-driven theories as opposed to theory-driven observations
c) The role of the attachment dynamic, activated by threat, separation or illness, leading to seeking caregiver proximity and soothing, and inhibition of exploratory play
d) Thus security, not sex, as the primary relational dynamic in infancy
e) The four main patterns of attachment: secure, insecure - avoidant, anxious and disorganised - as useful classification of future developmental pathways

f) The role of language and interactive speech patterns in adult relationships as reflecting underlying attachment dispositions, and their relevance to therapeutic conversations
g) The concept of mentalising, subsuming theory of mind, empathy (capturing the capacity to see another's point of view) and thus - to return to my therapeutic triad - to acknowledge their authentic desires, autonomy and relational projects
h) The importance of mentalising as a mark of secure attachment in caregivers and care-seekers, as bulwark against trauma and therapeutic goal in working with Borderline clients.

In parenthesis (or perhaps not so – there are no asides in psychotherapy, everything is grist to the mill of the unconscious), even my commitment to Attachment has an arms-length aspect to it – I have for instance only had a glancing connection with the Bowlby Centre, and, ever the 'other in the other', tend to be quite psychoanalytic when with attachment aficionados, and more 'attachment' when with psychoanalytic friends.

1995-2016: University of Exeter, Royal College etc

My sabbatical over, work life continued, but with a gradual shift of emphasis from NHS work towards the University. A significant encounter in the late 1990s was with my colleague (later friend) Clinical psychologist Eugene Mullan. Not untypically for psychologists and medical psychotherapists, we circled cautiously around one another for a year or so, although there was perhaps an instant mutual respect beneath our veiled rivalry. Eventually, however, we realised that it would make sense to make common cause and create a department of psychological therapies.

This rapprochement coincided with Eugene moving to head up the Psychological therapies programme at the Psychology Department at Exeter University, and I taking up a part-time Hon Senior Lecturer Post there, later converted into Visiting and then Honorary Professor, and, when I reached 60, my full NHS retirement. Together with family therapist Prof Janet Reibstein and CBT and Mindfulness therapist Willem Kuyken we then, with other colleagues, decided to set up a Masters in psychological therapies. This was informed by two aims. First, to provide a local training for would-be therapists in the South West and so obviate their need to travel to London, Bristol or further afield. Second, to attempt an integrative training where students 'majored' in their chosen modality, but were also exposed to other forms of therapy, their differences and overlaps. The programme ran, I would say, successfully for three years but then reverted into the three modalities where it had begun. This coincided with the move from London to Exeter of Jungian analyst Richard Mizen and Medical Psychotherapist Susan Mizen. Richard was an invaluable asset and as I gradually retired, he took over the programme which has morphed into a Department of Psychoanalytic Studies. It currently has over 100 students from all over the world, who undertake a Clinical Doctorate in Psychoanalytic Psychotherapy, coming to Exeter twice a year for an intensive week but otherwise working in their own locality and through distance learning. Other key members of the team include Jungian analyst and attachment theorist Jean Knox and group analyst Nic Sarra.

Whilst all this was developing, I was also, for 4 years, Chair of the Psychotherapy Faculty at the Royal College of Psychiatrists, with colleagues such as Anthony Bateman (who later was College Chief Examiner) I saw my job as maintaining a vocal psychotherapy presence amongst top psychiatrists; moderating internecine psychoanalysis/ CBT wars within

psychotherapy; and insisting that, as in Australia, a mandatory requirement for qualifying as a psychiatrist was a basic training in psychotherapy, including taking on short and long-term cases under supervision.

Thich Nhat Hanh and engaged Buddhism

Now for another digression. Fuelled by my passion for science, I have always been a convinced atheist, a brief moment of pre-adolescent religious fervour aside. But within the ambience of my mother and father's attenuated Judaism and liberal Christianity respectively, there has always been a religious space in my psyche. I was vaguely interested in Buddhism as a student, hoping perhaps that it would provide the 'answer' to an as yet unformulated question, and before I summoned up the courage to subject myself to psychoanalysis.

Then, some 30 years later, in response to family trauma and illness, my wife 'discovered' the Vietnamese Buddhist teacher Thich Nhat Hanh. We attended a number of his retreats, attracted by the quasi-secular nature of his teaching, his concept of 'engaged Buddhism', the emphasis on the ethics of 'right action', valuing the natural world, and finding ways, through mindfulness, to live in the 'present moment'. Some of this has filtered through into my psychotherapeutic work, especially in my theory (which is a species of anti-theory) and in my attempt to employ present-moment 'praxis' in the consulting room. I try to write about this in my latest book *The Spirit of Psychotherapy*, and it overlaps with my interest in Paul Gilbert's Compassion-based therapy (CBT) project, with which I have been peripherally involved.

2003-present: Karl Friston and 'Free Energy'

In 2003 I retired from the NHS. My clinical work was now in part-time private psychotherapy practice, and academically I worked, as above, in the Psychology Department at Exeter University, but also had strong links with UCL and the Anna Freud Centre through my colleagueship with Anthony Bateman, Peter Fonagy and Mary Target, and Julian and Joan Raphael-Leff.

Peter and Anthony made a huge leap forward in the contribution of Attachment to psychotherapy and psychiatry practice in the theory, research base, practice and pedagogy of Mentalisation Based Therapy (MBT), now recognised as an evidence-based treatment for people suffering from Borderline Personality Disorder. As with Compassion, my contribution has been peripheral in the extreme although in the early days of MBT I wrote a piece about mentalising, where I defined it as the capacity to 'see oneself from the outside and others from the inside', with which I am still happy. I also like to think that I urged Anthony to devise an acronym if his method was to succeed in the marketplace of competing psychotherapies.

If I think of my mentors, the list runs chronologically from Laing, Balint, Rycroft, to Bowlby – and now a fifth and final hero, Karl Friston. I first encountered Friston at one of the biannual neuroscience conferences organised by Peter Fonagy and the UCL Psychoanalysis Unit. My maths was never really properly up to understanding his work, but I immediately sensed that there was something here that could be of importance of psychotherapy. As he and Carhart-Harris had shown, there are parallels between Freud's idea of psychic energy (later renamed libido), bound and unbound, and the Fristonian notion of 'free energy' and the brain's project of 'minimising' or binding it. 'Fristianity' (as my psychiatrist son Jacob

calls it) consists of a series of dialogues. The first is between incoming information from the environment, external and internal, provided by the senses, and the brain's pre-existing top-down models of the world. Where there is a good fit, free energy is minimised; attention is then directed towards discrepancies in which bottom-up information is passed upwards in a hierarchical fashion until it reaches consciousness via the pre-frontal cortex. Beyond this bottom-up/top-down conversation there is then an internal dialogue in which we 'think about thinking', i.e. self-mentalise. This helps us to contextualise our thoughts and take our own desires and hopes and projects into account when striving to survive, adapt and live more creatively in the environment in which we find ourselves, or have to some extent fashioned. The third 'conversation' is what Friston and Frith call 'duets for one', in which we recruit intimate others (our attachment figures), to create a 'borrowed brain' (as I call it) with which to enhance our flexibility, complexity and adaptations.

I felt that these ideas had huge implications for psychotherapy, and tried to expound them in my extended essay *The Brain has a Mind of its Own*:

a) All these processes are vitiated in psychopathology – in trauma there are no pre-existing models with which to bind the free energy of painful intrusions or neglect; rigid adherence to outdated models of the world compromise the capacity to recruit significant others with whom to share and reshape these top-down models
b) They help explain transference which is essentially the over-emphasis on inflexible top-down models at the expense of bottom-up, present-moment experience
c) They validate the importance of free association in that it encourages people to attend to their bottom-up experience
d) Theorise the free energy binding role of the therapeutic relationship and dialogue
e) With the help of the Winnicottian notion of transitional space, it opens up a dialogic zone in which new ideas can be played with, developed, modified and eventually, as with dream analysis, built into the free energy minimising repertoire
f) They show how, in the context of joint attention and uncertainty toleration, free energy can be bound into more complex and adaptive ways of thinking, feeling and behaving.

From roughly 2015 onwards I reduced my clinical work to around a day a week of on-line therapy and supervision. There remained a residue of research restlessness, missing perhaps the essence of my work life: being afforded that extraordinary and privileged glimpse of a person's inner world.

Still influenced by Thich Nhat Hanh, I thought there might be interesting parallels between the journey undertaken by therapy patients, and those on a religious pathway, especially as, seen sociologically, in our modern secular world, psychotherapy and counselling now colonise the cultural space previously occupied by religion. I therefore embarked on a qualitative study based on an 'opportunistic sample' of friends, family and colleagues. Using a psychotherapy format of engaged listening I interviewed people from a variety of religious backgrounds: Quaker, fundamentalist Christian, Druidic, Islamic, Judaic, Buddhist, exploring not so much their cosmology, but the part that religion and religious practice played in their everyday lives.

The result is my most recent book *The Spirit of Psychotherapy*: *a Hidden Dimension*. Continuing with my attempt to understand and apply Friston's Bayesian prediction/ free

energy minimisation ideas, I suggest that religion and psychotherapy in different ways represent attempts to deal with the radical uncertainty which characterises our existence. Religion offers general top-down unassailable precepts, especially the 'golden rule' of 'do unto others', which encompass the ethical challenges of bottom-up experience. Psychotherapy deals with uncertainty by embracing it. By mentalising the top-down assumptions we make about ourselves and others, a zone of not-knowing and uncertainty is opened out which paves the way for more complex adaptive models of our worlds.

Conclusions

We are approaching a full circle. Excited by the certainties of science, and envy/ admiration for those at its cutting edge, I started this account of my work-life with a species of self-abnegation and sense of inadequacy.

However, with the help of psychotherapy, my own and life-long learning from my patients, aided by attachment theory, I have come to the paradox of a safe haven or secure base from which to explore and contemplate my own nothingness. Aporia, negative capability, the Buddhist idea of transience, the very unconsciousness of the unconscious – what we know is that we don't and perhaps cannot know. Friston's twist on this is the free energy which, to avoid madness we need to 'bind', and yet without the creative use of which we remain rigidly fixed, at the mercy of an ever-changing world.

The escape from this paradox, elaborated in *The Spirit of Psychotherapy* is the Winnicottian transitional space of intimate relationships. With the help of another the uncertainty of radical non-knowing can be tamed, tolerated, transformed. This leads to another rather sad valedictory irony. Whatever I have achieved or not achieved, I have worked hard. Time, love, and energy (free or bound) which rightly belonged to my family, parents, partners, spouses, children, grandchildren, has been robbed from them. In this, at least to an extent, I have enacted the socio-political mores of my culture and times. Men go to work. And yet, that's where my true legacy - love and pride and excitement, but also the neglect, let-down, and confusion - lives, however much I have, with Jane's encouragement, enjoyed collecting, as TS Eliot put it, these frail 'fragments I have shored against my ruins'.

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The 'Impossibility' of working in the current NHS: sacrifice to a primitive god

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Introduction

"The NHS is the closest thing the English have to a religion"
Nigel Lawson 1992

This paper examines the current crisis in the NHS, focusing on the impossible experiences of staff. It argues that the seeds of this crisis were planted at the organisation's inception, rooted in its foundational ideology and perpetuated by an entrenched idealisation, which fosters immature dependency dynamics. This persistent idealisation obstructs meaningful efforts to challenge the pervasive and increasingly disruptive dynamics within the system. These issues are explored through the author's experience as a consultant psychiatrist from 2008 to 2018. It focuses on mental healthcare to illustrate how symptoms of organisational dysfunction manifest and render the demands of day-to-day work 'impossible'.

The idealisation of the NHS emerged as a collective psychological response to the trauma of World War II. After years of hardship, people sought a system that promised control and reassurance in an uncertain world. The NHS became a symbol of hope, addressing anxieties about health, security, and well-being, while promoting a more equitable society (Stewart, 2002; The Times, 2023; UK Parliament, 2023).

Aneurin Bevan described the NHS as 'pure Socialism', opposing 'the hedonism of capitalist society' (Stewart, 2002). The NHS emerged from post-war adversity to offer 'healthcare available to all, regardless of the ability to pay, free at the point of use' (National Health Service Act, 1946). While ideal for its time, it now faces mounting challenges: increasing demand from a larger, more diverse population, rising complexity of chronic illnesses, escalating costs, political and social shifts, changing expectations, and the impact of COVID-19 (Cummins, 2018; Scambler, 2021).

Psychodynamically, the NHS, like all groups, is influenced by two competing tasks: the Primary 'Work' Task – improving health and treating illness – and the Basic Assumption Task, driven by unconscious fantasies of infantile dependency (Bion, 1961). This dependency involves the expectation that the NHS will provide all-encompassing support—'everything, for everyone, for nothing, now' – akin to unconditional love. When these unrealistic expectations inevitably go unmet, idealisation rapidly collapses into denigration, resulting in harsh criticism and hostility towards the organisation. Insecurely attached parts of us all unconsciously collude in this idealisation, maintaining a 'co-dependent' equilibrium that distorts the NHS's functioning and makes it difficult to challenge. Patients, staff, and society continually alternate between perceiving the NHS as a wonderful, omnipotent institution – central to British identity, as vividly celebrated in the 2012 Olympics opening ceremony – to subsequently denigrating it as 'broken', 'neglectful', or 'failing' (Adshead, 2010; Main, 1957; Obholzer & Roberts, 1994).

The balance between the Primary Work Task and the Basic Assumption Task shifts according to the level of anxiety within the organisation. When systemic anxiety remains manageable, efforts are focused primarily on the realistic 'Work' Task. However, as anxiety escalates –

due to increasing demand, limited resources, or external pressures – the balance is tipped towards Basic Assumption functioning. Elizabeth Menzies Lyth and Bion show how unconscious dynamics create social systems of defence that protect staff from anxiety but hinder growth and progress (Bion, 1961; Menzies,1960). As these defences harden in response to an overwhelmed system, the organisation drifts further from its primary task, leading to dysfunction. Table 1 proposes 10 social systems of defence in mental healthcare (Gibbons & O'Reilly, 2021).

