Faculty of Medical Psychotherapy Executive Committee

Chair: Susan Mizen, Devon
Vice Chair: Steve Pearce, Oxford
Financial Officer: Mark Morris, London
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Editors’ Welcome

Maria Eyres and Harriet Fletcher

Dear Readers,

Welcome to our Spring/Summer 2016 edition of the Newsletter; after our initial pledge to co-edit for a year, we have so enjoyed sharing the responsibility of the job that we have decided to carry on for a little longer. If this sounds like an invitation to our new Executive Committee recruits to consider joining us, that is indeed what it is. We also extend a very warm welcome to the new Service User representatives. Both Aakta and Stephanie will be writing to introduce themselves in the next edition and we look forward to discussions with them about developing the role of Service User Editor.

We would like to say goodbye to Angel Sanchez-Bahillo, who worked under Jan Birtle’s editorship as International Editor, and then worked with us for the past year, linking with colleagues overseas to provide some fascinating articles about medical psychotherapy in other countries, as well as submitting some interesting opinion pieces of his own. Many thanks, Angel, and very best wishes for the future. This is also an invitation to anybody who would like to take over from Angel. We are also saying goodbye to Tiago Gandra, who has been the Trainee Voices editor for a few years now, organising some very refreshing and interesting contributions from junior doctors training in psychotherapy either as specialist or core trainees. Tiago has been succeeded by Alex Chatzgiorakis and Anna Croxford: welcome, and we look forward to working with you.

With the recent article in the BMJ entitled “Doctors are emotionally damaged by complaints”, which cites studies by Tom Bourne (see references below) as well as the recent news that the junior doctors have voted to reject the new contract, Jan Birtle’s piece on the work of the Member Support group has gained even more significance. We also have an article by Gwen Adshead exploring the impact of cuts to Medical Psychotherapy posts through an account of her own experience, which ends on a hopeful note. Another highlight of this issue is the article by Anne Ward and Danny Goldberger about parent-infant psychotherapy, which comes at a time when there is considerable focus on mental health in the perinatal period. The article is an excellent exploration of the contribution which some of our psychotherapy services may be well-placed to make.
We think it would be good to use the newsletter to raise awareness of new publications both by Faculty members and of potential interest to members, and to this end we would like to introduce book reviews. For example, the Oxford Handbook of Medical Psychotherapy is due to be published in the autumn and we would like to include a review in the Autumn-Winter newsletter. If anyone would like to put their name forward as a co-editor to lead on the Book Reviews section, we would love to hear from you.

Transatlantic Link

As a legacy of Angel’s last contribution as International Editor, we now have a link with the American Psychiatric Association (APA) Psychotherapy Caucus, formed approximately 3 years ago, which presents us with the task of working out how best our two organisations can collaborate. There is potential scope for collaboration in projects or even joint research projects, contributing to each others’ publications and/or conferences, sharing experiences from the coal face as well as facilitating personal links between professionals involved in particular fields of mental health. Maria has been taking this forward together with Sue Stuart-Smith. Please contact Maria and Sue via Stella if you have any further thoughts or suggestions.

In the process of linking up with the Caucus, we have come across some interesting facts about our Faculty and the Exec which we thought are worth sharing. Any member of the College with an interest in Psychotherapy can join the Faculty, and we currently have 4,415 members. 876 members report that they work in Medical Psychotherapy and there are 102 members who report working in Forensic Psychotherapy.

As for the history of the Faculty, this is what our archivist said. The Psychotherapy and Psychopathology Sub-Committee was set up when the Research and Clinical Committee began in 1927, and was still referred to with this title in 1942. The formation of a Psychotherapy Section discussed at the November 1948 Council meeting and the Social Psychiatry Section was renamed the Psychotherapy and Social Psychiatry Section at the Council meeting in February 1949.

The Executive committee has 15 Elected members, who serve a four-year term of office, and 18 co-opted members (this is usually a four-year term but can be extended). There are also 16 Regional Representatives who are not Executive members but are invited to attend Exec meetings; some of these are also elected or co-opted members. The Executive also has a number of task groups whose work focuses on specific areas; Medically Unexplained Symptoms, Historical Childhood Sexual Abuse, Tier 3 / Tier 4 PD Services, Tier 2 Psychotherapy Services, Psychosis, Perinatal, Eating Disorders, Forensic, Primary care (CR151), Reflective Practice, Support to Faculty Members and Neuroscience; we aim to report on their work regularly in this Newsletter.

We will leave you with these statistics and wish you happy reading! As always, your contributions are welcome, both articles and photos for the next edition. Please send them to Stella for forwarding to us.

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References:


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**Message from the Chair of the Faculty of Medical Psychotherapy**

Susan Mizen

Whilst the country is in the grip of democratic turmoil, at least the Faculty has exercised its right to vote decisively and the new Executive is securely in place to take on the task that lies ahead. I am very pleased to welcome Dr Steve Pearce as vice chair. Dr Gillian Bluck, Dr Marcella Fok, Dr Anis Janmohamed, Dr Alison Jenaway, Dr Tennyson Lee and Dr Andrew Williams have also been elected as executive committee members. A number of members have reached the end of their term and are leaving. I wanted to say a particular thank you to Jan Birtle who has come to the end of her time as vice chair and has worked tirelessly in the areas of member support and public engagement for many years. Her experience and dedication will be very much missed. We have also said goodbye to the Celeste Ingram and Helen Gill who were the first service user reps on the Exec. I think they and we learned a lot about service user involvement during the years they have served on the exec, it has been a really valuable experience for us and I want to thank them for bearing with us and for all they have contributed to our thinking. We have two new Service user reps, Aakta Patel and Stephanie Guidera, who will be building on the work they started.

We had an excellent conference at Weetwood Hall in Leeds in April. Academically, clinically and as our main opportunity to get together in the year it was, I think a great success. Many, many thanks to Mark Evans, Jo Stubley and Jo O’Reilly for the work they put into organising this and the next conference which will be at the Royal College in London on themes related to Trauma. We are developing our conference programme with two additional one day conferences this year, advertised here in the newsletter.
The clinical working groups have continued to develop and are producing work of national importance for the future of our work and patient care. The MUS working group has completed the work on the Joint Commissioning Panel Guide and the Historic Childhood Sexual Abuse group have been consulting to the College response to the Ministry of Justice’ proposals to introduce Mandatory reporting.

The ‘psychotherapy collaboration’ has been gathering momentum with monthly meetings of the six member organisations, The Faculty, the APP, the BACP, the BPC, the Society for Psychotherapy Research and the UKCP. We now have a name, The Talking Therapies Task Force and have developed a programme of work. Below is a briefing statement describing our work in producing a national infrastructure to promote the development of psychological therapies services for people whose needs fall outside the remit of IAPT.

For myself I am particularly pleased that the neuroscience day at the conference was such a success we were fully booked and enjoyed an excellent presentation from Oliver Turnbull introducing us to Neuroscience for psychotherapists with research presentations and papers for discussion for the rest of the day. The day was met with enthusiasm and the interest group is growing. We are likely to hold further interest days at future conferences. We will be holding two reading groups this year between 3pm and 5pm on the 21 September and 14 December. Please let Stella Galea know if you would like your contact details to be added to the mailing list for these events.