Social systems of defence in NHS mental healthcare
(1) Denigration of boundaries due to idealisation of care possibilities: The organisation colludes with the fantasy that omnipotent care can be provided to all, irrespective of actual resource and clinical constraints. This creates unsustainable expectations, leading to overextended staff and preventing the system from acknowledging real limitations. The denial of these boundaries perpetuates a cycle of over-promising and under-delivering, further contributing to systemic dysfunction.
(2) Ritualisation of form-filling and task completion without clinical effectiveness (e.g., Risk Assessment, Mandatory Training): Excessive bureaucratisation turns form-filling and training into ritualistic activities disconnected from clinical outcomes or staff development. These tasks are often done to meet organisational expectations or manage anxiety about liability, with little regard for their practical relevance or impact on staff skills. This ritualisation diverts attention from more meaningful and reflective forms of training or action, fostering a culture that prioritises superficial task completion over genuine clinical effectiveness.
(3) Defensive scapegoating as a response to paranoid-schizoid dynamics: The system unconsciously aligns with primitive superego functioning by routinely scapegoating staff and initiating suspensions and investigations without due process (Klein1946).
(4) Concretisation of boundaries and projection of blame onto other teams: Boundaries between teams become rigid, and badness is projected onto other teams, creating a fragmented work environment. This leads to increased blame and avoidance of internal reflection.
(5) Destructive use of email for projection: Email becomes a medium for projecting split-off aggressive and destructive aspects of staff functioning, amplifying dysfunctional communication and conflict within the organisation.
(6) Idealisation of new service initiatives as the 'messiah': New service initiatives and transformation processes are idealised as solutions to all of the organisation's problems. This reflects the hope that these initiatives will 'rescue' the system, even though they often fail to address the deeper issues (Bion, 1961).)
(7) Collusion with concrete thinking and devaluation of reflection in favour of action ('doing' activities): This dynamic is based on the assumption that action is always better than reflection. By prioritising concrete 'doing' over more symbolic, introspective forms of problem-solving, the system bypasses the complexity required for thoughtful planning. This undermines reflective practice, distorting the balance between thinking and action, and leads to impulsive and ineffective responses to problems within the organisation.

(8) Idealisation of patient-led care and opposition of staff and patient needs: Patient care is idealised to the point where the needs of staff and patients are seen as being in conflict. It is assumed that patients require care that is unlimited and unconditional, while their responsibility for their own care is minimised. This dynamic neglects the care needs of staff, leading to burnout and further strain on the healthcare environment.
(9) Use of language to obscure and deny difficulties: Language is manipulated to downplay challenges and mask underlying issues. Phrases like 'cost improvement' soften the reality of cost-cutting measures, while terms like 'pursuit of excellence' obscure the developmental pressures staff face. This strategic use of language fosters confusion, inhibits open dialogue about real problems within the organisation, and perpetuates a culture of denial that contributes to dysfunction.
(10) Entrenched omnipotent belief in 'making people safe' - from their own minds and through inpatient admission: This defence reflects the belief that mental health systems can protect individuals from their internal distress through external control, such as constant supervision or inpatient admission. Despite lacking evidence, the assumption persists that these interventions reduce suicidality and mental disturbance. In reality, inpatient wards are often chaotic environments where patients confront their own and others' disturbances, which may increase risk and regression. These beliefs help manage organisational anxiety but neglect more effective, reflective approaches to care.

Table 1. Social systems of defence in NHS mental healthcare

To understand the rise in systemic anxiety within the NHS, it is useful to examine recent changes in service pressure and funding within mental health services. Since 2008, demand for mental health care has substantially increased without a corresponding increase in resources (National Audit Office, 2024). In fact, resources have effectively declined due to austerity measures implemented from 2008 to 2015 following the financial crisis (Cummins, 2018; Nuffield Trust, 2024). Funding growth sharply fell from an annual increase of 5.5% under Labour in 2010 to just 2.1% under subsequent Conservative administrations (King's Fund, 2024a, 2024b; Nuffield Trust, 2024).

In the last eight years alone, demand for mental health services has surged by 20%, with a staggering 353% increase for Child and Adolescent Mental Health Services (CAMHS) (British Medical Association, 2024). This strain on services has been exacerbated by the reduction of 1,700 mental health beds, soaring bed occupancy rates from 85% to 100% in many areas, increased use of private, out-of-area bed placements – driving spending on private providers up by over £100 million – and rising waiting times (House of Commons Committee of Public Accounts, 2024; House of Commons Library, 2024; Royal College of Psychiatrists, 2020).

Simultaneously, the NHS has faced significant workforce challenges. High turnover rates, voluntary redundancies, and retirements have led to critical staffing shortages. In 2021–22 alone 17,000 (12%) staff left the NHS mental health workforce (British Medical Association, 2024; General Medical Council, 2024; House of Commons Library, 2024). One in seven full-time equivalent roles in the mental health sector remains unfilled, with around 50% of psychiatrists now being international medical graduates (British Medical

Association, 2024; General Medical Council, 2024; House of Commons Library, 2024). Expenditure on bank staff, who work extra shifts at higher pay rates, more than tripled from £1.8 billion in 2015/16 to £5.8 billion in 2022/23 (House of Commons Library, 2024). Vacancy rates in acute inpatient mental health services have reached 'up to and around 20% plus', while mental health issues have become one of the two biggest drivers of sickness absence for NHS staff more broadly (British Medical Association, 2024; Trades Union Congress, 2024).

As the NHS has faced these rising demands, the anxiety of both patients and staff has increased, causing these infantile dependency fantasies that underpin basic assumption functioning to emerge and dominate daily life, contributing to a pervasive cultural disturbance. Many staff are demoralised and systemically abused, while some patients are neglected. Idealisation obstructs the acknowledgment of the 'impossibility' of meeting these early dependency demands given the real financial and workforce challenges. To illustrate how these dynamics manifest in everyday practice, the following section explores the authors personal journey through the NHS from 2008 to 2018.

Personal journey 2008–2018

I do not regret a single day I spent in the NHS; I worked with wonderful people, both staff and patients, had interesting experiences, and witnessed amazing things I would never have otherwise. However, I also do not regret leaving when I did in 2018. By the time I left, I felt as though I was in an abusive relationship that had become toxic. I never thought it would end like this. What happened to me? Had I lost my mind? I felt overwhelmed by noxious fumes from various experiences. I was preoccupied with the questions: 'When does a relationship become abusive? And what does this feeling of toxicity mean?' I concluded that a relationship feels toxic when your boundaries are violated, when there's no love left, and you are left in an infantile dependent state – too scared to leave because it feels like stepping into an abyss. You are filled with hatred towards your own dependency, allowing violations and abuse because of this fear of leaving (Rachel Gibbons, Tavistock Institute, 2024).

Significant changes in the NHS began just as I started as a consultant in 2008. After years of training, I was delighted to secure a position as an inpatient consultant in an inner London hospital, despite the role now being condensed to 60% of its previous time. On my first day, I learned the inpatient unit was scheduled to close within a year to reduce bed numbers. Staff, many of whom had worked together for years, were to be dispersed and 'hopefully' reassigned elsewhere in the hospital. The unit was dilapidated, with only 80% of the needed nursing staff. Four nurses were off on extended leave after suffering serious assaults from patients. The toilets in one ward were blocked with concrete, causing faeces and urine to leak across the floor. It was a relentless nightmare, marked by repeated deaths by suicide. Yet over three years, a dedicated team fought to survive, keeping our wards open while others were closed (Hayes et al., 2012).

In response to funding difficulties, the organisation cut more beds, staff, and services. Non-medical staff were required to re-interview for their jobs, with many leaving, being made redundant, or returning at reduced pay. Annual Cost Improvement Projects (CIP's) demanded 4–5% funding cuts from all services under the guise of improvement. Managers had to identify which underfunded services could be reduced to function more 'leanly', or external cuts would be imposed, causing greater damage.

After five years, I moved to a community consultant role, combining the responsibilities of two previous jobs without additional time or support. While I worked with a creative, dedicated team and wonderful patients, the job came with a relentless stream of serious incidents and complaints. By 2018, 25% of my time was consumed by addressing complaints and investigating serious incidents (SIs), overwhelming the under-resourced infrastructure.

During this second role, staffing shortages became clear. What had once been an excess of staff fearing for their jobs had reversed into too few, leading to a surge in expenditure on temporary (bank/agency) staff. As funding and staffing dwindled, demand for services surged, increasing organisational anxiety and exposing the primitive fantasies of infantile dependency and the basic assumption functioning seen in systems of defence.

Lived experience of the 'Impossible' demands and the systems of defence

I see things in the team that don't make sense, but I can't challenge them… I'm overcome by an irrational mutism (Nurse, Crisis Team).

In infantile dependency, there are no boundaries; what is wanted must be provided immediately. This fantasy was evident in various NHS situations, where boundaries were often seen as cruel or neglectful.

Email: A prime example was the use of email. Each day, I arrived to find 100–200 emails, sent at all hours. Initially, patients and families were encouraged to email clinicians directly, but this practice was soon seen to pose risks to patient care, especially when unanswered emails were implicated in incidents of self-harm. To prevent fragmentation, we adopted a single team email account. Despite this change, concerns persisted that any delay in response could be disastrous.

Each day, 10–20 emails I received involved serious clinical issues from the crisis team, liaison team, or other team members requesting urgent attention. The underlying belief seemed to be that you could 'email away' your anxiety – once sent, the concern was off your hands, regardless of whether it was received. For example: 'Mr. X says he will harm himself tomorrow unless someone contacts him' - read the next morning - or 'I'm concerned about Ms. Y because something felt off during my contact today; can you see her urgently?'

Email issues were numerous, with some being angry or abusive. A colleague who moved to the private sector was shocked by how polite and respectful communication was in his new environment.

This issue affected all staff, tethering us to our inboxes. The more anxious we became, the more time we spent on emails, fuelling the cycle of anxiety. I spent considerable time trying to manage this flood – setting up out-of-office messages, limiting email checks to 30 minutes a day, establishing strict email protocols and on occasions just saying I was not going to answer them. The overwhelming influx of emails became a serious symptom. How could we spend all day answering emails and still do clinical work? It was 'impossible'.

The 'Gaps': It all became about 'the Gaps' – who would fill them? 'The Gaps' became central to the language of dependency, referring to any shortfall in care that deviated from the collective fantasy of perfection. There could be no 'Gaps', so those remaining in the system were expected to fill them.

Professional Boundaries: Establishing realistic boundaries around my available time became unattainable. My diary was booked months in advance, leaving no flexibility for the many urgent situations. Questions about managing personal and service capacity amidst overwhelming demands were constant. Junior doctors, in particular, were preoccupied with how to say 'no'. The dilemma was clear: refusing could lead to poor evaluations, overburdened colleagues, and more chaos, while agreeing to everything led to burnout – both were 'impossible'.

Waiting times: Waiting times were rising, yet we were told this was unacceptable. Central targets were imposed: 4 hours in A&E, 2 weeks from referral to assessment, and 13 weeks from assessment to treatment. To cope, boundaries had to be set covertly. Phrases like 'they don't meet our criteria' worked for some services, but for teams like mine in community psychiatry or crisis care, this approach wasn't possible.

Crisis team boundaries: The Crisis team managed 40–80 patients at a time, fielding calls all day. With over 10 new referrals daily, they had to discharge 10 patients to keep the caseload around 60 - a relentless production line with no time to breathe or think. When the caseload exceeded 60, the team began to break down. A typical team of ten clinicians struggled to keep up with assessments, leaving little time for actual treatment. If the consultant or team manager went on holiday, caseloads would balloon to 100, making it an exceedingly stressful environment.

'The Hub': To address difficulties contacting the crisis team, 'The Hub' was established as a call centre for GPs to reach secondary mental health services quickly. However, it soon evolved into a 24/7 borough-wide crisis line, filling another 'Gap' in local services. Initially aimed at improving accessibility, the scope widened so anyone – neighbours, family members, or the person in distress themselves – could call. Unlike the Samaritans, who only listen, The Hub lacked such boundaries and became an active crisis intervention line, far beyond its original administrative purpose or the training of the staff who manned it.

Recognition of 'Infantile Dependency' facilitating service development

The team I joined had a history of creative developments but was recovering from a 'transformation' process that had ended just before my arrival. Under pressure, they began to stabilise and developed an 18-month psychological treatment pathway to help patients recover and re-engage with their lives. However, the plan did not materialise as expected. Patient numbers increased, but they didn't leave the system as anticipated, leaving it 'blocked' for unclear reasons.

Some psychologists began identifying potential root causes. On the surface, patients sought treatment to move forward, and staff wanted to help them. Yet, in many cases, this didn't happen. They speculated that the approach might trigger attachment behaviours in both patients and staff, counterproductive to therapy. They also wondered if some staff might benefit from patients remaining 'hidden' in the system.

To explore these concerns, the team audited service use and found many patients had been with services for over 20 years without a recent treatment review. Some were shuffled between teams, repeatedly diagnosed with different illnesses to justify their transitions across service boundaries.

The team developed a group-based treatment programme to address immature, dependent attachment patterns. Previously, when recognised, the response was often abrupt discharge – typically carried out by the most junior staff member – causing iatrogenic harm and replicating the patients' early abandonment experiences. The new approach aimed to support, not penalise, attachment needs and to foster open and straightforward discussions about attachment dynamics within treatment. Clearly defined phases - 'Welcome', 'Treatment', and 'Goodbye' – encouraged patients to actively understand and address relational patterns rather than unconsciously act them out with staff. This promoted healthier, more autonomous relationships with services. The programme proved highly effective: patients demonstrated improved engagement and reduced crisis admissions, while staff morale increased as clinicians felt supported and better equipped to manage complex relational dynamics constructively. Even in this increasingly challenging environment the team gradually rediscovered their enjoyment in working together again.

Increasing 'Impossibility'

Meanwhile, pressure in the wider system continued to escalate. The only viable ways to establish boundaries became drastic: closing services, experiencing psychological breakdowns leading to sick leave, or leaving the NHS or profession entirely. As the situation worsened, the language of fantasy and war – denying reality – took over, with terms like 'Fill the Gaps', 'Re-enablement', 'Chasing Excellence', 'Zero Suicide', 'Make Safe', 'Red to Green', 'Black Alerts', and 'Gold Command'.

It became impossible. A pervasive sense of irrationality took hold. Team members expressed their exasperation: 'This is impossible; how can we answer emails all day and still see patients? How can we take on more patients without space to think or rest? How are we expected to meet these endless demands and provide everything for nothing?' The answer was always the same: 'We can't. It's impossible'. When someone raised this concern in a meeting, they were often seen as 'mad', 'difficult', or both. Occasionally, their sanity was acknowledged, but with a resigned sense that nothing could be done.

In many consultant meetings, discussions often centred around abuse, complaints, or assaults. One consultant, assaulted three times, was advised to take a break. His response captured the dilemma: 'But how can I? Who will see the patients?'

My team had started to recover and function well. I mentioned this in a meeting, only to receive an email the next day announcing another 'transformation', just three years after the last, to save money and 'improve patient and GP experience'. We were to merge with another department that was struggling. At the first meeting, I found everyone was temporary staff, most of whom would leave within three months. That was enough for me – I decided it was time to go.

Conclusion

This reflects my experience in the NHS from 2008 to 2018 in Inner London. While not universally applicable, these dynamics are widespread. Since 2018, the situation has worsened, particularly due to the Covid pandemic. Psychological distress has increased, pushing the NHS further away from its primary task and deeper into unconscious dependency and basic assumption functioning.

The issue with this mode of primitive dependency is that it operates under a persecutory superego – a 'god' figure demanding omnipotence (Klein, 1946). The failure to meet these impossible demands creates fear of retribution or destruction. Living under this terrifying 'god' day after day is unsustainable.

Many in the NHS are extraordinary, creative, and thoughtful. Yet, the normalisation of scapegoating, abusive behaviour and aggressive language is disturbing. Frequent staff suspensions – targeting the system's most valuable asset – further strain its already stretched capacity. This punitive atmosphere, instead of addressing deeper issues, only worsens the problem.

Real change must come from both inside and outside, top down and bottom up. We need to recognise the conflicting tasks and unconscious dynamics within ourselves and our systems. By making the unconscious – particularly our co-dependency and institutionalisation – conscious, we can challenge the shame and guilt of complicity, reducing reliance on organisational defences. The hardest part is confronting the idealisation of the NHS and facing the primitive god that threatens us when we speak this truth. We must detach from political ideologies and rebuild the NHS as a 'good enough' system, balancing compassion with economic realities. Funding alone won't solve these issues – cultural change is essential.

Ultimately, we must confront the unconscious expectations of this 'primitive god' of omnipotent healthcare. If we can't tolerate the gaps, we risk losing the very essence of what makes the NHS valuable.

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Full article: The 'Impossibility' of working in the current NHS: sacrifice to a primitive god

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Wait, was that racist?
(from the Med Psychotherapy Faculty Conference)

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This was the title of my first drop-in session as the mental health lead of the British Ugandan Medical Doctors Association which is an organisation bringing together people of Ugandan heritage that are also living in the UK and are medical doctors. Some members of the association did not like us being called British-Ugandan because they feel Ugandan first and then British but the acronym BUDA was easier than UBDA so we went with that. I also did not originally like BUDA first as I was not even British by the time we were having these discussions so did not relate with that as my identity at all. I have recently been naturalised as a British Citizen so now do feel a bit British but don't yet feel it in my bones :-)

Another identity that is more surface level than my bones is about my skin colour and that is about being black. I have often said I did not become black until I moved to the UK which is a very strange thing because while I have always been myself, I only became racialised as black when I moved here. It is the society around me that changed and not me. I did not before coming here have to choose an ethnic group from the white, black, Asian option under demographics.

The closest I got to having to make that choice was at a social medicine course when I was in medical school in January 2015, 2 years before I moved to the UK and at a time in which I had zero plans for doing so. I was doing an optional course that was organised by some Americans that I like to say were doing reverse colonialism. They organised a one-month course to teach about 30 medical students the social, economic and political causation of illness. Half of the students were from the US and the other half Ugandan like me. The Americans were mostly white and it was also my first time coming into close contact with white people that I had only seen on TV, or maybe some random tourists once in a while. It was also the first time I actually saw the option of Black as an ethnic group on the registration form on our first day of the course. When I saw white, black, mixed, other, etc the only obvious choice for me was to choose 'other' and write Ugandan.

In my mind I was so removed from the concept of race and racism that I felt black people meant the ones we saw on TV usually African Americans in the mostly American TV that is very popular in Uganda. I was so perturbed by the question of race that I asked one of my Ugandan friends what she had chosen as an option and felt really comforted when she told me she too had chosen 'other' and written Ugandan.

I completely rejected the idea of being black until 2 years later when I moved to the UK to do an MSc in Global Mental health. This was hugely influenced by the Social medicine course as I had an interest in psychiatry but after learning of the higher structural determinants of mental health, I thought I would rather do that MSc and get work in an international organisation helping design and evaluate mental health programs in low and middle income countries, which is exactly the kind of thing the MSc prepared me to do. I later found out

that most of the jobs I would really want also needed/preferred me to be a consultant psychiatrist which is how and why I ended up in my current psychiatry residence program at the Kent, Surrey and Sussex deanery.

I have been in the UK for nearly 8 years but only recently accepted more the identity of being black. In the visa and postgraduate school application processes, I had to choose black so many times that it became easier to do so. On most forms online when you choose 'other', then you have to type out what the 'other' is. It was just easier to select black – African, which was also easier for me because it had African included which I definitely feel that I am. The earlier American form did not have any African in it - it just had black, which perhaps made it harder for me to choose. For the first 3 years I was choosing black on paper but not really feeling it in real life. My MSc was at the London School of Hygiene and Tropical Medicine which has a very diverse and international community. In my cohort alone, I believe we had more international students than local British ones. This was also due to the nature of my course that was tailored for the global south. While I was a student I still mostly identified by my Ugandan identity because most of my friends were also not local so I did not face any discrimination based on race that I can remember. I might have done but just didn't know as I was blissfully ignorant about racism.

I have been learning about racism mostly through my own experience but also through other people's experiences. I started the 'Wait was that racist' drop-in sessions for other people like me who might have been unaware what was even racist. In day-to-day life, if someone is overtly racist to you, you will know. That kind of racism is the in-your-face kind which would not leave you in doubt of what is happening.

But the majority of racist experiences are those where you aren't sure what exactly just happened. Like the co-worker who doesn't make eye contact with you or acknowledge your presence at meetings. Passing you over for someone else when you want to contribute something and they are chairing it. It's the nurse in charge asking you to please grab the leg because they think you are the health care assistant not the on-call doctor when you come to do the seclusion review. It is having a whole conversation with someone at work only to realise that they think you are someone else. You realise that they are confusing you with the other black female staff member.

These are micro aggressions. They are the death by a thousand cuts and have been described as everyday racism. Microaggression is a term coined by African American psychiatrist Dr Chester Pierce to describe commonplace daily verbal, behavioural or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory or harmful racial slights or insults to 'people of colour' which is another interesting term. Who are these people without colour? Don't we all have colour?

The problem with the microaggressions is that they are not always intentional, which makes it even harder to deal with. When the patient or whoever mistakes you for someone else and they are sure you are the person, you can see that they genuinely believe you to be the other black staff member. It might seem innocent but underlying that 'innocence' is the racism saying that you don't matter. 'I won't even make an effort to try and differentiate you because you all look the same to me'. I get the being confused about faces because even I used to get white people mixed up all the time when I first came here. But I made an effort.

I know they are not all the same, so I take the time to get the differentiating features. And it's a lot more work for me because there are usually a lot more of them than people like me in a place. So if there are only 2 or 3 other black people you see at your workplace or wherever you are regularly, please make the effort to really look at them and know the difference. On that note I would also ask for allyship from others. To call out any instances of racism you witness because a lot of the time when I have a racist experience it has been so shocking that my fight or flight response goes straight to freeze mode.

I have had positive experiences of allyship that have given me hope in the humanity that resides in all of us. My name is short and very easy for Ugandans to pronounce but can be confusing for non-Ugandans. I had a brand-new name badge ordered with my name phonetically written by a previous supervisor who also told the whole team when I was away about how to pronounce my name correctly. Dale Carnegie is quoted to have said "A person's name is to that person, the sweetest, most important sound in any language" and I would agree. So please after you correctly identify the 'person of colour' that you are speaking to, please try and pronounce their name correctly too. ☺

Hear my name **https://namedrop.io/cissyatwine**

Applied Transference-Focused Psychotherapy Workshop
(Improving clinical confidence and attitudes of psychiatry trainees)

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Abstract
The management of personality disorders is complex and poses unique clinical challenges, particularly for psychiatrists in training who often report limited confidence in managing patients with personality disorders. To better equip trainees with evidence-based tools in the management of personality disorder, a three-hour, online workshop on applied transference focused psychotherapy (TFP) was delivered to higher trainees under the East Midlands School of Psychiatry teaching programme. Participants were invited to complete two psychometric questionnaires before and after the workshop: the CCPDQ (Clinical Confidence with Personality Disorder Questionnaire) and the APDQ (Attitudes to Personality Disorder Questionnaire). Results demonstrated a statistically significant improvement in the clinical confidence of higher trainees after the workshop ($p = 0.014$). There was a positive trend in the attitudes of higher trainees following the workshop, although this result did not reach statistical significance ($p = 0.469$). These results indicate the effectiveness of a brief, resource-efficient and scalable workshop on applied TFP in improving the clinical confidence of higher trainees in managing personality disorders. Findings support previous research in this area and strengthen the recommendation for TFP teaching on personality disorders to be incorporated in the core psychiatry training curriculum. Further research is needed to assess long-term outcomes and broader applicability.

Introduction

Patients with personality disorders often face stigma and therapeutic disengagement, which can result in poorer outcomes, increased healthcare utilisation and iatrogenic harm through polypharmacy (Evans et al., 2017; Konstantinidou et al., 2023; Meuldijk et al., 2017). Psychiatry trainees frequently serve as the initial point of contact across various services and are often responsible for managing complex interactions with patients with severe personality disorder pathology. Psychiatrists frequently report low technical confidence in managing these patients, which contributes to the perpetuation of these challenges (Chartonas et al., 2017). The Royal College of Psychiatrists' 2020 position statement emphasises the critical need for enhanced training of all clinicians to improve recognition and management of personality disorders (Royal College of Psychiatrists, 2020). This suggests that there is an educational gap that needs to be addressed in postgraduate training to better equip trainees with the knowledge and tools to treat these patients.

Transference-focused psychotherapy (TFP) is a manualised, evidence-based treatment for severe personality disorders based on a psychodynamic approach that focuses on contemporary object relations theory (Clarkin et al., 2007; Doering et al., 2010; Levy et al., 2006). This approach offers a structured framework to better understand personality disorder psychopathology and provides clinicians with strategies, tactics, and techniques to therapeutically manage the often emotionally charged relational dyads at play in clinical encounters with this patient group. TFP aims to help patients 'understand and resolve unconscious conflicts and work towards greater personality integration' (Kanteret et al., 2022). More recently, 'applied TFP', which uses core TFP principles and tools, has been implemented into wider psychiatric settings such as in crisis management, community clinics and inpatient units (Hersh, Caligor, & Yeomans, 2016; Lee & Hersh, 2019, Hersh & Panfilis 2024).

Applied TFP teaching for psychiatrists in training has been delivered on both the national and international scale, including in India, Italy (Sinisi et al., in press), Malaysia (Rassip 2025), and South Africa (Temmingh, 2024). Within the UK, a 4-hour teaching series on applied TFP for personality disorder was found to significantly improve the attitudes and technical confidence of psychiatry trainees (Sinisi et al., 2022).

Methodology

A cohort of higher psychiatry trainees based in the East Midlands attended a three-hour long workshop on applied TFP, delivered as part of the teaching programme funded by the East Midlands School of Psychiatry NHS England. The workshop was conducted online by Medical Psychotherapists, one of whom is an accredited TFP Supervisor. The workshop involved didactic teaching of the key theoretical concepts of TFP, with the use of clinical vignettes and role play to demonstrate how TFP can be applied to the clinical encounter with a patient with PD.

Two outcome measures were evaluated in participants using relevant psychometric questionnaires: 1) clinical confidence with managing personality disorders and 2) attitudes towards personality disorders. To assess the clinical confidence, the CCPDQ (Clinical Confidence with Personality Disorder Questionnaire) was used which comprises 13-items on a 6-point Likert scale focusing on key aspects of TFP such as establishing and maintaining the treatment frame, managing countertransference, and implementing core techniques

(Sinisi et al., 2022). To assess attitudes, the APDQ (Attitudes to Personality Disorder Questionnaire) was used which is a 37-item measure with a 6-point Likert scale. It measures the attitudes of mental health professionals toward patients with personality disorders across five dimensions: enjoyment, security, acceptance, sense of purpose, and enthusiasm. The APDQ has a robust structure and strong psychometric properties (Bowers & Allan, 2006).
The two questionnaires were circulated to all workshop participants via a Google survey and they were invited to complete the questionnaire before and after the TFP workshop. Unique participant identifier codes were used to link the participants questionnaire responses before and after the TFP workshop, ensuring all participant responses remained anonymised.

Statistical analysis using the Wilcoxon signed-rank test was conducted by an independent assessor to identify any differences in the two outcomes pre- and post-workshop and to determine the statistical significance of any change.

Results

Limitations and Generalisability

There are several limitations to the study. The sample size was relatively small (n = 35), and participants were drawn from a single training region, which may limit the generalisability of the findings. The evaluation exclusively focused on short-term outcomes immediately following the workshop. Therefore, future research could include longitudinal follow-up to assess longer term outcomes and the persistence of any changes. In addition, it may be necessary to make iterations to the structure, content, and delivery of the workshop to improve its effectiveness.

Data Summary

Analysis of data from the CCPDQ indicated a statistically significant improvement in the clinical confidence of participants following the workshop. The mean pre-workshop score was 41.20, increasing to 47.23 post-workshop, representing a statistically significant change ($p = 0.014$). This suggests that the workshop was effective in enhancing trainees perceived clinical confidence in working with patients with personality disorders.