We had many volunteers who wanted to be involved in contributing to the new College Neuroscience Curriculum funded by the Gatsby and Wellcome Foundations. The applications to join this process are open and I will do my best to ensure the Faculty is involved in the process. I will be contacting those who have volunteered when I have more information about the next steps.

There are very many other pieces of work we are involved in. I will say more in future editions as they come to fruition. Enough for now perhaps!

Sue Mizen
Faculty Chair
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Message from the Academic Secretary

Mark Evans

The 2016 Medical Psychotherapy Faculty conference was held from 13th to 16th April at Weetwood Hall in Leeds. The conference team consisted of Jo O’Reilly, Jo Stubley, Sue Mizen and myself. We have not yet had the formal feedback but informally it felt like a very enjoyable, stimulating and more intimate conference than the larger London one of a year ago.

The conference title was ‘Attachment across the Life Cycle’ and the programme reflected the fact that the conference was presented in collaboration with the Old Age Faculty. It was also jointly sponsored by the APP and the BPC. This year, we continued to extend the conference, again offering the option of pre-conference workshops on Wednesday afternoon prior to the guest lecture but also introducing an extra full day on Saturday coordinated by the Neuroscience interest group.

The two well-attended pre-conference workshops on Wednesday were on the subjects of professional misconduct (John Hook, Jonathan Coe and Gwen Adshead) and the use of CBT to remain an effective psychiatrist (Paul Blenkiron). In the evening, Margaret Heffernan and Penny Campling together movingly described their approaches to thinking about ‘The fragile business of healthcare’ for the guest lecture. Although describing different approaches to the subject, Margaret and Penny found lots of common ground and stimulated a fruitful and thoughtful discussion about developing more compassionate and less competitive healthcare.

The programme on Thursday, the first full day of the conference, included three internationally well-known speakers on the subject of attachment theory and its clinical applications. Jeremy Holmes set the scene with an overview of the subject area together with a description of the particular challenges that the mental health professions face at this time. Peter Fonagy then elucidated the concept of ‘epistemic trust’ and how key this is to human learning, including learning about the self in therapy. Finally, Steve Suomi described his work with parent reared and sibling reared Rhesus Macaque monkeys. The latter group showed similar behaviour to poorly attached human children and what was clinically fascinating were the suggested methods for improving communication and (apparent) wellbeing in this group. These included the use of early mouthing techniques as well as grand parenting to reverse some of the effects of the lack of secure parent attachments as evidenced in epigenetic marker studies. There was a full and informative plenary discussion between the three speakers.

Workshops in the afternoon were offered by Jo Stubley and Maria Eyres (Historical childhood sexual abuse), Ronald Doctor and John Lowe (A psychodynamic approach to psychosis), Anne Ward and Danny Goldberger (Psychotherapy in the perinatal period) and Steve Suomi and Rob Hale (Attachment, epigenetics and transgenerational transmission in a man who murdered). Delegates had a chance to attend two of the four workshops.
There then followed the poster presentation slots in which all poster authors were given a strict 60 seconds in which to bring alive the key points from their poster. This was informative and fun and brought a good energy to the afternoon session encouraging more poster viewings throughout the conference. One brave presenter even chose to sing about the contents of his poster to guitar accompaniment! The posters were later judged and the winners announced at the close of the day. The afternoon ended with attendees splitting in to groups for small group discussions. This was a revival of an aspect of the Faculty conference that has not been available for the last few years and it offered to delegates a boundaried time for engaging and reflective discussion in order to digest and make sense of the (hopefully) epistemic learning of the day under the calm facilitation of Group Analysts from within the faculty. Following the annual general meeting there was an enjoyable conference meal, augmented by the improvised strains of a jazz duo and the witty and engaging after dinner speech from Bishop Nick Baines.

The Friday programme began with two talks relating to Older Adults psychiatry. Andrew Balfour and Liz Salter of the Tavistock described their programme offering an intervention focusing on attachment in couples where one partner suffers with dementia. Sandra Evans then gave a useful general overview of attachment issues in old age before an enlightening plenary discussion.

The late morning plenary consisted of three lectures from members who had volunteered their presentations following a call for papers. This was the first time (at least in recent years) that we have invited submissions from the general membership of the Faculty and something we intend to repeat next year as it offers a chance to hear about a variety of initiatives, developments and research from the grass roots. Jason Hepple spoke first about a novel development of cognitive analytic therapy for understanding and treating obsessionality and anorexia. Next Haroula Konstantinidou, Chris Evans and Alice Shelton described their research into the psychodynamics of prescribing and how Medical Psychotherapists can be helpful in this interaction. Finally, Amy Kothari, Jane Dammers and Peter Shoenberg presented their work on the use of Balint groups as an educational tool for medical students and the particular developments in Bristol.

Small group discussions were repeated in the early afternoon with the two day delegates staying in their same small groups whilst Friday only attendees joined a new group. The final plenary on Friday was dedicated to the other end of the lifecycle (to the morning session). Amanda Jones presented her work with mothers and babies in the perinatal period. She included some very moving video footage and allowed us to think about how crucial secure attachment is in the first stages of life and about how to work with mothers who are struggling to bond with their babies.

Friday’s programme was closed in the afternoon with the announcement of the poster prizes and a farewell and heartfelt thank you to Jan Birtle for her extensive work as Vice Chair of the Faculty. The poster prizes were as follows: 1st Prize went to Dr Geoffrey Ijomah (The Effectiveness of Analytically Informed Team Supervision in Reducing Sickness Absence Rates); the 2nd Prize went to Dr Binuja Justin (Personality Disorder Service Proposal in 2gether NHS Foundation trust, Gloucestershire); and 3rd Prize went to Mr John Baxter (A Reflection on a Balint group based Student Selected Component).

Saturday was dedicated to thinking about neuroscience and psychotherapy and was led in the first morning session by Oliver Turnbull. In the late morning, Cynthia Fu and Sue Mizen presented their research proposals to the group on the neural correlates of depression and the potential for developing predictors of clinical response. These were then critiqued by Oliver Turnbull with a group discussion. In the afternoon, two pre-circulated papers were discussed before the
Neuroscience day ended with a group discussion about future developments for this interest group.

The papers discussed were:


The next Faculty conference will be held in the College offices in London from the 5th to 7th April 2017. The focus for the conference will be ‘Dissociation and its implications for clinical practice’. We will shortly be putting out a call for papers and workshops as well as posters. So please get the date in your diary and we look forward to seeing you for what should be an exciting conference next year.

Mark Evans
Academic Secretary
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Message from the Chair of the Faculty Education & Curriculum Committee (FECC)

William Burbridge-James

The therapeutic education strategy 'Thinking Cradle to Grave' outlines the principle of developing psychotherapeutic psychiatry and helping psychiatrists to become more therapeutically minded.

When I think about the essential training experience that we would like trainees to gain from their Psychotherapy training, it is the foundation of undertaking "the long case". Trainees will work up to taking on a patient by engaging in reflective practice throughout the first year of core training through attendance at a case based discussion group, they may have undertaken a short case, and are already in regular attendance in a supervision group, where their long case will be supervised.