In comparison, results from the APDQ demonstrated a non-significant increase in scores, with a mean pre-workshop score of 144.74 and mean post-workshop score of 147.69 ($p = 0.469$). Although the direction of change was positive, the difference did not reach statistical significance, indicating that a single workshop may not be sufficient to produce measurable changes in attitudes. This pattern is consistent with a dose-response relationship, whereby greater exposure to teaching tends to yield stronger outcomes. See table 1 for comprehensive results.

	Pre-workshop Scores		**Post-workshop Scores**		
	Mean	**s.d.**	**Mean**	**s.d.**	***p* - value**
CCPDQ	41.20	10.35	47.23	7.68	0.014
APDQ	144.74	17.16	147.69	11.23	0.469

Table 1. Mean participant scores with standard deviations before and after the workshop, with associated p-values.

Conclusions and Recommendations

Key findings and Conclusions

The findings of this study demonstrated that a three-hour online workshop on applied TFP therapy and techniques was effective in improving the clinical confidence of higher trainees working with patients with personality disorder. This was evidenced by a statistically significant increase in the mean participant CCPDQ scores following the workshop ($p = 0.014$). Mean participant scores on the APDQ increased marginally but did not reach statistical significance which indicates a possible positive shift in clinician attitudes that warrants further exploration ($p = 0.469$).

An improvement in the clinical confidence of trainees in managing patients with personality disorder may have numerous downstream benefits. Improved management of personality disorders could lead to more meaningful and therapeutic patient engagement, and reduced contact with healthcare services, such as fewer crisis admissions and emergency interventions. By equipping clinicians with effective treatment strategies, an applied TFP approach could help steer both patients and clinicians away from unnecessary polypharmacy. This, in turn, may contribute to reducing the NHS's carbon footprint. Furthermore, the workshop served an educational benefit for trainees by helping them meet several curriculum requirements outlined by the Royal College of Psychiatrists (Royal College of Psychiatrists, 2022). By addressing these requirements, TFP educational initiatives may result in trainees making more appropriate and effective use of supervision when managing challenging cases moving forward.

The workshop was delivered online via videoconference and is thus a resource-efficient and sustainable educational model. This mode of delivery also makes it a scalable and accessible teaching model for wider implementation. TFP workshops have already been delivered to psychiatric trainees based in East London NHS Foundation Trust to good effect (Sinisi et al., 2022), and globally in psychiatric training programmes in India, Italy, Malaysia, and South Africa.

Recommendations

Based on the study's findings, it is recommended that teaching on applied TFP for personality disorders be incorporated into the psychiatry training curriculum to enhance trainees' therapeutic competence and confidence in managing these complex conditions. Delivering the training at an earlier stage, such as during core psychiatry training, may offer additional benefits by allowing trainees to integrate key concepts and skills into their clinical practice from the outset. Early exposure can enhance confidence, reduce stigma, and promote more effective management of patients with personality disorders throughout their subsequent training and careers. This recommendation aligns with the Royal College of Psychiatrists' 2020 position statement, which highlights the urgent need for improved training of all clinicians in the recognition and management of personality disorders (Royal College of Psychiatrists, 2020).

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The catch-22 of autonomy

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Autonomy is an ethical and philosophical concept which is at the core of the modern idea of personhood. It is used in close connection with other concepts such as authenticity, self-control, freedom and free-will. While the restriction of patients' autonomy was a common and matter-of-fact practice in asylum psychiatry, nowadays, autonomy is regarded as a foundational ethical medical principle, and it should always inform the provision of care. Autonomy is also a precondition for treatment, especially when treatment relies on motivation and commitment for change.

The conundrum, as a patient recently called their dilemma in the context of psychotherapy, is that a mental disorder may have an impact on autonomy, impairing the ability to think, act and self-govern. In the presence of suicidal risk and refusal of treatment, acknowledging the patient's autonomy may incline the clinician to accept their choice, even if that could lead them to attempt suicide. On the contrary, an emphasis on patient safety may lead to a compulsory treatment which may protect them from self-harm in the near term but will hinder their autonomy even further as a consequence.

In clinical practice, this often turns into a catch-22 situation. On the one hand, mental disorder may have a deleterious impact on the patient's autonomy; on the other hand, autonomy must be respected, because not only do we consider autonomy a value in itself, but also the patient needs to be autonomous in order to engage in treatment, and forced treatment may lead to further harm. This is the conundrum that I would like to reflect on, from the perspective of a psychiatrist who works with patients diagnosed with complex needs or personality disorder and who often suffer from chronic suicidality.

Autonomy as a philosophical and psychiatric concept

John Feinberg (1989) states that autonomy includes: a right that must be respected (in which the individual is the sovereign authority to govern himself); an ability (which has different degrees); an ideal of character, or the condition of self-control and associated virtues, which include, among others, self-determination, individuality, integrity, self-control, responsibility and authenticity. These meanings can be used in combination and lead us to two conditions frequently discussed in debates on autonomy: the condition of authenticity (the ability to identify, reflect on, and act on one's desires and values) and the condition of competence (the ability for rational thought, self-control, and self-understanding) (Christman [et al.], 2005).

In psychiatry, autonomy can be thought of as a cognitive capacity (the ability to understand, retain, use information and communicate decisions), as a moral capacity (the capacity to act according to our moral values) and as a condition for authenticity (which enables one to know and act in accordance with one's own desires and motivations). For authors who defend autonomy as resulting only from cognitive capacities, the idea of authenticity is not only useless but may also be harmful, as such a concept can be used to characterise and thus validate as "authentic" what are in fact limitations inherent to the disease.

However, a purely cognitive assessment tends to neglect the impact of the emotional state on autonomy (Charland, 2015). The assessment of autonomy does not only depend on the subject (his biography, personal narrative and ability to formulate and convey his choice) but also on the disorder (its severity and type), the choice being made (its adequacy, acceptance or predictability), the assessor (his beliefs, learning and values), and its context (namely if there is risk for self or others). Overall, autonomy depends on the patient's cognitive and moral capacities, and on a common agreement on what it means to be autonomous - which includes attributions of responsibility, and the acceptability of choice and behaviour. This highlights that questions about autonomy do not have a straight yes or no answer. Probably, this is why there are important disagreements when autonomy is being considered.

The conundrum

I will now restrict my reflection to patients with personality disorders and complex emotional needs who may suffer from chronic suicidality and for whom the treatment is mainly psychotherapeutic or focused on "getting a life" (engaging in meaningful activities and interpersonal interactions). The "positive approach to risk", which means managing risks to maximise people's choice and control, has long been debated. Despite its benefits, it can sometimes lead to a "all or nothing approach" (for instance, if the patient is autonomous, they can refuse treatment). For some patients and their families, this leads them to think that the psychiatrist does not care about the patient's safety and accepts that they may die. We can all easily agree that, when in crisis, the emotional state of the patient may impact the weighing of information, the acting on self-harm urges, and the compliance with treatment. This means their autonomy can be temporarily impaired. However, compulsory admissions and restrictive measures may have detrimental effects on patients and their treatment, namely preventing them from being responsible for their care, and further hinder their autonomy. Let's look into that more closely.

Psychologically, the use of restrictive measures impairs patients' self-awareness and self-control, which prevents dialogue and negotiation, leading to a fight/ confrontational relationship with those providing care. This relationship becomes centred on risk and self-harming behaviour becomes the way through which patients communicate their suffering, feelings of hopelessness and even asking for help (as more risk means more care). Often, it also prevents exploring and understanding the meanings of self-harm behaviours. In younger patients, a focus on safety may sometimes lead to long-term admissions, which tend to harm their family and social relationships and stop them from engaging in activities in the community. As a result, patients are prevented from developing their autonomy, they learn how to adapt to an artificially controlled environment, and, when adults, tend to maintain parent-child dynamics throughout their treatment, expecting strict rules and fighting back. The lack of freedom and inability to explore the world around them activates their primary defense mechanisms, namely regression and splitting (switching between "I need you, please save me" and "I hate you, please leave me"). This can be described as the agoraphobic-claustrophobic oscillation (Mizen, 2014), veering between wanting to be cared for, on one end, and desiring to be left alone, on the other. Mainly, restrictive measures avoid flexibility and ambiguity, which are both needed for treatment. This may ensure the patient's safety but it is certainly less therapeutic.

Is there a catch-all solution?

The solution to a catch-22 is rarely a catch-all approach. The idea that suffering or illness diminishes the ability to think and hence limits the freedom of action does not mean a dichotomous outcome, i.e. that the patient's autonomy is either completely impaired or fully present. Keeping in mind that autonomy is not only a cognitive ability but also an ethical principle, and that its assessment depends on the individual person, on the situation and on those who treat or assess them, allows us to be more flexible when considering it in a clinical setting. A possible way to deal with this conundrum could be to endeavour to maintain a psychotherapeutic stance, even when risk to self is present, which is focused on dialogue and meaning. That means exploring feelings and thoughts behind the behaviour and working with the patient's autonomy (what they are able to engage in, and how we can work together). Engaging in playful, provocative and sometimes heated ways of disagreeing and expressing emotions may also lead to finding a way out of risk behaviours and of making sense of them together. This should take place from a young age, fostering the patient's autonomy and choice, and working through risk and not against it.

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Climate and Social Justice

Climate Cafés

Dr Dasal Abayaratne
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Sheffield Health and Social Care NHS Foundation Trust

Climate change can provoke a range of emotional reactions. Many people feel anxious or lost. It can be hard to navigate these reactions on our own, especially amongst the seemingly non-stop demands of daily life. This is how I felt when a friend suggested I attend a Climate Café about 4 years ago. I hadn’t heard of them before, but I was drawn in by the offer of cake and tea! Since that first Climate Café, I have gone on to train as a facilitator and have facilitated several Cafés in a diverse range of contexts. In this piece I will introduce Climate Cafés, discuss some of my experiences, and maybe inspire one or two readers to have a go at attending one in the coming months.

Over hot drinks, away from the busyness of daily life, the Climate Café provides a respectful, confidential and welcoming space to connect with others, share and welcome thoughts, feelings and reactions related to climate change. They are based on a similar model called Death Cafés that created space to talk about a similarly emotion-riddled taboo topic: death

and dying. They are advice free zones. Rather than advocating specific actions, they instead provide an opportunity to reflect and ground ourselves. No previous knowledge is necessary, and you can share as little or as much as you feel comfortable doing.

In my first Café, I was taken aback by this freeing and welcoming space. It allowed me to sit with uncomfortable feelings, and know that I wasn't alone with them, nor in facing climate change. Indeed, this "journey from isolation to connection" was found to be a key active component in climate cafés in a recent study[1]. A few months later, after attending a further couple of cafés, I decided to contact the Climate Psychology Alliance to pursue facilitator training. This is largely experiential and thankfully low cost! Whilst a psychotherapy background isn't necessary, I found that my experiences in running groups, and facilitating reflective practice stood me in good stead.

The first Climate Café I helped facilitate was a 'taster' at the 2023 Medical Psychotherapy faculty conference. 10 or so conference attendees, from medical students to the faculty chair, chose to spend their lunchbreak navigating the variety of complicated personal thoughts and feelings brought up by this topic, and by a two-day conference all around the intersecting covid, climate, refugee, and psychological crises that the conference was themed around.

Following on from this, I helped run a Café over lunch at last year's Royal College International Congress. We were blown away when over 50 people turned up. We frantically modified the plan for a 'traditional' Café, instead setting up 6 or so separate tables, where people could take a step back from the hustle and bustle of Congress and connect on a topic that we rarely have a chance to consider, especially in our professional lives. Following positive feedback, the college invited our team back to facilitate a further session at this year's Congress in Wales on 23rd June.

These first two facilitation experiences were one-off 'tasters'. Recently however, I've had the fortune to facilitate an ongoing series of 5 online and in-person Climate Cafés jointly between the mental health, physical health and paediatric trusts in Sheffield. Each time, a range of inquisitive people turn up, including administrative staff, nurses, consultants, dietitians and peer workers. Some have only come to one Café, others have been to all, everyone commenting on the same freeing space that the Café offers to think about the Climate Crisis. Even though I am facilitating the sessions, I too gain much and can participate to a degree; always feeling lighter as a result.

When I was getting ready to go to my first Climate Café, I would never have believed that 4 years later, facilitating them would become part of my job role as a medical psychotherapist. They've become increasingly recognised and valued by NHS trusts, the Royal College, and by the countless people who have attended them. Whilst there are other ways of navigating the sometimes-murky world of feelings associated with climate change, the Climate Café offers a unique warm, safe and welcoming space that can be adapted easily. As medical psychotherapists, we possess a range of skills that mean we are well placed to offer them to our communities and organisations.

If you are interested in learning more about Climate Cafés, attending one, or even training, please get in touch, or take a look at the Climate Psychology Association and other resources listed below (www.climatepsychologyalliance.com).

Reference:

1. Calabria, L., & Marks, E. (2024). What happens in Climate Cafés? Exploring responses to the psychological burdens of climate change in seven UK women. *the Cognitive Behaviour Therapist*, *17*, e33.

I practise sustainable psychiatry, here's how you can too. See these ten practical steps to becoming a sustainable psychiatrist.

News from the Climate action and sustainability working group of the Med Psychotherapy Faculty Exec Committee

Dr Nora Gribbin (Psychotherapy Faculty Sustainability Champion 2021 – 2025) and **Dr Pamela Peters** on behalf of the working group:
(Nora Gribbin, Marion Neffgen, Dasal Abayaratne, Josie Fielding, Pamela Peters, Louise Robinson)

Since 2021, the PHSC (Planetary Health and Sustainability Committee) has collaborated with the College to establish a network of sustainability champions across divisions, devolved nations, and faculties. This initiative aims to embed sustainability principles into college activities through knowledge sharing and collaborative engagement.

The CAMHS Faculty led early efforts by focusing on eco-distress and eco-anxiety. Within our Psychotherapy Faculty, sustainability has long been a core value. Dr Phil Davison founded the original College sustainability committee, and our late faculty chair, Steve Pearce, fully embraced the network, appointing a Psychotherapy Faculty Champion in 2021. In this role, I've built and led an active working group comprising members of the Faculty executive and wider colleagues. We report regularly to the PHSC and collaborate with champions across the College as the network continues to grow.