The long case has its essence in the experiential process for a trainee to be with "another" in a therapeutic encounter that is comparatively long-term, with the potential for a consistent
therapeutic endeavor that is beneficial for patients and trainees alike. This gives trainees the opportunity for therapeutic development that will stand them in good stead for their future as psychiatrists.

As trainers we do not know the outcome when we allocate a particular patient with a particular trainee but try our best to match patient with trainee, balancing clinical, training and governance factors in our decision making.

It can be all the more pleasurable as a supervisor when a creative therapeutic process is enabled that was unpredicted and allows new unknown material to come to light, through which new personal and relational learning can take place, that is then a source of knowledge for patient and trainee, and an authentic training experience. The difficulties entailed are not to be underestimated too; both practical, in freeing up trainees to be able to have adequate protected time, and those of the therapeutic process in terms of affective storms, challenges and ruptures to the alliance. Weathering these challenges and sticking with the process, with the support of supervision is all part of the learning experience.

As I wrote in November, there are as yet no clear guidelines as to what training experience is required in higher psychiatric specialty training. The curriculum states that trainees should carry on their psychotherapy training experience into higher training in a way that is relevant to their training, and there is an expectation that higher trainees across subspecialties would be undertaking a SAPE every year to monitor their progress. There is a mandatory section for psychotherapy training in the clinical and educational supervisors’ end of year reports for ARCP, which should be linked to evidence in the trainees’ portfolios. It is also unclear who has the responsibility for providing higher psychotherapy training experience and quality assurance, as this is outside the current remit of the psychotherapy tutors who are responsible for core training.

However, we might expect that the "long case" is the sort of experience that we would like trainees to continue to have into higher training. An in-depth therapeutic encounter, supported by supervision, alongside cased based reflective practice, and other psychotherapy experience relative to their psychiatric specialty and special interest.

I hope by next time I write in the Autumn the results from the UK 2016 psychotherapy survey will inform my newsletter feedback. If you know of anyone who is yet to complete this, please get into contact with me directly.

Dual training curricula continue to be progressed. Higher dual training with Child and Adolescent Psychiatry and Medical Psychotherapy is awaiting submission by the college to the GMC and work is underway by colleagues in Yorkshire mapping the Intellectual Disability curriculum and Medical Psychotherapy curriculum as the first step towards a dual training between a dual CCT in intellectual disability and medical psychotherapy. James Johnston reports separately on the medical student psychotherapy developments.

William Burbridge-James
FECC chair
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EXECUTIVE COMMITTEE TASK GROUPS

The Member Support Task Group: a review of the first seven years from the outgoing lead

Jan Birtle

The Medical Psychotherapy Faculty has traditionally supported colleagues over many issues, responding to approaches and requests for information, to those requiring assistance and proactively driving forward issues of importance at Regional and National level. Over time there were signs of mounting numbers of approaches and queries coming forward, this often registered through informal discussions at Faculty meetings.

In small specialties such as Medical Psychotherapy colleagues often work in relative isolation and there is a significant added value brought by face to face meetings, opportunities to share, enquire “how are you...how are you really getting on?” that brings more depth and sensitivity to communication than for example letters, emails and teleconferences, helpful communication processes as they are. Soft data, gathered over the “tea time chat” was indicating a trend, many colleagues were struggling and some were reaching burn-out.

In response the Member Support Group was established, as a task group of the Faculty, in 2009 to focus on these needs. The early sense was that putting together the soft intelligence from tea time chats with harder information (not always easy to ascertain) about cuts in consultant Medical Psychotherapy posts and to specialist psychotherapy and personality disorder services that a serious problem was brewing. There seemed to be an escalation of a trend, reversed for a period by investment in personality disorder pilots, of widespread cuts to services, changes in management arrangements, lack of clarity of the role and contribution of Medical Psychotherapy resulting in colleagues not feeling valued, resulting in a gradual erosion of morale in the speciality.

Alongside other developments the work of member support has provided a strong forum to both respond to colleagues in distress and to pro-actively consider the strategic development of Medical Psychotherapy moving forward.

We agreed the initial approach as follows:

1 To develop an information pack supporting Medical Psychotherapy as a shared resource available to colleagues to provide a platform for service developments and to assist in situations where services are under threat.
2 To strengthen communication, monitoring and information sharing in order that there is a strategic overview of the Medical Psychotherapy workforce and local availability of advice when required.

3 To develop a support system for Medical Psychotherapy colleagues, including strategic advocacy and professional support.

Progress to date:

1 The information pack is taking shape with a range of key documents gathered together, this including: The Role of the Medical Psychotherapist, Council Reports, Training and Core Curriculum documentation, all of which are in the public domain.

The key areas we have outlined are:

1. Training

Significant impact has been achieved through the psychotherapy component of core psychiatric training having been determined by the GMC as mandatory together with a mandatory requirement that a Medical Psychotherapist oversees the quality of training and assessment of competencies as a key element of core psychiatric training. At the time of writing there are enhanced requirements for the continuation of psychotherapy into higher training which will become mandatory in almost all specialties.

Higher training in Medical Psychotherapy has now become accepted as dual speciality training, in recognition that the future workforce requires enhanced flexibility, whereas a single CCT was limiting the employability of Medical Psychotherapists.

Reflective practice is now recognised as essential to developing and maintaining learning and resilience, which has become an increasing challenge to all doctors. Reflective practice is a core component of professional medical life, a necessary part of continuing professional development and required to satisfy the regulatory process of enhanced appraisal and revalidation. This is now becoming the norm, with Medical Psychotherapy colleagues leading on the development of Balint groups in Medical Schools, through foundation training and increasingly provision of reflective practice forums through to retirement.

CPD is another area to develop further, with attention being given to events such as the Annual Faculty of Medical Psychotherapy (FMP) Conference being jointly run with other Faculties or Royal Colleges and with contributions such as Balint Groups being established as a norm in the International Congress. There are opportunities to assist the learning and quality of practice of colleagues across a wide range of specialty branches of Medicine and wider healthcare, particularly utilising knowledge and experience from specialist Medical Psychotherapy practice to enhance and sustain compassionate care, to ensure that this can be consistently provided in environments which enable empowerment.

2. Economic case

Considerable progress has been made through the FMP developing Health Economic cases demonstrating both clinical and economic benefits of providing services particularly for those with complex presentations including Personality Disorder and Medically Unexplained
Symptoms.

The research interest group has also been gathering a portfolio of evidence of the impact of Medical Psychotherapy including a focus on the evaluation of psychotherapy, of the impact in specific clinical presentations, such as Antisocial Personality Disorder, and evaluation of Balint groups.

Work is progressing to develop further documents focusing on key areas where the group considers Medical Psychotherapy makes a significant and unique contribution to quality of services, organisational risk and financial management. These build on existing work, including the approaches colleagues have had from their Trusts to provide expert advice to risk management committees, and cross-reference to other strategic work groups. The intention is to base these on local practice but develop general documents which can be shared with colleagues. These in turn can support informed (evidence based?) job planning and feed into and be informed by the workforce planning group.