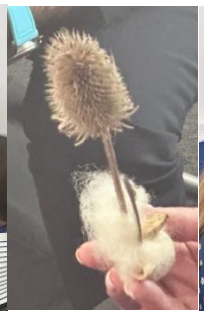
Under President Adrian James, climate was a priority for mental health, and with the PHSC, he contributed to discussions at COP26 in November 2021. Sustainability is now embedded within the psychiatry curriculum.

Our working group currently includes the six members listed above and holds regular meetings to connect with and support each other, as well as plan for events we are facilitating. We trained in facilitating Climate Cafés – in 2024, Dasal hosted one at the International Congress fringe event, and he and Marion interviewed a climate scientist. At our Faculty conference, we delivered Climate Cafés alongside Sustainability Stands featuring QR-linked resources. Dasal presented at the BABCP CBT medics conference in 2021. Nora and Josie delivered a workshop at the 2024 Psychotherapy Trainees Conference, and in 2025, we delivered two further workshops outlined below:

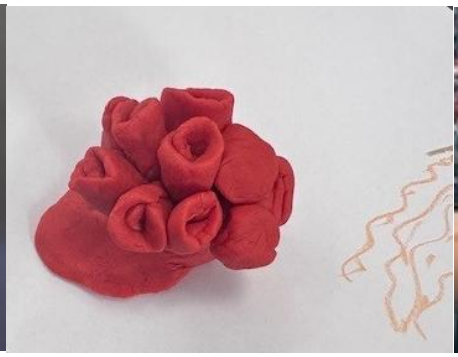
Medical Psychotherapy Faculty Conference:
Three of us (Marion, Pam and Louise) facilitated a Climate Workshop at the Faculty conference. This can be a heavy topic, and we decided to use art as a medium to express our feelings and reflect with each other. We used a variety of art materials – natural objects e.g. shells, stones, leaves and pine cones; Lego; playdough (made by Louise!); pens, paper and glue. The tactile nature of the objects drew people in and there was a lot of free exploration and different interesting combinations of media. The session was structured, with

time to make a piece of art, and time to reflect on the meaning in a small group. There was feedback to the whole group at the end.

It was striking how much felt emotion there was in the room, with some people expressing a strength of feelings they had not realised until now. However, it did not feel bleak but engendered a sense of hope that we are all in this together and that there are actions we can take to make things better. People appreciated the time to stop, reflect and be playful and creative.






Rcpsych International Congress:
The three of us also facilitated a lunchtime Climate café at the ICC in Wales on Day 1 of the International Congress. We had 2 groups of people who had lunch together and we reflected together on our feelings about the climate emergency. We began by sharing our experiences and what had brought us to this awareness. A lot of commonalities emerged. Themes were around guilt, a sense of how small we are and questioning therefore what impact we could have as individuals. This was moderated by thoughts of what we are able to achieve either singly or in groups and in organisations of like-minded people.

These events were both highly valued and we hope to offer them at future conferences.

If you're interested in joining our working group or would like support in integrating sustainability and climate action into your area of work, we warmly invite you to get in touch. You'll also be welcome to connect with the wider sustainability champion network.

List of resources for the climate crisis:
https://1drv.ms/w/c/7fd9e6993a275ed9/EfdT6jIPHqlGr3VTjhJ93lMBq_Zk40IRGjymCBMuueVbug?e=me3HfZ

Save the date: 27 February 2026 – A one-day in-person conference at the Royal College around the Climate Emergency and why it is important for Psychiatrists
This conference is being organised by Psych Declares (an environmental campaign group of psychiatrists that lobby the College to take more decisive action on the climate emergency) with input from the Faculty Climate and sustainability working group and we will also be running a workshop. It's looking to be an exciting and inspiring day. More info to come! Put it in your diaries.

Climate Group - a monthly reflective and regenerative space

Marci López Levy, Group Analyst and Chair of the Latin America Bureau
Marion Neffgen, Medical Psychotherapist and XR activist
(members of the Climate Psychology Alliance)

We look forward to seeing you in our monthly open online group to share our experiences, thoughts and feelings around the climate and nature crisis. The group aims to be a regenerative and reflective space, unstructured but containing, that has grown out of our conversations during last year's climate justice dialogue series, hosted by the Institute of Group Analysis (IGA). Everyone feeling and thinking about the climate crises is welcome to join, to connect and recharge.

We meet monthly on the **2nd Friday of the month, at 4.00 - 5.30 pm (UK time)** and we will open the Zoom room from 3.45 pm.

The group is convened by Marci and Marion, and co-created by its members.

Convenors: Marion Neffgen, Medical Psychotherapist and XR activist, and Marci López Levy, Group Analyst and Chair of the Latin America Bureau, both members of the Climate Psychology Alliance.

For further info and resources, or to register, check out **https://linktr.ee/climatejusticeiga**
Context article: López Levy, Marci; Neffgen, Marion (2023) Conversations about Climate Justice

Please get in touch with us if you have any questions or want to share some thoughts, at **climatejustice@playen.net**

Trainee Voices

Similarities Between the Beginning and End of Life

Dr Camille Wratten
ST6 in General Adult Psychiatry / Medical Psychotherapy
South West London and St George's Mental Health NHS Trust

Returning to work as a Psychiatry Higher Trainee after twelve months of maternity leave following the birth of my son left me with a sense of trepidation. The world of work in an NHS service - its complex dynamics, the intensity of clinical interactions, and the demands of a busy team - felt disconnected, almost as if it belonged to a different life. It seemed worlds apart from the new normal I had carefully cultivated during the year spent nesting with my growing son.

However, stepping back into a registrar role on a busy inpatient psychiatric ward, I gradually found my rhythm and responsibility. As part of my special interest sessions, I also organised weekly work at a local hospice, providing psychiatric advice for terminal patients and their families. Looking back, I realise that these sessions played a pivotal role in my transition back to work. The parallels between the experiences of those at the beginning and the end of their lives, which I had not expected to find, gave me a unique perspective.

Emotionally, the separation from my son was significant. Like me, he was learning to tolerate being apart, which heightened my sensitivity to the emotional aspects of my work. Having spent a year away from the inpatient environment, I no longer felt desensitised to the raw, intense, and deeply human interactions that are a daily part of medical and psychiatric care. It was as though I was encountering patients for the first time, my heightened emotional receptivity allowing me to connect more deeply with their stories.

The hospice patients spanned a wide range of ages: from near centenarians to young patients being supported by their families. There were also adults in their thirties and forties with terminal cancers, including parents of young children. As I interacted with these patients, I was struck by the similarities between the caregiving required for those at the end of life and my own experience as a mother of an infant. Both groups are vulnerable, dependent, and in need of nurturing. I saw family members and caregivers instinctively trying to absorb the patients' fears and anxieties. Staff members, skilled in nonverbal communication, would intuitively comfort patients who had lost the ability to speak, using both words and actions to reassure them and provide a sense of safety.

Another striking similarity between the first and final stages of life was the need for connection. Many patients, like my son, showed a determination to be understood, expressing themselves in different ways to convey their physical and emotional needs. Some who still had access to words wanted to share long-held stories, ask long-pondered questions, or reflect on their lives. As I helped my son find words to make sense of his daily experiences, I found myself also listening to and making sense of the life stories of the patients in the hospice. These conversations were full of vivid memories, poignant reflections, and sometimes surprising anecdotes. I felt acutely aware of the fundamental human need to be seen, to be heard, and to be remembered.

In parallel, my son was learning to communicate his thoughts, and I was constantly aware of the importance of seeing him, of understanding his needs, and taking time to reflect on his development amidst the busyness of life. Similarly, I saw the hospice staff creating space for patients' voices, whether through recording their stories or listening and sharing them with family members. This act of honouring their narratives provided a sense of continuity and significance after their death.

In the hospice, I encountered patients experiencing cognitive difficulties due to conditions like hepatic encephalopathy or delirium. One patient, for example, struggled with fear and fragmented memories of unresolved family conflicts, which surfaced in her distress. This made me reflect on the psychological struggles faced by terminally ill patients — how some were in denial about their diagnosis, while others faced the reality of their mortality with acceptance.

I noticed how terminal illness could trigger regressions. I saw patients who had been fiercely independent, only to become dependent on others for basic needs as they approached death. One particular patient, who had spent his life being self-reliant, became enraged and upset when confronted with the reality that he could no longer care for himself. His emotional outbursts were understood as a response to his helplessness and fear. Another patient in his final days was struggling to swallow food; despite this his family felt compelled to feed him against the recommendations to refrain. In a way, this mirrored my own experience as a mother. When my son fell ill and lost his appetite, and regressed to a more vulnerable state, I felt an intense drive to feed him. The instinct to care, to nourish, to protect, and to nurture was as strong in me as it was in the families of the patients at the end of their lives.

The redefinition of roles in a family facing terminal illness reminded me of the shifts that occur when a child is born, when parents transition into a caregiving role. Similarly, in families contending with terminal illness, the dynamic shifts as a parent or loved one becomes the recipient of care instead of the care giver, challenging existing family structures and systems. This shift in roles is often accompanied by feelings of vulnerability and dependency and is one of the parallels between the beginning and end of life.

Existential concerns also arose in both contexts. Babies, learning who they are and who they are not, face their own existential inquiries. They experience separation anxiety as they begin to understand the boundaries between themselves and their caregivers. At the end of life, patients similarly confront existential questions about their existence and their own mortality, the meaning of their lives, and what they leave behind. I thought of Erikson's concept of integrity versus despair, and how some of the terminal patients seemed to achieve peace with their impending death, while others struggled with regrets, unresolved conflicts, and unfulfilled dreams. One patient, for example, calmly accepted her fate, having sorted out her affairs, while her family, particularly her adult children, struggled with their grief and reacted with intense anger and denial. These emotional responses to loss were not unlike the regression and fear of abandonment experienced by infants faced with separation.

Finally, I also reflected on the cross-cultural aspects of caregiving. My own struggles with the cultural expectations around motherhood - such as the debates between my in-laws, and my own perspectives on breastfeeding and various other aspects of parenting - echoed some of the conflicts I witnessed in the hospice. One particular family's resistance to palliative care

highlighted the role of cultural and religious beliefs in shaping how families cope with terminal illness. The family's refusal to accept the patient's wish to stop active oncology treatment and to opt for symptom control, driven by grief and denial, ultimately led to intense emotions after the patient's death. This situation reminded me of the struggles I sometimes faced as a mother trying to balance different cultural expectations with my own instincts and needs.

Ultimately, my work in the hospice, alongside my experiences as a mother, has deepened my understanding of the emotional and existential journey that both infants and the terminally ill undertake. Both groups experience a vulnerability that requires care, connection, and understanding. Whether at the beginning or the end of life, the need for compassion, support, and meaningful connections is universal.

Outreach group for patients with Emotionally Unstable Personality Disorder – a co-facilitator's reflection

Dr Maria Moisan
ST6 Gen Adult Psychiatry
Kent and Medway NHS and Social Care Partnership Trust

As part of my higher training in general adult psychiatry, between February and October 2024, I co-facilitated an outreach group for clients with Emotionally Unstable Personality Disorder (EUPD). I attended 20 of these sessions. There were between four and seven group members. Some transitioned to the Therapeutic Community, some left the group, and one was paused. New members were introduced while I was a co-facilitator.

Ms W, a very experienced psychoanalytic psychotherapist, was the group's lead facilitator and my supervisor. The frameworks used in the sessions were those of Mentalisation-based therapy and psychoanalytic psychotherapy. During debriefs and supervision, we mostly used a psychoanalytic framework to reflect on and make sense of the group's experiences.

This learning experience has been rewarding. It has offered a unique opportunity to support patients in identifying and tolerating emotions, developing a sense of connection within the group, and seeing them grow and improve their coping skills. It has allowed me to observe the sense of cohesion members develop as a group, their unwavering support for one another, and their compassion and care for each other.

As I became more established within the group, Ms W offered me the opportunity to take the lead during the initial part of the session (the check-in) with clients. We then identified themes and invited group members to choose a focus/ theme and to take space and time within the group. Gradually, with support from the lead facilitator, I became more confident in the input I provided within the group. At times, Ms W and I also checked each other's understanding and perception of issues discussed in the sessions to model checking in with the other person's understanding, intentions, and perspective rather than making assumptions or misinterpreting.

However, I had to abruptly stop co-facilitating when Ms W took unexpected leave due to unforeseen and sad circumstances. This unexpected absence led me to reflect on the interruption's practical and emotional impact on the group.

My initial worries were for the group members. As consistency and stability are crucial in clients with EUPD, my concern was that the abrupt change in facilitators would evoke feelings of abandonment and lead to emotional dysregulation and possibly self-harm. Despite the sudden transition, the Brenchley team psychotherapists managed the disruption effectively. A different psychotherapist subsequently integrated the group members into other outreach groups.

I was also concerned about my supervisor and lead facilitator, Ms W, and for myself. The Brenchley lead offered me a space to reflect and debrief, for which I am deeply grateful. This allowed for a safe space to make sense of the experience, summarise the journey, discuss concerns, and have closure. Professionally, this experience highlighted the collaborative nature of group facilitation. Working alongside Ms W provided learning opportunities, shared responsibility, and the possibility of approaching complex situations from different perspectives. Ms W's absence – and the subsequent transition of the group to a different facilitator – emphasized the importance of contingency planning and the need to maintain continuity of care, particularly in this group of clients. It also reinforced the significance of teamwork in maintaining the therapeutic environment, even during periods of transition.

As I continue in the final part of my training, I intend to integrate these lessons by developing strategies to manage similar situations in the future. Ultimately, while stepping back from the group was unexpected, it provided valuable insights into patient care, teamwork, continuity, resilience, and adaptability – essential skills as I progress toward becoming a consultant psychiatrist.

This is Us - a tale of four and more

Dr Elizabeth Aderibigbe
Higher Specialty Trainee
Nottingham Healthcare NHS Foundation Trust

I told her to be patient. I told her he was probably just struggling with it all and she should give him some time to adjust to the change. That was what I said to that nurse.

She got her job through the employer's sponsorship route and moved to the UK. The children and her husband followed. He was a doctor; I am not sure if he was already a consultant or close to being one. He soon started looking for jobs. I am not sure if his GMC registration and all that were already in the bag. Role reversal meant she was now the breadwinner (I don't even know why we coined that word). Back in their home country he was the higher earner. That time where she would sort out getting the children up, doing the school drop-off, the school pick-up and then doing it all over again.

For him, being a stay-at-home dad was hard. She felt he was just being difficult. She felt that if the situations were reversed, she would have given him her full support. Here he did not do school drop-off. He did not want to stay at home "babysitting" the little one though he was at home. She is going to have to pay someone else to do that. He has changed, she said. He said he was better off returning to their home country. He was going to go back with or without her.

I couldn't relate .... he was not waiting to adjust to the change.

I met another one. A seemingly great guy with what seemed to be very lucky fortune. Just under fourteen months of moving here with his family - he got a job and was now close to the dream of being a consultant. He should be happy. He was a bit evasive about a lot of things but he talked about giving up so much to get to where he was. That it came at a huge cost and he made a lot of sacrifice. He kept alluding to being depressed and every conversation went back to how he wished he had moved here sooner. He now regrets not making up his mind on time. He still talks about how his junior colleagues who made the move earlier are now settled in their career paths.

Now another one, this young man was going back. He had only been married for less than a year. At the time, it made sense that he moved to the UK alone as his wife was doing pretty well in her career. He started off as an RMO with hopes of getting into resident training. Now he wasn't enjoying the job as a resident medical officer. His wife was lonely and the distance as well as the covid restrictions was taking its toll on them. His marriage, he said, was the number one priority at this time. He was returning home.

Now let’s get back to me. I checked and it's been four weeks. I have had no notifications to my ad for a babysitter. I wouldn't have had this problem back home. I am going to give it another go. "Hi everyone, I am a doctor. I am starting a new role at a hospital further from home. When school reopens and the lockdown is lifted, my partner will be commuting to work with just a few days of working from home. I am looking for a "babysitter" for my 12yr old for before and after school. Do get in touch if you need more details”. Press send!

For many doctors that qualify overseas and then move to the UK, “following your dreams” is a journey that is unique and personal to each one. Whilst there are opportunities and promises of a rewarding career, the challenges are immense with impact on personal and family life. It is a journey that may test your commitment, connections, and your ability to adapt into new communities. Some have been able to make the move with their families adapting as a unit, but some have not. This piece of creative writing is a fictitious narration that follows the lives of four doctors as they navigate the unfamiliar phases of their move to the UK and adjusting with their families.

Poetry/Art

Surgical exposure: *Publishing a poetry collection as a Psychiatry trainee*

Dr Jen Dunn
CT2 in Psychiatry, Aberdeen

I stumbled upon a pleasing passage where Sigmund Freud likens psychotherapy to surgery whilst I was still a surgical registrar and mulled this over as we prepped and draped a patient for their orthopaedic procedure. As a patient, you probably wouldn't want your surgeon to be occupied by these thoughts (at least not to distraction) rather than your hip replacement and, ultimately, I agreed which is why I left my role as an 'Orthopod' and applied for Psychiatry training. Around that painful and uncertain time, I also wrote a poem I called 'The Fix', as a sort of love letter to my first experience in an operating theatre. Upon resigning, I was soon faced with something I hadn't had for 5 years of surgical rotas: Free Time. I joined a writer's group and, a few weeks later, submitted said poem to a competition which, to my great surprise, it won.

The fix

I still remember, even now,
that first sharp *shuck* of breaking bone,
the acrid air and steady chime
of metal driving metal home.

The surgeon stoops, a standing stone
above that ancient altar place,
your pain and faith trace worry-lines,
a map-work on a frowning face.

The concentrated murmurs shroud
your little form as fingers flash,
and all her will is gathered there
in every neatly knotted lash.

I still remember heady weight,
the first flushed scrub and gown and glove,
to alter that last death-march time
and fix your broken hands with mine.

I had always written poetry but suddenly using words to structure the somewhat bewildering emotional milieu of my 'break up' with surgery became increasingly important and satisfying. Spurred on by my one success, I started to publish more widely in literary magazines (facing as many rejections as I did encouragements) and soon discovered a vibrant Scottish poetry open mic scene.

And so, having entered psychiatry training and an analysis, I found myself – two years later - in a tiny bar back-room in Edinburgh. The walls were clad in black, shiny vinyl discs layered one over the other like fans, chipped dark wood tables, red leather booth seating. Everything was sticky and an audience of around 30 spilled over the too-few seats onto the floor, or stood around the walls clutching pints. I'd thought carefully about my 'set' for the 7-minute open mic slot, and I read The Fix then a poem about the death of my father (which happened

a few weeks after resigning my surgical post), then one about psychotherapy. A publisher, unbeknown to me, was in the audience and – like some glamorous, clandestine spy-novel – slipped me her card with barely a word and vanished.

In an airport in China on the first anniversary of my dad's death

Sandwiched between two long-haul flights
is something softer, buttery,
this leftover stop-over night
that crumbles into its hours.

There are eyes everywhere,
people watching people all at once,
gazes snag, retreat, slide
from indifference to child-like boredom.

I fear they will unravel me,
an old unmaking made anew,
hot tears pulled from bolted seams
which barely hold these thoughts of you.

An alien sun is rising,
red marble in a pink dough sky,
I write you back to life, flying
low through fog and infant cries.

The therapeutic frame
(the established conditions, conventions and boundaries of a therapeutic relationship)

Fill me up with life, with little certainties and
familiar lies. Supine, I'll open to you like a sunrise
spread thin on a crisp white bed-sheet sky.

Stay a while and break with me –
a thunder-rumble of reality as we split,
refract our new-born thought

through rivulets of remembering.
Today the light seems over-bright,
barely contained within the frame

you stretch out like a rainbow,
in the after-storm's sweet drenching rush -
it whispers all my colours grey.

What followed was a 3-month process of editing my body of work, which by that point was almost entirely made up of poems covering my junior doctor years and departure from surgery, processing my Dad's death and my reflections on the process of psychotherapy both as a psychiatry trainee and as a patient. What emerged was a collection of around 50 poems exploring those themes.

What I found difficult to process was the degree of self-disclosure involved in an autobiographical poetry collection. How did this chime with my future aspirations as a medical

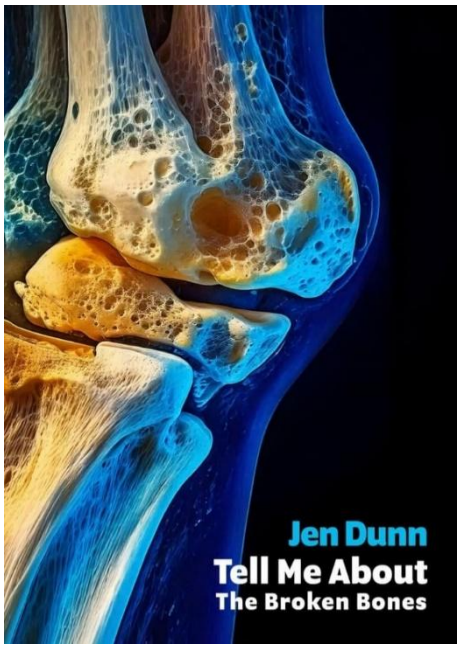
psychotherapist, where patients (of course) tend to Google you? A fairly well-known analyst, I discovered, also writes and publishes poetry. I was met with a very stern response when I reached out to ask her how she deals with the issue and to review some of my work. I sensed, rather than just taste, there were larger questions at play: of self-disclosure – does one publish under a pseudonym? How will you deal with the fallout should it end up in the hands of a future patient? Why the need to publish thoughts and feelings which can (or should) remain private? Should the inside of an analysis ever be disclosed in a public space? All excellent questions, some of which I am still wrestling with.

I state at the start of the collection that there are no poems about discrete patients in my book, although sometimes clinical experiences will be used and mixed with others to create a fictionalised, 'composite' patient - a technique now common in publishing case vignettes. I felt this was important to protect confidentiality, but I also state I will adopt the stance of patient myself in some poems, and in others, of doctor or (trainee) therapist. Some of the 'patient perspective' poems will be autobiographical, and I felt it was important for this first collection to be published in my own name in terms of authenticity.

I have been fascinated by written examples of others' experiences in Psychotherapy, both as a patient and a therapist. A few that come to mind are the writings of psychoanalysts Margaret Little, who was in analysis with Winnicott, and Harry Guntrip, who writes of his treatments by Winnicott and Fairbairn. More contemporary examples might include feminist and analyst Kim Chernin's account of her three analyses in 'A Different Kind of Listening'. I was likewise interested to read a beautiful poetry collection 'The Sessions' by Totman, where he reflects on psychotherapy sessions from the perspective of the therapist (available from Pindrop Press).

So, what have I learned from the experience? In terms of the dream of 'getting published', I think some of it was luck, but some of it was also increasing my exposure by reading at events. Publishers sometimes want those who not only write but are able to perform their work, as that sells books. They also want someone whom they have seen involved in the local poetry/fiction/flash-fiction 'scene' – particularly as small poetry presses increasingly rely on community networks. I think I'd counsel anyone interested to also try to give space to the book launch in the first few months – for me, this involved 5 events all over Scotland and, along with other big life events around the same time, proved busy and gruelling, if exciting!

As to these bigger questions around self-disclosure, I think these need to be decided for the individual. Given my own sense of being 'companioned' on my journey through grief, career change and psychoanalysis by others who had 'been there', what I have put out into the world works for me. In surgery, my consultant would sometimes bark 'exposure!', meaning 'please retract that muscle/skin flap/piece of tissue more so that I can view the deeper structures'. The process of putting together this collection, and now seeing it out in the world, has been an important way for me to gain access to these deeper layers of myself, and I hope may also be of some help to others on their journey.



My collection 'Tell Me About The Broken Bones' is available here from Seahorse Publications: https://seahorsepublications.com/catalogue/

Email comments or queries to Jennifer.dunn1@nhs.scot

Review:

Jen Dunn's first collection of poems is a stark and, in places, raw read. Terse yet vivid lines examine a range of experiences in the life of a medical professional. The colours and sounds of an orthopaedic surgeon's daily interventions are contrasted with the mournful internal dialogue of psychoanalysis. This collection marks the emergence of a new voice with rich experience of trauma in its variant forms, and an impressive range of poetic instruments with which to investigate those experiences.

(Andy Jackson, poet)

Conference and event reviews

Finding Voice, Belonging, and Hope in Uncertainty

Dr Yu-Tsen Yeh
CT2 Psychiatry
Cambridgeshire and Peterborough NHS Foundation Trust

Attending the RCPsych Medical Psychotherapy Annual Conference was a humbling and quietly transformative experience. Over three days, I found myself reflecting not only on the future of psychotherapy but on my place within it as a trainee, as an immigrant, and as someone finding a voice.

The conference opened on Wednesday evening with a powerful dialogue between Dr Femi Oyebode and writer Horatio Clare. Horatio spoke openly about his experience of psychosis, his ambivalence toward the label of bipolar disorder, and the distrust he felt when clinical care became a list of options rather than a relationship. I sat silently in the audience, as I often do, feeling like one of many junior doctors in the NHS, too inexperienced, too peripheral to contribute.

During the audience discussion, some challenged the diagnosis-led model, and others wondered if Horatio was seeking a more paternal form of care. I was moved by the crowd in its ability to hold different views. I started to wonder if my voice could also be held, if I might belong here. I was also thrilled to see a few familiar faces: other core trainees from my trust and our consultant.

The second and third days brought further reflection. We debated the relevance of diagnosis in psychotherapy and asked the difficult question of what place psychotherapy holds in modern psychiatry. Dr Cissy Atwine's talk on racism and microaggressions particularly stayed with me. I admired her warmth and strength, and her words resonated with something long buried in me.

I am Taiwanese, from a small and politically controversial country. I came to the UK in Year 13 and have spent my adult life trying to blend in. I learned to speak with an English accent and complain about the weather when greeting others. When asked about racism, I often denied ever experiencing it personally. But I remember the battles with admissions offices over my visa, and fellow international students who were afraid to walk alone during the pandemic. Listening to Dr Atwine made me realise that I too have internalised microaggressions, silencing parts of myself to feel accepted. It is perhaps simply human to long for belonging, and I wonder what it would be like to be in a world where inclusivity does not come with a prerequisite.

I remained quiet through most of the conference, but something in me was beginning to shift. During the large group, I found we were circling around the theme of futility. Earlier that week, a foundation doctor had asked me, "How do you deal with sitting in front of a patient, knowing you're not offering the best treatment?" I felt the need to give a positive response to this aspiring psychiatrist. I said perhaps it wasn't about trying to fix the pathology, but about witnessing the experience of the person in front of you, walking part of the journey with them. The same question emerged at the conference, unspoken yet palpable, especially in discussions about under-resourced services and unmet therapeutic ideals. I found it almost unbearable to sit with the hopelessness in the room. I spoke, unexpectedly. I shared my uncertainty about the answer I had given that foundation doctor and wondered if it was based on my need to hold a positive outlook for the young doctor, as well as myself. Nevertheless, I felt hopeful that the community continued to speak about, instead of silencing, the harsh reality. Naïve perhaps, I want to hold onto hope as a conscious choice, despite everything.

The highlight of the conference for me was the climate change workshop, where I reconnected with my inner playful self. The colourful Play-Doh and the Lego blocks laid out were a wonderful contrast to the grey-scale meeting room. We were asked to express our feelings around climate change: anger, helplessness or anxiety, through play. The topic was heavy, but I felt a tiny relief. I noticed the weight I had been carrying, including the anxieties about limited training numbers and posts, and where I belong in this grand schedule of making psychiatry better. I felt grounded and present. It felt as if I had been given permission to pause and step outside of striving. In that moment, I remembered the hopeful part of me, the child who believes in possibility, and who quietly trusts that imagination and care can shape the future.