3. Case scenarios, business cases anonymized

There is an opportunity to share expertise and knowledge through making available anonymized case scenarios and business plans, with the caveat that care be taken to respect confidentiality in relation to commercial or clinical issues. While this may be contentious due to the competitive environment in which we increasingly operate the sharing of intelligence and arguments for service developments have been influential and add to clinical quality in being a strong factor in commissioned services.

The workforce in Medical Psychotherapy is under pressure nationally, with several retirement vacancies being deleted from budgets. The situation is being monitored and the Faculty is engaged in actively lobbying and reviewing the bigger picture, working to influence the College through the central workforce development group.

Communication is the key to progressing member support

The Faculty Regional Representatives are core to our communication strategy, they sit on their local Divisional Executive Committees and through this are in a position to highlight local workforce issues and raise the profile of psychotherapy. They are known to local colleagues, provide advice on job descriptions and can lobby for service and training quality. The Regional Reps are often the first port of call for colleagues when services are under threat and we encourage this contact, especially as an early step, often relieving pressure for those in the hot spots. The Faculty has developed a Regional Representative Network to assist in the sharing of information, in finding solutions to difficulties and to escalate matters of concern in a timely manner to allow a response.

Contact between Regional Reps and Member Support can assist in accessing information, support and input from Faculty colleagues, for example response to consultations around service reconfiguration.

Member support can similarly signpost colleagues to others who may have a knowledge or experience based perspective that can assist a specific query, they can lend a listening ear, provide resources and intelligence, information and also signpost to other services provided by the College such as the central Psychiatrists Support Service.
The Faculty web pages are being developed including a secure area where sensitive documents will be available to Faculty. There is also attention paid to information for the public, with College leaflets having input from colleagues.

Service user engagement can be very effective when services are under pressure. The importance of service user voice was endorsed along with ideas about how to engage the optimum inputs. The contribution of Experts by Experience to the FMP Executive Committee has been growing during the past 6 years and, following some initial hesitancy, has become a very well established and valued ‘norm’.

The newsletter, in tandem with member support, has evolved to be an important vehicle for communication, with updates from the Faculty Executive which all members can access, along with engagement of Experts by Experience, who have submitted regular sections, a section for and by trainees and an international perspective. The newsletter continues to thrive and underlines communication, communication, communication, a mantra for all Medical Psychotherapists.

The Psychiatrists Support Service, PSS, is progressing several developments centrally within the College, a major focus being strengthening the Mentorship scheme with which Member Support has established close links, both informing and being informed by this.

**Where next for member support?**

As can be seen from the above description, member support has changed and adapted as time progressed. Issues brought up by individuals have often been replicated elsewhere and this has helped facilitate coordinated focused responses, leading to learning that can be shared while confidentiality regarding specific circumstances is maintained.

The linking with other strands of work, initiatives and task groups in the FMP has proved to be very influential as much of the energy and effort has been referenced elsewhere. This includes group such as communication, workforce, training, Regional Representatives Network and research developments.

Member Support has evolved over time. The membership has comprised a changing group of the Executive team of the FMP who draw on a wide range of resources, including through networking and contacts, to assist colleagues who seek help or are for a variety of reasons under pressure. The role is currently linked to the Vice Chair of the Faculty, more through personal interest of the author than through other reasons. The FMP is considering whether to continue this initiative, or whether the work has been sufficient to bring it into mainstream work of the Faculty and College, including PSS.

As Medical Psychotherapists we recognise that we need to look after ourselves in order to be present for others, this being a core part of our training, as reflected in the central role of personal therapy. The sensitivity of work in the consulting room, with traumatised and highly alert patients, requires a high level of self-containment and self-awareness alongside, over a consultant career, the maintenance of very long term emotional receptivity.

Similarly, over the long period of time of a consultant career, most of us will experience
challenging or trying life circumstances. Many of us are aware, from personal experience or through colleagues, of the stresses experienced professionally when services are under pressure. It is hoped that member support has helped to make a difference, and that it will continue to do so, both directly when colleagues are in need of someone to talk to and more generally by assisting colleagues in the Faculty to share and work together more effectively, in recognition of the rich benefits for all that can be realised.

Dr Jan Birtle  
Outgoing Vice Chair of the Faculty  
Member Support Task Group Lead, 2009-16  
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Update from the Historical Childhood Sexual Abuse Task Group

Maria Eyres and Joanne Stubley

The terms of reference for this task group have previously been published in the Newsletter, but it may be helpful to remind you that we wish to influence thinking in the clinical, training, political and personal arenas in relation to Historical Child Sexual Abuse (HCSA). With this aim in mind we have been involved with the following activities in the last few months.

Firstly, we held a workshop at the annual Faculty conference in Leeds this year entitled Historical Child Sexual Abuse: The Banality of Evil. We found it helpful to think with others from the Faculty and to share recent research findings on HCSA as a basis for asking the following questions:

- Do we need to re-consider the psychiatric diagnostic classificatory systems in the light of emerging evidence on HCSA?
- Do we need to re-design psychiatric services to move away from diagnostic-based interventions towards a model based on individual formulations or trauma-based and relational interventions?
- What prevents medical / psychiatric training from adequately addressing this issue in training for detection, aiding disclosure, engagement and management of HCSA – related problems and presentations?
  - What research questions should we be asking?
  - Epidemiology
  - Resilience
  - Evidence-based practice
  - Service issues
- What role do Medical Psychotherapists have to play?
  - What role does the Faculty have?
  - What role does the College have?
We would be very interested to hear from any of our readers who were unable to attend the workshop what thoughts they may have on these areas of interest; please contact us via Stella Galea whose e-mail address can be found at the end of the Newsletter.

The second piece of work was to offer feedback to the government through the College on the proposals for a “Failure to Act” legislation. This links with the current governmental work on Mandatory Reporting and has raised considerable concern across the College as to the outcome. Failure to Act is a less intrusive system of punitive responses to evidence of neglectful inactivity in relation to acting upon or reporting possible child abuse. We are still awaiting the final consultation documents from the government which will determine whether mandatory reporting or failure to act is the primary focus of the legislation. We were greatly assisted in our work on this matter by Ms Helen Gill and Dr Sue Stuart-Smith.

In the clinical arena, we have been asked to respond to a document entitled “Guideline for the Treatment and Planning of Services for Complex Post-Traumatic Stress Disorder” (CPTSD) which was prepared by the UK Psychological Trauma Society (UKPTS) as a guide to planning and commissioning services for people with complex post-traumatic stress disorder (CPTSD). The document gives an outline of the diagnosis and then makes recommendations for treatment. These recommendations are essentially for a phase-based approach with TF-CBT and EMDR used in the active second phase. We think it would be helpful to give you an outline of our response below, after giving a brief outline of the three stage approach to the treatment of complex trauma which we refer to in the text.

Judith Herman (“Trauma and Recovery: the aftermath of violence, from domestic abuse to political terror”, 1992) proposed that the psychological treatment of multiple and prolonged trauma consists of three stages;

- Phase one; safety, symptoms reduction and stabilisation (improving symptom management, self-soothing and addressing current life stressors to achieve safety and stability in the present)
- Phase two: remembrance and mourning (trauma-focused work to process traumatic memories)
- Phase three: resolution, integration and recovery (re-connecting with life; re-establishing social and cultural bonds, and building on treatment gains to enable the patient to develop greater personal and interpersonal functioning)

Those stages are not linear but overlapping and there may be a need to re-visit the earlier stages.

This is our response to the UKPTS document

“We would like to highlight to the authors our concerns in relation to the absence of psychodynamic / psychoanalytic / relational modalities of working with this group.

1. As the authors describe, this is a new diagnostic category, which is likely to come into use with the publication of ICD 11. This has several implications.
a) It is likely that at present these patients are receiving other diagnoses and therefore different treatments to those outlined. Some will have been diagnosed in trauma services with complex PTSD but many will probably fall into the following:

- Emotionally unstable/ borderline (ICD/DSM) personality disorder
- Treatment resistant depression
- Anxiety disorders
- Dissociative disorders
- Medically unexplained symptoms

There is a considerable body of evidence in support of psychoanalytically informed treatments in these groups, often with clear evidence that this includes patients who have had significant developmental trauma. (The Tavistock Adult Depression Study is an example of this).

b) As this is a new diagnosis, the authors are clear that of course there is no current evidence base for treatment. However, the paper clearly reads as though – and the length of references attest to this – there is a solid evidence base for their proposals. A new diagnosis will require research into different approaches and modalities in order for commissioning, service planning and development to be clear.

c) This links with the basic assumption made in the paper that Herman’s description of the second phase requires “trauma focused treatments” that have an evidence base for PTSD can simply be transposed on to this complex population. There is – as yet – no clear evidence to support this.

2. Complex trauma, when originally described by Judith Herman and as described by the authors of this document, is a relational trauma. This is true of both developmental trauma (such as child sexual abuse) and chronic or sustained adult trauma (such as combat, torture, domestic violence). Herman highlights that it requires captivity for complex trauma to develop and thus inevitably it is part of a relationship with the other – the persecutor in its many forms.

Psychoanalytic, psychodynamic and relational psychotherapies hold the relationship as central to the therapeutic process and might be particularly helpful in trauma processing phase described by Herman as “remembrance and mourning”. It is relational trauma that is being worked with and a psychodynamic understanding is helpful in addressing more fully some of the issues that are touched on by the authors such as:

- The therapeutic relationship
- Therapist competency
- Supervision
- Vicarious traumatisation

Adding to this list would be issues around boundary violations, self-harm and suicide and therapist enactments.
The evidence base for emotionally unstable/borderline (ICD/DSM) personality disorder shows how psychodynamic approaches including mentalisation based therapy can be vital in working with this population.

3. Although there is some evidence for a phase based approach in using TF-CBT or EMDR, there is less evidence for other modalities and some studies suggesting the overall evidence remains unclear. (De Jongh et al 2016) In suggesting this is how services should be commissioned, there is a risk of fragmenting the care of these patients. Thus they may obtain phase one approaches from one clinician or service before moving to a different one for the active trauma work. They may then need to move yet to another service for the third phase. Although this is only implicit in the document, it highlights the concern we are raising about the need to hold in mind this is relational trauma.

Engagement requires a relationship and drop-out rates will inevitably increase if these movements between phases occur. The use of phase based approaches in severe dissociative disorders has demonstrated both the importance of the therapeutic relationship through all the phases, and the need to work flexibly with this notion so that patients may move back and forth between different needs and different issues and the phases may not be linear.

**Recommendations:**

1. We would like to suggest that this document needs broader consultation to include experts in emotionally unstable personality disorder, treatment resistant depression, medically unexplained symptoms and dissociative disorders as these are likely to be the populations that are currently capturing the proposed new diagnostic group.

2. We would recommend the addition of a section that includes a discussion on the role of “relational therapies” – specifically psychodynamic, psychoanalytic and mentalisation based therapies as this is the treatment that many of these patients may already be getting and for which there is already a sound evidence base.

3. Furthermore, this section should include a description of psychoanalytically informed trauma work - both group and individual - that is currently used in the treatment of childhood sexual abuse.

4. We feel the document needs to be clear and to encourage research that addresses some of the issues we have raised – the evidence for phase based approaches as well as evidence for a variety of modalities, not only those related to PTSD.

5. We postulate that the document states the importance of training on the impact of the work with highly traumatised patients and recommends high quality supervision and reflective spaces as a safeguard to avoid burnout, to prevent vicarious traumatisation, traumatic re-enactments and potential boundary violation across all the approaches used in work with patients with CPTSD.

6. As for the commissioning of future services, we recommend that a variety of treatment approaches are recommended to accommodate clinicians’ experience as well as patients’ choice which alongside research constitute evidence based practice.”
We feel very concerned that the document produced by the UK Psychological Trauma Society will be used, once ICD 11 is published, to commission services based on this model despite an insufficient evidence base. We feel the next step needs to be a robust gathering of research that supports psychodynamic/ psychoanalytic as well as other approaches in treating this group of patients. We would welcome any offers of help or suggestions of research evidence that would support this aim.

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*Update from the Medical Student Balint groups and Psychotherapy Schemes*

James Johnston

The Royal College of Psychiatrists Medical Student Psychotherapy Schemes working group first met in June 2014 with the aim of working to develop schemes across all 34 UK Medical Schools.

The working group meets four times a year, and by the time of writing in June 2016, we have established schemes or are working towards establishing schemes in 30 medical schools. 10 schemes are established and 20 are in the preliminary planning stages.

The model adopted is of establishing Balint groups: in contrast to the case-based discussion groups in the psychiatry core training curriculum, where the model is not prescribed, the expectation is that the student groups are run explicitly as Balint groups and in many schemes they will be co-led by an accredited Balint group leader and a trainee. The establishment of the Balint groups is seen as a foundation for the development of psychotherapy schemes for a selected smaller number of medical students in the future, along the lines of the long established scheme at University College London led by Dr Peter Shoenberg.

Peter is the Medical Student Psychotherapy Schemes Liaison Officer and he is the person who contacts Medical Psychotherapists and psychiatrists to advise on the process of planning to establish Balint groups.

One of the questions which scheme organisers raise is when in the curriculum to offer the Balint groups. In some schemes such as Bristol, which has trainee led Balint groups supervised by accredited Balint leaders, the students are in medical and surgical placements. In other schemes the psychiatry placement is used. The number of Balint groups per cohort of students varies according to the length of the placement but will average between 5 and 10 groups meeting weekly.

Waiting to negotiate curriculum change has been found unhelpful and a smaller scale pilot project is a way of starting small and building student interest and influence through feedback. Medical Schools around the UK vary considerably in their receptivity to the schemes, with some very actively embracing them and others more resistant.
Formal evaluation of the schemes will require local ethical approval, so establishing a UK wide evaluation will take time.