Over the course of three days, I heard how difficult it is to advocate for psychological care within a system governed by evidence and limited by resources. I saw how things could fail despite the best intentions from all parties. But I also witnessed something remarkable in our capacity to reflect, repair, and remain honest in the face of challenge. I was finding my voice, not just as a trainee, but as a person navigating identity, uncertainty, and hope within psychiatry. The conference reminded me that I have the power to shape my own sense of

belonging, and that even amidst futility and hopelessness, we lean toward care, toward courage, and toward our capacity to remain human with one another.

Reflections on the Med Psychotherapy Faculty conference

Dr Eralp Guner
Academic Clinical Fellow
Cambridgeshire and Peterborough NHS Foundation Trust

I have always been interested in psychotherapy since I started my own journey of therapy about nine years ago. I believe my journey of therapy steered me into psychiatry, and my interest continued during my core training journey as well.

I have not had a chance to attend any of the conferences of the psychotherapy faculty (what a miss!) so far. I guess my perception of conferences in general made me a bit reluctant to engage. Apart from the trainees' conference I attended last year, the other conferences I have been to were mainly medical and, in my opinion, rather mechanical.

It was the Faculty's email about the conference that caught my attention this year. I had a look at the programme, which looked very fresh, with all the discussions we have in our clinical practice, such as sexuality, stigma, racism, trauma diagnosis, framed by inclusivity and exclusivity. Luckily, I have a very supportive clinical supervisor in this rotation, and as soon as I shared my plans with him, he approved and voilà, I signed up immediately!

I would have normally shared the conference in our core trainee groups. This time I am not sure why I did not - maybe the depth of the topics made me want to be by myself to have the mind space to think deeply. I now think it should have been the opposite. Or maybe it was just my tiredness and dying social battery after the heavy clinical work. But luckily, in a teaching event I attended on Wednesday morning, I discovered that my colleague was going to London in the evening, for - of course, the conference! Later I realised it wasn't only her, we had more core trainees and our lovely psychotherapy tutor there too!

Moving on to the conference itself: I knew of Prof Femi Oyebode from his well-known book Sims' Symptoms in the Mind and I have been fortunate to attend one of his talks at the trainees' conference. With a topic like "Is Psychiatry Working? What is the place of psychotherapy in psychiatry?" and the inclusion of an expert by experience, I knew it was going to be a rich conversation. I believe we should have the voices of experts by experience more in our practice. Our work is not merely related to human relationships, it is human relationships. It would be a real shame to exclude patients' voices and speak only from within our glass houses. I was delighted by Prof Oyebode's candid style and sometimes provocative ideas which sparked questions and brought new perspectives to the first day of the conference, alongside Horatio Clare's passion for transforming psychiatric care. What a start!

The second day stood out for the honesty of the presenters and their lived experiences. Dr Graeme Whitfield's "Sexuality and stigma" and Dr Cissy Atwine's "Wait, was that racist" created space for attendees to openly share their thoughts, experiences and fears, and set

the tone for the "Experiential Large Group". Looking back, I think the discussions in that group made me feel I belonged to a community of like-minded people. I am grateful that these individuals were brave enough to be vulnerable in such a large setting. That courage fosters the kind of change and self-reflection we need in psychiatry and psychotherapy.

The meaningful workshops continued with "Psychotherapy in a warming world: reimagining our role" delivered by Dr Pamela Peters, Dr Louise Robinson and Dr Marion Neffgen. It was beautifully designed with Lego pieces, Play-Doh and plant fragments, to help us reconnect with our child-self as we reflected on our future and the world we will leave for our children. I was vegan during a period of my life in Sydney, and witnessed the wildfires first-hand. But over time, as I lost hope due to inaction by governments and large corporations, I gave up that activist side of myself. Learning about the Royal College's climate-related working groups, and meeting others who shared these concerns, rekindled my sense of purpose. I now feel inspired to rejoin the movement and be part of meaningful change through small steps.

The third day continued with a talk by Dr Joanne Stubley and Dr Maria Eyres on their brave and persevering work on the impact of non-recent child sexual abuse on mental health. Hearing the shocking prevalence of non-recent child sexual abuse and the clear-as-water necessity of work on this topic preceded the reality of facing the muddy road of bureaucracy. The experiential large group on the second day was again as impressive as the first day, touching on political subjects that are normally censored by the Ministry of Truth of modern life, and featuring candid contributions from the attendees with sincere self-reflection.

I attended a conference full of sensitivity, honesty, bravery, sincerity, curiosity and openness. I have not been able to mention all the valuable content and contributions, but I can say with confidence that seeing my colleagues and seniors pursue their passions while overcoming many challenges and staying sensitive and empathetic, motivated me. I hope to carry these values into my own practice and remain committed to helping psychiatry and psychotherapy evolve.

Cassel Hospital Summer Conference 2025: Drawing the Line - Authority and the management of self-destructive behaviours in Complex Trauma

Sally Arthur
Adult Psychotherapist, Cassel Hospital

The Cassel Hospital is a highly specialist, centrally funded NHS service for patients experiencing severe and enduring mental health problems, often with a background of complex trauma. In a psychoanalytically-informed therapeutic community, patients work on the difficulties that have marred their lives. Psychosocial nurses, a social worker, group and individual psychotherapists, psychiatrists, a community doctor and the patients themselves all make a contribution to the running of this complex treatment setting which aims to engage patients at every level, from the healthy, functioning parts of their minds to the unconscious conflicts that wreak havoc from places beyond their rational control. It is also a setting in which cups need to be washed, dinner cooked, food shopped for, meetings attended and so

on. And it is itself situated in a much larger context with its own demands and expectations. Where does authority lie in such a complex system? And what is its role? Does it help or hinder? Do we need it? Who needs it? Who exerts it?

These questions were explored with conference guests from community mental health teams, charities and other mental health settings, alongside previous Cassel patients now working in the field. Three fascinating papers gave differing viewpoints and highlighted the tensions inherent in such a complex subject. The first paper entitled 'Acting Out: Authority and responsibility in a therapeutic community' was presented by Emma Davson, Psychosocial Nurse & Simmi Protab, Clinical Nurse Manager. They spoke of the authority held in the 'structures' of the Cassel Hospital, that is individual and group therapy, community meetings and the everyday necessities of breakfast, lunch, teas and supper – all occasions when the patients and staff work through interpersonal and intrapsychic difficulties. They spoke of the role of psychosocial nurses in upholding boundaries to encourage patients to attend these structures, especially when the unconscious and destructive wish is to sabotage them.

The second paper was given by Psychotherapists Ricardo Readi and Beate Schumacher, entitled: Must we take 'No' for an answer? Authority, safety and (psychic) development. The paper outlined psychoanalytic theories on the importance of boundaries in infant development, and on the work of negotiating 'yes' or 'no' throughout the span of childhood and adolescence. Bringing in Freud and Bion, they spoke of the 'contained state of mind' that grows from learning not to discharge upsetting emotional states through self-harm or other destructive actions. They described the work of the Cassel in helping patients to develop an internal containing function by means of the introjection of the containment of treatment – a treatment that needs the function of authority, both outer and inner. The paper spoke to the superego's role in a patient's inner authority, and of its potentially punitive force: 'If we promptly manage the attacks a patient makes on us (staff, setting, etc.), even when doing this through attacks on themselves (Bell, 2008; Freud, 1917), we might be able to stop feeding the severity and even sadism of this kind of superego'. They write: 'escalation in risk depends on extreme guilt, craving for punishment and a confusing pleasure attached to it.' The paper explored the challenges of authority with narcissistically fragile patients, and it linked the rise in borderline phenomena to the increasing permissiveness and pleasure-driven culture of today. 'Vertical' and 'horizontal' authority were explored, alongside the responsibility of all staff for 'rescuing the lifesaving symbolism of authority'.

The final paper was: The Importance and Challenges of Holding Authority in a Complex Organization delivered by Dr Kimberley Barlow, Consultant Psychiatrist in Medical Psychotherapy, Clinical Lead Cassel Hospital & Dr Miriam Barrett, Consultant Psychiatrist and Medical Psychotherapist, Cassel Inpatient Service/ Psychoanalyst. This paper provided an organisational perspective on the task of supporting patients to develop healthier relationships with authority, and of the structure of authority within the Cassel Hospital that is not fully devolved to patients, as it might be in a traditional therapeutic community. This paper described the judicious mix of all types of authority required in a setting where we combine the authority proscribed by NHS structures with a more fluid flow of authority between staff and within the community. They write: 'we operate in an area which attempts to deconstruct some of the structures which perpetuate the sick role/ non sick roles of healthcare, whilst at the same time also recognising the value of differences between us and the reality that there is value to our expertise and training'. Their paper went on to illustrate

Obholzer's (1994) ideas of 'good enough' authority from above, below and within, the latter being largely dependent on the nature of one's relationship with figures in our internal world. It is suggested, that if patients can develop healthier relationships with authority, they may not need to attack themselves in the same way and can look after themselves differently. The authors describe the oscillation between staff, or patients taking more control, and the continuous Cassel process of a culture of enquiry into these dynamics and the meaning behind them. They spoke of the ongoing work of the therapeutic community in challenging the split between 'healthy' staff and 'ill' patients, and the need for reflective practice when working with patients who have complex needs. They write that: Stephen Frosh (2025) highlighted in a recent paper the importance of staff 'surviving sufficiently well for patients to experience the setting as unbreakable, even when exposed to their most utmost rage ('attack me today and I will still be here tomorrow').

The conference was well received by all those who manage risk with complex patients, and who struggle with an authority that can sometimes hinder rather than help in their work. Our experience within the Cassel Hospital was shared and scrutinised and provided an opportunity for all of us to learn more about our understanding of authority in the challenging work that we do.

A special day at the House of Lords with Dr Sue Mizen

Dr Lawrence Congdon and Dr William Burbridge-James
Consultant Medical Psychotherapists
Essex Partnership University Trust

It was an honour and a privilege to attend the House of Lords on Wednesday 2nd April to be present at the launch of the new Centre for Mental Health report making the economic case for developing psychotherapeutic pathways for people with complex mental health conditions. It was the culmination of many years of hard work and dedication from Dr Sue Mizen and her team. A compelling economic analysis and evidence-based case has been made in her report for people with complex mental health difficulties (defined in the report) receiving an alternative to long term hospitalisation and out of area placements in the form of community intensive day- and outpatient-psychotherapeutic treatment. The new service established by Dr Mizen in Devon significantly reduced the number and duration of hospital admissions (locally and out of area) as well as reducing emergency service attendance and provided a better experience for service users and their families.

Dr Mizen, when she was Chair of the Faculty of Medical Psychotherapy, was instrumental in convening the 'Talking Therapies Task Force' as a group of organisations (RCPsych, BPC, APP, BACP, UKCP, SPR-UK) with the aim of collaborating to develop the case to ensure parity of psychotherapeutic service provision for patients with the most complex mental health difficulties, akin to those with mild to moderate mental difficulties who are helped by NHS Talking Therapies (formerly IAPT).

On the day there were important and moving speeches by Baroness Hollins (Emeritus Professor of Psychiatry at St George's Hospital), Sojan Joseph (Member of Parliament for Ashford and mental health nurse), Dr Lade Smith (CBE and President of the Royal College of

Psychiatry) and Dr Sue Mizen (Chair of the Talking Therapies Task Force). As the glorious spring sun shone and bathed the Cholmondeley terrace in a bright light, a spirit of optimism and hope also filled the room. Dr Lade Smith's speech was a helpful rallying cry to members of our profession to continue Dr Mizen's work in making a strong evidence-based case for psychotherapeutic pathways.

We were most grateful to be able to attend and would like to humbly thank Dr Mizen.

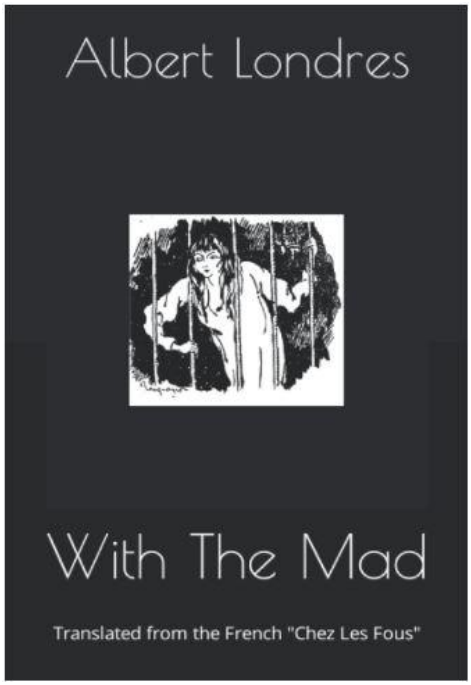
Book Review

BOOK: "With the Mad" by Albert Londres

Translated from French by Stephen Wilson, Oxford, 2021

Dr Ioana Toma
CT1 Psychiatry
Tees, Esk and Wear Valleys NHS Foundation Trust

James Joyce once famously asserted that *'In the particular is contained the universal'*, pointing out the generalizing, all-encompassing quality of artistic masterpieces which survive beyond time. 'With the Mad' is one such remarkable achievement which continues to carry its prophetic warnings a hundred years after its publication. Albert Londres, whose impressive life and achievements are detailed in the foreword of the book which I will not repeat here, not only *'injected a syringe full of ironic humour'* (Stephen Wilson), but his use of sarcasm and satire throughout the writing are pervasive, uneasy and invigorating at the same time.



From the administrative obstacles encountered to enter the asylums which determine him to partake in becoming one *with the mad*, to his astoundment at the spectacle of unusual behaviours of patients in Doctor Toulouse's waiting room, and to having to forge various identities to get access to the madhouses scattered all over France, everything is piercingly depicted through his journalistic lens.

We encounter an endlessly vast array of psychopathological manifestations: visual hallucinations (*'His enemy certainly is in front of him, but only he can see him'),* thought disorder (*'If the conversation seems incoherent, it's only to us, they understand themselves'*), persevering delusions (*'Without the idea which persists, she would be set free'),* lack of insight (*'Madness is a misfortune which isn't aware of itself')* and paranoid and persecutory beliefs, to which he dedicates a whole chapter (*'His madness gives him no respite. It grips him, pursues him, tortures him. In the night it lies in wait for him, it spies for him, it insults him.')* They all eloquently point towards the hardest truth: if madness

seems un-understandable, it's only because we are refused access to it, and genuinely knowing it requires a journey from within both ourselves and others.

The author employs both an objective and subjective attitude, he views them from afar, from a necessary distance which creates the containing space, but also joins them in their folly with authentic curiosity. This polarised but unified view reminded me of the psychotherapeutic stance, where the therapist meets the client in their experience, and not only through a set of standardized techniques, but with replete interest. This unique setting invites an equal subject-subject relationship rather than a more hierarchical, instrumental subject-object one.

Two chapters are poignant representations of extreme descents into madness: *'The furies' meal'* and *'One night'*. In the pre-neuroleptic psychiatric era, the only means of control were purely mechanical or the strait-jacket, which resulted in an atmosphere of complete frenzy, where food has all functions apart from nurturing: as weapons, dangerous poisons, peculiarities and toys in a carnival of madness. *'One night'* opens with philosophical caution, '*The human mystery, which madness is, thickens in the buildings during the night'.* Night carries a plethora of symbolic meanings, from complete collapse of reason and descent into an obscure abyss of the soul, a representation of mental and emotional breakdown where hope has taken a leave of absence. The link with death is made subtly by the metaphor '*The beds are open coffins',* which connects with one of the author's reflections at the end: *'We take away their life without giving them their death'.*

The allegorical meaning of death reminded me of the psychodynamic framework of understanding mental illness: an intricate form of protection against intolerable reality for fear of disintegration of the self. It is a *Catch-22* situation where, in order to survive, an individual suffocates parts of oneself, which renders them emotionally dead, deprived of the privilege and liberties of being a true self.

'*Doctor Dide's Gentlemen'* illustrates a moving account of the Moral Treatment introduced by Philippe Pinel, where monstrous façades conceal sophistication and a taste in arts. Doctor Dide is non-hierarchical and a promoter of leaving madmen alone, even stimulating them to work and create, to sublimate insanity into productive, socially-acceptable occupations, as demonstrated by the variety of workshops.

Londres' perspective is sharp and enlightening and utters uncomfortable truths: *'If asylums are there to soothe the guardians and not to treat the mad, let's take off our hats, they've achieved their purpose'.* Contemporary psychiatry is no stranger to operational difficulties and staff shortages, and despite solid investment in research, we still know little about *what is going on.* In his approach, he is deeply humane and truthfully postulates that caring for the mad starts with understanding them.

Each of the remaining chapters deals with relevant themes in psychiatry, such as social stigma, crimes driven by motherhood envy, rich in psychoanalytic meanings, special privileges and social stratification of madness, relational aspects of day visits and estrangement from families, agony and ecstasy in substance misuse, and what complete recovery looks like. The latter, narrated in *'Isoard is cured'* reveals two aspects of a painful

reality: the taken-for-granted sanity of unsane men, and prolonged effects of having once been a patient.

The book ends with terrifying contemporaneous reflections, in a circular manner, which summarize in an all-encompassing way the whole ethos of the book. I would like to emphasize how wonderfully paired is the body of writing with the illustrations by Rouquayrol: the minimalistic aesthetic conveys an infinity of emotions and mental states, as there are in any human being.

This book is available on: https://www.amazon.co.uk/Mad-Translated-French-Chez-Fous/dp/B09VWK1ZNJ

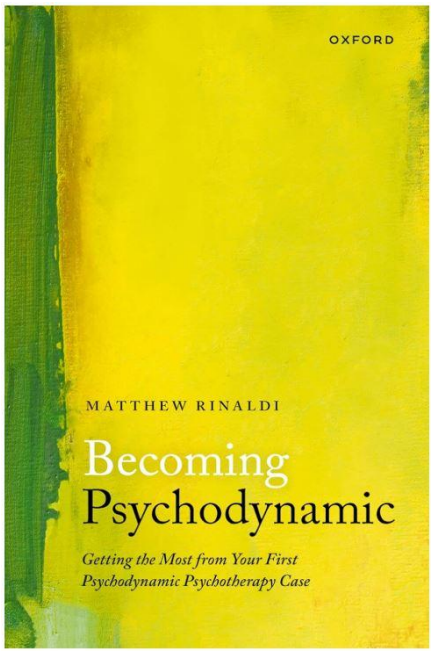
***Acknowledgement**: I am much obliged to Dr Stephen Wilson, who drew attention to this jewel of a book in the Medical Psychotherapy Autumn/Winter 2024 Newsletter.*

NEW BOOKS: Call for reviewers

Becoming Psychodynamic: Getting the Most from your First Psychodynamic Psychotherapy Case Matthew Rinaldi, 2025, OUP Oxford

Dr Matthew Rinaldi
Consultant Medical Psychotherapist and Psychiatrist
West London NHS Trust

"*Who the hell are you to write this?*" I am asked.
"*I have gathered a posy of other men's flowers, and nothing but the thread that binds them is mine own*," answers Michel de Montaigne on my behalf.



A practical, accessible guidebook for core trainees embarking on their long case has been long overdue. Existing texts are too lengthy to fit into their demanding schedule, disconnected from modern theory, or impenetrably mystical to the initiate.

Like you, I'm frequently asked to recommend reading that can reduce their anxiety by orienting the psychiatric mind to what is expected of them in psychodynamic psychotherapy. While I love the books I suggest, I'm also aware that I couldn't have digested them until I'd begun personal therapy and gained experience with several cases—an opportunity not always available to core trainees. This spurred me, three years ago, to begin compiling guidance on key aspects of the core training curriculum: the frame, transference, dreams, ending, supervision, personal therapy, and the working alliance. What began as notes later took shape as Becoming

Psychodynamic—an approachable introduction to answer the questions most trainees ask during their first case.

Then the doubts crept in. They crystallized when Oxford University Press asked whether I'd be writing alone or if an expert in the field would be penning the preface. I admitted it would just be me, and felt like an impostor, as though my words lacked legitimacy. The publisher then requested evidence of interest, further fuelling my uncertainty.

Fortunately, I had that evidence in abundance. Core trainees who proofread chapters expressed gratitude for the clarity, or suggested additional content they'd find helpful. Their enthusiasm reignited my confidence that as a higher trainee I sat sufficiently ahead of their situation that I had some knowledge to impart, but also not so remotely that I had forgotten what their experience was.

The project made me reflect on the political importance of medical education and the long case. We work in an NHS increasingly fragmented and detached from relational models of care. I believe this shift correlates directly with the declining involvement of psychiatrists in talking therapies. Fifty years ago—or even now, in many parts of Europe—it was standard for psychiatrists to engage in psychotherapy. Today, fewer than 5% of UK psychiatrists receive formal training in a psychotherapeutic modality. Given our role as advocates for mental health care, this trend represents a missed opportunity. The long case, as it stands, could be far more than a tick-box exercise; it could instil in future policymakers a deeper appreciation of relational work and the transformative power of being-with.

Thus, the project took on a new seriousness. Any naive fantasies of fame or fortune quickly dissipated once I discovered how little most academics earn from their publications. Instead, the book became a mission to empower junior colleagues to reclaim psychotherapy as part of their practice. It also evolved into a kind of memorial to my higher training, with its publication coinciding with the start of my first consultant post. The process of distilling my experiences, trainings, and supervisions into essential principles clarified for me what I believe to lie at the heart of psychotherapy, and I was surprised that after various trainings I had come to a conclusion on many of these matters.

The book is simple. I do not view this as a flaw. As we know, trainees' first two or three psychotherapy cases often yield better outcomes than their later ones, thanks to the attentiveness and humility of the beginner's mind. The depth of knowledge conveyed in Becoming Psychodynamic is, I believe, sufficient for trainees to begin meaningful, effective therapy.

Overcoming the sense that I was merely echoing my supervisors or psychoanalytic idols was challenging. I credited sources wherever possible, yet words alone cannot convey the depth of my gratitude to those who shaped my understanding of this work. I've had to strike a balance between my impostor syndrome and the narcissistic drive of feeling that I have something unique to say on the matter. Ultimately, I've come away from the project satisfied with the new thread I've woven into a century's writing on the topic.

In particular, I'm proud of the book's structure - a sort of ladder or chronology of skills that builds upon trainees' existing communication skills. My hope is that this framework reassures

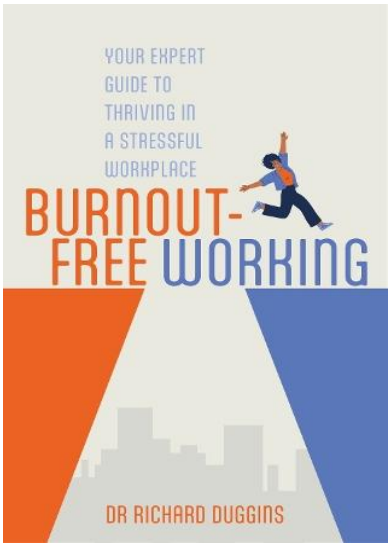
them that they already possess most of the necessary skills and are simply refining and expanding them to become increasingly psychodynamic over the year, rather than starting something alien. By offering a developmental path, I aim to demystify the process and provide a compass bearing to navigate their first case.

Words cannot describe the boredom of re-reading one's own words to the point of delirium during the editing process. Yet, they also cannot describe the joy of seeing the final product in a core trainees hand, feeling more oriented, and able to work.

Becoming Psychodynamic is available from Oxford University Press or Amazon
Becoming Psychodynamic: Getting the Most from your First Psychodynamic Psychotherapy Case eBook: Rinaldi, Matthew: Amazon.co.uk: Books

Burnout-Free Working – Your Expert Guide to Thriving in a Stressful Workplace Richard Duggins, 2025, Jessica Kingsley Publishers

Dr Richard Duggins
Consultant Psychiatrist and Consultant Psychotherapist
Newcastle upon Tyne



Richard Duggins, a Consultant Psychiatrist and Consultant Psychotherapist, in Newcastle upon Tyne, has written a book about his work with people working in high stress jobs!

Released on 21 April 2025, the book offers a fresh, warm and practical take on burnout.

Known as 'the doctors' doctor' for his work supporting NHS and social care staff across the UK, this book isn't another call for more "resilience." It's a powerful way of thinking about how we live and work, so burnout doesn't stand a chance.

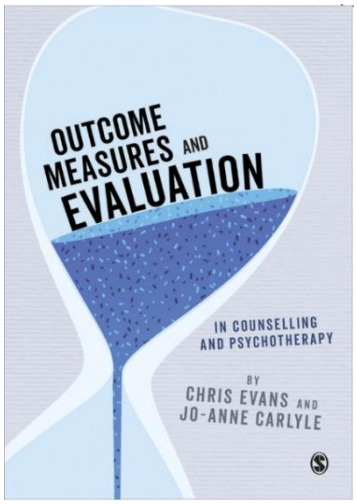
Ideal for professionals feeling the heat, and for employers seeking evidence-based ways to retain and revive staff.

"The best book on the ever-increasing challenge of burnout I have ever read." — Dr Helen Garr, GP and Medical Director, NHS Practitioner Health

Available from Amazon and all good bookshops.

Outcome measures and evaluation in counselling and psychotherapy (1st ed.)

Evans, C., & Carlyle, J. (2021). SAGE Publishing.



Evans, C., & Carlyle, J. (2021). Outcome measures and evaluation in counselling and psychotherapy (1st ed.). SAGE Publishing. https://ombook.psyctc.org/book/

Psychoanalysis, Society and Culture

Roger Kennedy (2025). Routledge.

Call for future book reviewers and contributions

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

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

We are sometimes able to negotiate access to review copies of books. If this interests you, please email me at pamela.peters@cpft.nhs.uk.

College Events, notices & dates for your diary

EDI survey - We need your help!

The EDI working group, Medical Psychotherapy Faculty

Message from the Medical Psychotherapy Faculty Exec:
Hopefully, we have caught your attention so please keep reading. In line with the Royal College of Psychiatrists Strategy (2024-2026) and the Medical Psychotherapy Faculty Strategy (2024), we in the Medical psychotherapy faculty executive committee set up an 'Equity, Diversity and Inclusion' working group in 2024. The group has set up a survey; the objective being to understand you, our faculty members from an EDI viewpoint. The survey has been carefully constructed over the past year (with the support of various teams within the college) and we hope it will be disseminated to all faculty members before the end of 2025. This will be the first survey of its kind to be widely distributed to our faculty.

The information gathered will deepen our understanding of the composition of the faculty and the lived experience related to equity, diversity, and inclusion within Medical psychotherapy in the NHS and beyond. The survey itself will take approximately 10 minutes to complete and the amount of information shared will be voluntary. Obviously, the more you are willing to complete, the richer the data we will collect and analyse. All responses will

remain anonymous. This will be an important and exciting opportunity to contribute to a clearer picture of our professional landscape and support future research in our speciality.

Please keep an eye out for the survey which will be sent from the Medical psychotherapy faculty in the next few months with the subject header Equity, Diversity and Inclusion. We value your voice - please do take a few minutes to be part of this vital conversation.

Psychodynamic Psychiatry Day: If grief is the 'sea we swim in', what does this mean for psychiatry?

In this event we will look at the central role of mourning in mental health.

This will be held on **14th November 2025**. **Location:** RCPsych, 21 Prescot Street, London, E1 8BB

Psychodynamic Psychiatry Day 2025: If grief is the 'sea we swim in', what does this mean for psychiatry?

Conference: The Climate Emergency and why it's important for Psychiatrists

Save the date: 27 February 2026 – A one-day in-person conference at the Royal College around the Climate Emergency and why it is important for Psychiatrists

This conference is being organised by Psych Declares (an environmental campaign group of psychiatrists that lobby the College to take more decisive action on the climate emergency) with input from the Faculty Climate and sustainability working group who will also be running a workshop. It's looking to be an exciting and inspiring day!

Faculty Group

The group for consultants and higher trainees in Medical psychotherapy meets on the fourth Thursday of each month at 17:30-19:00.

If you would like to join, please contact the facilitators:
David Fainman (david.fainman@nhs.net) and Radha Bhat (radha.bhat@nhs.net).

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

Call for submissions

My grateful 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 **27th February 2025.**

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