Please save the date: A Medical Student Psychotherapy Scheme Symposium with the title Medical Student Psychotherapy Schemes in the UK 2017: Developing tomorrow’s doctors will take place on Friday 20th January 2017 in the Royal College of Psychiatrists and will be targeted at scheme organisers who want to hear how established psychotherapy schemes and Balint groups for students are working, and to learn how to set up their own schemes. Presentations will include student experiences and Dr Peter Shoenberg will present on the theme ‘Developing a Student Psychotherapy Culture in Medical Schools’. Two UCL student speakers will speak about a Student Psychotherapy Case and the Balint Group. Dr Jessica Yakeley will speak about the evaluation of the student schemes.

Professor Sir Simon Wessely, who sponsored the establishment of the Royal College of Psychiatrists Medical Student Psychotherapy Schemes, stands down as President in June 2017, and his support has been invaluable in providing a College foundation for this ‘cradle’ element of the Thinking Cradle to Grave therapeutic education strategy which I devised in my time as Chair of the Medical Psychotherapy Faculty Education and Curriculum Committee. The College has confirmed that there will be ongoing support from the Training and Workforce Department for the Medical Student Psychotherapy Schemes under the umbrella of the Medical Psychotherapy FECC after Simon has departed.

Medical student Balint group experience as part of Psychiatry Summer Schools (which form part of the recruitment drive in the College) can be a good way of exploring the value of this space to reflect on the student-patient relationship for students interested in psychiatry. As well as evaluating the impact of the psychotherapy schemes on the students’ capacity to reflect on their relationship with their patients and their own minds Dr Jessica Yakeley (London) and Dr Paul Moran (Bristol) will also evaluate the impact of the student psychotherapy schemes on national recruitment to psychiatry.

Notwithstanding this important but secondary aim of recruitment in psychiatry, a very useful psychotherapeutic side effect, we see the primary aim of the Medical Student Psychotherapy Schemes as developing psychotherapeutic medicine. The other hope is that psychotherapeutic psychiatry will also be further developed in future by students who are drawn to psychiatry because of their early experience of placing the relationship with the patient at the heart and soul as well as the brain in the matter of minds.

With this matter in mind it may be helpful to remind ourselves of some of the aims of a student space to reflect emotionally on their patients for future doctors:

1. Doctors would understand more about the experience of being ill as well as the symptoms and diagnosis of illness.

2. They would understand the impact of illness, death and dying on patients and their families and include their thinking about this in the planning of services as a matter of course rather than as an exception.

3. They would understand something of the impact upon teams and professionals of working with these difficulties and be able to identify the signs of institutional defences and know to obtain help in addressing them.
4. They would understand the meaning of the doctor patient relationship for all patients and be able to think relationally about their work.

5. They would understand the implications of working with those with disordered patterns of relating and how this is related to physical symptom presentations.

6. Those medical students with a particular interest in this area would be offered the opportunity of taking on a supervised psychotherapy case.

The *Thinking Cradle to Grave* therapeutic education strategy, which proposed the medical student psychotherapy Balint groups across all medical schools, will be published by the Royal College of Psychiatrists as a position paper in autumn 2016.

One of the other products of the *Thinking Cradle to Grave* therapeutic education strategy is the Oxford Specialist Handbook of Medical Psychotherapy (edited by Jessica Yakeley, James Johnston, Gwen Adshead and Laura Allison with 60 authors), which will be published by the Oxford University Press in late August 2016. The handbook is informed by the principles of developing psychotherapeutic medicine and psychiatry, reflected in the aims articulated above. One of the target audiences will be medical students and newly qualified doctors as well as trainees in psychiatry, and in keeping with the lifelong development theme, another will be post membership psychiatrists, who in the spiral curriculum of therapeutic development called life continue to wish to learn from cradle to grave. As a senior psychiatrist, not quite at the grave I hope, co-leading the medical student Balint groups in Leeds has been a profound pleasure; I have felt impressed and moved by the thoughtfulness and emotional engagement of the students we have encountered which inspires hope for the future of psychotherapeutic medicine.

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Update from the Talking Therapies Taskforce

Sue Mizen and Gary Fereday

Who? Six leading psychotherapy and counselling bodies have come together to make up the Talking Therapies Task Force. The six bodies are

- The Association for Psychoanalytic Psychotherapy in the NHS
- The British Association for Counselling and Psychotherapy
- The British Psychoanalytic Council
- The Psychotherapy Faculty at the Royal College of Psychiatrists
- The Society for Psychotherapy Research
- The UK Council for Psychotherapy.

What? We are developing a national infrastructure for psychological therapies for people with complex mental health needs, to parallel existing services for people with common mental health problems, such as IAPT (Improving Access to Psychological Therapies programme). People with the most complex mental and physical health problems access health and social care services intensively. We have established working groups led by senior clinicians focusing upon five areas in which provision does not meet the mental health needs of these patients. We think improved outcomes for patients and cost savings for services can be achieved by developing formal therapies and psychologically minded practice:

- Personality disorder
- Historic childhood sexual abuse
- Primary care
- Medically unexplained symptoms
- Psychosis

In addition, we have established a Reflective Practice group to develop psychological minded health and social care practice across agencies working with complex cases.

We are developing an economic case, which we will bring to Government and key stakeholders, for large scale investment in psychotherapy and counselling services for people with highly complex mental health needs.

Why? We recognise, following development of IAPT, there has been investment in NHS counselling and psychotherapy. Having a health economic case, a national data collection system, a workforce development plan and an associated training programme have been essential in
delivering a national programme. To date, the success of IAPT has been predominantly with those with mild to moderate mental health problems. We are now making the case for national investment in services for those with the most complex physical and mental health difficulties. Without the national infrastructure we are developing, this patient group will remain out of sight and out of mind.

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Update from the Psychosis Task Group

Miomir Milovanovic and Alison Summers

The Psychosis Task Group met for the first time on 27th June with active contributions from several external stakeholders, including people with personal experience of psychosis and family members. This was an encouraging meeting where the group identified common concerns and also motivation to work together on strategies to improve psychological and emotional aspects of the care offered to people who experience psychosis. As a next step we plan to hold a full day workshop to articulate a shared view of psychologically informed care for people with psychosis, and what this might look like.

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CONTEMPORARY PRACTICE IN MEDICAL PSYCHOTHERAPY

Maternal Mental Health – Everyone’s Business

Anne Ward and Danny Goldberg

I once said: ’There is no such thing as an infant’, meaning, of course, that whenever one finds an infant one finds maternal care, and without maternal care there would be no infant.

DW Winnicott, 1960 “Maternal Mental Health – Everyone’s Business”

More than 1 in 10 women develop a mental illness during pregnancy or within the first year after having a baby and that, if untreated, these perinatal mental illnesses can have a devastating impact on the women affected and their families. (Maternal Mental Health Alliance, 2014).

This is not news to clinicians and therapists who are used to thinking developmentally. However there has for many years been a kind of institutional and societal blindness to the experience of perinatal illness and its effects on those around. Women are primarily affected but there is
growing recognition that men too may be affected. Effects on the children of untreated maternal depression have now been documented into the third decade (Plant et al, 2015). The Maternal Mental Health Alliance, of which the college is a member, launched a campaign “Maternal Mental Health – Everyone’s Business” to increase awareness of these issues, to which there has been a welcome response if still inadequate in terms of overall funding.

Therapeutically the campaign had boosted an already growing interest in the area of parent-infant therapy, and there are various mainly community / CAMH-based provisions springing up around the country. There has not, however, been an overall strategy linking these to adult mental health services or vice versa. Our experience in adult psychiatric services points to an overlapping but distinct role for secondary care practitioners, and both the need and opportunity for greater psychotherapeutic involvement.

Pregnancy / early parenthood is a life-changing experience typically involving heightened emotional states, the frequent resurfacing of childhood memories, increased involvement of the extended family, and a time pressure generated by the biological processes involved. In a very intimate way, there are not one but two individuals to consider, sometimes with competing demands. Thus pregnant women are often reluctant to take medication, even when the balance of risk is in favour of this, and referrals for psychotherapy may ensue. At the other extreme, safeguarding concerns are an issue, and one can have the painful task of assisting separation where mother herself has been an abused child; in such cases ‘long-term’ therapy may be ‘recommended’ which may or may not be helpful. There can be multi-system involvement that at its best works smoothly but in more disturbed situations is a potent arena of splitting needing containment. The increased complexity and turbulence of this period provides a potentially fruitful ground for therapy which is invested with increased hope as there is a baby involved. On the other hand, a therapy that is more than supportive may be contra-indicated if turbulence is too great, and a level of expertise is needed in assessing this. Even if therapy is not indicated, however, the involved professionals often value psychotherapeutic understanding and expertise.

We are trained to assess for and deliver therapies in secondary care, keeping a psychiatric eye out for deterioration and / or risk. We work closely with our psychiatric colleagues, and share information as needed within that system. Not infrequently, our patients present with the sequelae of childhood neglect and abuse, so that issues of parenting can be complex and loaded. This can be present in diverse ways including ‘difficulty bonding with the pregnancy,’ intrusive thoughts of abusing the baby or even ‘loving my baby to death,’ to which one needs to respond rather than react. Developmental issues are thus alive in the therapy in a more than usually vivid way, complicated further in the not infrequent situation of a therapist’s own pregnancy. In some ways, this is our bread and butter, but it is salutary to learn of so many missed opportunities for intervention, often years later when disturbance in the system has become entrenched.

Difficulties in the parent-infant relationship may manifest as infant dysregulation and present to GPs, sleep clinics, mother-baby groups or community practitioners. Interestingly the statutory CAMHS services rarely see children under 5 as the referred patient unless they have a dedicated infant-parent service. Parent-infant interventions in such settings will involve the mother crucially in any intervention, and in that sense the mother too is having therapy. What we find in adult services, however, is that many of our mothers are reluctant to engage with such interventions for various apparently practical reasons that on further analysis emerge as consequences of their own upbringing / difficulties. The provocation of such a focus on their infant in the face of their own deprivation can be experienced as intolerable. Thus our therapy has needed modification to
ensure that mother too has time and space to process her longer-standing and sometimes entrenched issues, or at least to have the experience that this may be possible. It has been important in our work to have both adult and child trained therapists as the pull to one or other position is compelling. Communication with secondary care team-based colleagues has also been an important element of the setting, enhancing containment of risk, reducing the likelihood of splitting and allowing a more dynamic understanding of events that colleagues find valuable.

The work is complex, at times exhausting, but never dull and often inspiring. There are few periods with the potential for such widespread influence - likewise this is a window of social and political opportunity that it is surely our business.

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References:

Security matters: notes on a job change

Gwen Adshead

The end came slowly; in what many Medical Psychotherapists now recognise is a gloomily predictable process. First there was a claim that if there were less patients, then we needed less therapists; and then an external review was commissioned to examine this claim. Of course there were no psychotherapists on the review panel, and their examination of our work took less than two hours. It was concluded that our hospital only needed half the amount of psychotherapy previously provided; and so the Medical Psychotherapists would have to compete with each other for jobs, which would be reduced in time (and of course pay).

This process did not appeal to me for a variety of reasons (not all of which are printable), so when an opportunity came to take up a job as a responsible clinician (RC) in a medium secure unit (MSU), I applied and was glad to be appointed. I left the job and the service where I had worked for nearly 20 years with hardly a backward glance; it was, intriguingly, both the hardest and the easiest experience of my working life to date.

So for the last three years, I have been back working in my first specialty, as a forensic psychiatrist in an MSU. For those who don’t know, MSUs offer long term residential secure care to people in
one of three groups; (a) people who have been so disturbed in general adult psychiatric services that they need extra containment, or (b) people who have committed offences when mentally ill and can't go to prison because of this or (c) people who become mentally ill while serving sentences for violent offences in prison. The work of the RC is to oversee the psychiatric care offered and work in a team to ensure that patients recover their mental health and reduce their risk of violence to others.

The people who reside in an MSU are hugely varied, as are the staff who work there. I find my training as a group analyst immensely helpful for thinking about both the group dynamics on wards where staff and patients live together, often for years at a time; I also find it helpful in thinking about organisational dynamics and the primary tasks of secure units like the one in which I work. But most of all I find my psychodynamic training invaluable for thinking with my patients about the meaning of their offences, for them and for the people they hurt. The value of this reflective process is that it treats the offender as a person who makes choices: bad ones in the past but hopefully better ones in the future. The reflective process that looks at the meaning of violence also helps staff to manage their responses to patients who often don't get better quickly, or know how to make use of good care when offered; or who are frightened and frightening.

I was lucky to come to work in a unit that takes quality work seriously and values person-centred care. Forensic services can be culture carriers for a new and updated model of psychodynamic psychiatry, where the psychiatrist holds the narrative and meaning making task for the team, and helps other team members to go beyond the manifest content of behaviour to the latent meaning beneath. If we are going to have to continue to live in this austere and depriving health service regime, we are going to need psychiatrists who can be thinkers and feelers; not just action figures. If you are a psychotherapist and have time, go and help out in your local forensic services; you can help good people there to make a real difference to patients' lives.

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Therapeutic Equipoise – talking cures or re-experiencing cures

Gordon Barclay

A note from the Chairs of the Faculty Executive Task Group on Historical Child Sexual Abuse

Current NICE guidelines for PTSD recommend trauma-focused Cognitive Behavioural Therapy (tf-CBT) or Eye Movement Desensitisation and Reprocessing (EMDR) as first line treatments. As outlined in our working group update, as Complex PTSD is yet to formally enter the psychiatric classificatory systems (although it is likely to do so with ICD11), there are currently no NICE guidelines around treatment. This has led to a proliferation of treatments that do not have an evidence base.

At the end of a first appointment in my general adult psychiatry clinic, we took a comment about her housekeeping made recently by a relative and used it as a metaphor for what she did with her emotions (maintained a calm exterior, didn't get angry, lots of resentment underneath), and leaving her armed with this mini–reformulation, I arranged to see her again in 3 to 4 weeks, with the intention at that future appointment of doing some focused "processing" therapy on something traumatic that had happened in her past. At that next appointment, however, she was eager to tell me that she had used this understanding/insight and really applied it diligently in her day-to-day life. And so, as an example, when someone close to her started to make assumptions in his usual manner, and wanted to change arrangements which they had fixed clearly, she neither 'reacted' against that, nor did what she usually did, which was to meekly agree, with lots of attendant resentment. She simply said, 'no, we are going to leave the arrangement as it was'. And so as a result she did not feel deep resentment, and had stopped cutting herself. And moreover, what she found truly remarkable was that this other person in particular had himself changed!!, and had started behaving very reasonably with her. This change in her circumstances, and in her mood, had been so dramatic that she was very happy to be discharged after this second appointment, and she felt no need to do any work on what had happened in the past. And so talking therapy, of whatever hue, is often about talking with a therapist in order to reach some understanding of the presenting issues, which we can then use to become aware of habitual patterns of interaction, of thinking, or feeling, or behaviour, in our day-to-day life, with luck then using this recognition to do things differently, and so bring about change. (Many other things, of course, happen in talking therapy and so this is clearly a gross simplification.)

Alongside this case history I also use the following regularly in clinic for psycho-education purposes. I ask people to imagine ("this didn't really happen!") that I have a traumatic memory following a savage attack by an Alsatian dog when I was five years old. I am walking past a securely locked gate, behind which there is a mean looking Alsatian, securely tied up, and inside a securely locked cage. With my mind, I know absolutely that I am completely safe. But if that dog, a few metres away, snarls at me and begins to bark, can the "top down" control of my understanding override the "bottom up" physiological response of increased heart rate et cetera which relates to the triggering of an ongoing traumatic memory? Most patients get the answer to this quasi-rhetorical question correct. And understand when I then go on to say that we can reach a very refined understanding of a traumatic event in the past, and the effect that it might continue to have in our lives, without this understanding always being able to change our ongoing experience of that traumatic event. I will never forget one patient telling me that seven years of
three times a week therapy with an excellent therapist in London had let him understand why he had been depressed at a young age, and why he used to bang his head against the wall. But, he said, this understanding, very useful though it had been, had changed *nothing* in terms of his ongoing experience of low mood.

My first few experiences of using EMDR, possibly the most well-known trauma "processing" therapy, completely shifted the axis of my psychotherapeutic world view, due to the rapidity and depth of its effect, and I also trained in Sensorimotor Psychotherapy around the same time. EMDR is probably the most well-known treatment for processing trauma, and utilises bilateral stimulation, often in the form of asking someone to follow one’s finger as one moves it from one side to the other of their visual field. But in actual fact, the essence of EMDR, which can be incredibly rapid and effective, is not primarily about the bilateral stimulation, but lies in the opportunity it creates for someone not just to *talk about* what has been traumatic, but to re-experience in their embodied imagination what happened in a way where feelings/(defence)responses frozen or blocked at the time of the trauma can be re-experienced in a different context, such that what became ‘frozen’ at the time of the trauma can (as defence responses and associated feelings) ‘complete’, and ‘unfreeze’, and so be “processed”, with the associated traumatic memory achieving resolution.

And so my first submission is that *there is a paradigm shift occurring in psychotherapy, which* relates not only to the need for our therapy to become more "embodied", but also to the understanding that "*The Talking Cure* needs to be complemented by "The Re-experiencing Cure".

My second submission, turning to this realm of "The Re-experiencing Cure" is that the key concept in successful trauma therapy is *Dual Focus Awareness*. Dr Frank Corrigan, a much respected writer and clinician, and the doyenne of trauma therapy in Scotland, told me three years ago that a therapy called Brainspotting was "quicker and deeper than EMDR". Dr David Grand, the discover of Brainspotting, was working as an established training psychoanalyst in New York, when a workshop in EMDR had revolutionised his practice, after he recognised how rapidly and effectively change could occur using EMDR. He went on to become an international trainer in EMDR, and noticed during a session that eliciting a *fixed* eye position (that is, asking the patient to hold their gaze on a fixed point elicited by the therapist) seemed to facilitate even more rapid "processing" than using straightforward EMDR. My own personal experience at a first Brainspotting workshop of the effect of using fixed eye positions was so powerful that I immediately took trainings wherever I could, started using it carefully in my own practice, and was soon using Brainspotting rather than EMDR for processing trauma.

However, as is recognised with EMDR, so with Brainspotting can “taking someone into" the re-experiencing of a traumatic event lead to traumatic rather than therapeutic abreaction. The therapeutic imperative of *Dual Focus Awareness* relates to the necessity during therapy of "keeping one foot in" the present, while "with the other foot" someone may be re-experiencing thoughts/feelings/sensations/images relating to the past. And without adequate preparatory work to help someone, in their embodied imagination, *remain adequately centred in the present even as they are exposed to their traumatic past*, they can easily be pulled into dissociative, rather than therapeutic, abreaction, and this can simply be re-traumatising.

The Comprehensive Resource Model (CRM) was developed by Lisa Schwarz during her time as an EMDR, and then a Brainspotting, trainer in response to her experience working with more severe trauma and dissociation, and out of her understanding of the need to facilitate the experience of
neuro-physiological stability to keep our patient in the "window of tolerance" between hyper- and hypo-arousal. This helps keep them adequately in the present even as they begin to connect with traumatic images and feelings from the past, in this way avoiding the loss of Dual Focus Awareness, and significantly reduces the likelihood during processing of a dissociative abreaction. In using "resourcing", CRM uses techniques which include breathing, somatic "grounding", the use of fixed eye positions, ego-state (or "parts") work, as well as combining these with the power of our deep imagination to create an embodied experience of "protection and connection" before stepping into or engaging in any way with the traumatic past.

If during therapeutic re-experiencing (whatever the modality) we are not able to "keep one foot in the present" even as we have "one foot in the past", and we find ourselves "in trauma time", with both feet in the past, the experience of what in the past was overwhelming is again often overwhelming. If we re-experience the past simply as we did in the past, without the simultaneous experience of being anchored adequately in the "protected and connected" present, the overall experience can be re-traumatising. Primum non nocere. First, do no harm.

Writing these paragraphs on Remembrance Sunday, I was reminded on Radio 4 that "for some the injuries sustained are invisible... yet no less grievous", and the forthcoming massive public enquiry in Scotland into historical abuse in care will also bring further into public consciousness the harm caused by other types of trauma; a corollary of the increasing awareness of the prevalence of all types of psychology trauma, of PTSD, complex PTSD, and dissociative disorders, is a recognition of the need for effective treatment. From my own experience as a four day a week NHS consultant general adult psychiatrist in Argyll, doing 15-20 hours of therapy a week between Argyll and Glasgow at the end of the week, I have come to understand that for many of my patients the aetiology of their distress is explicitly "traumatic". And while it is with the attunement and understanding/formulation of "Talking Therapy" that I start, which is often incredibly useful, this approach often needs to be complemented by what I have here described generically as "The Re-experiencing Cure", which can reach and heal the parts which Talking Therapy sometimes cannot.

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REGIONAL REPORTS

Update from Scotland

Emma Hargreaves

We welcome the opportunity to provide some feedback from the Scottish Psychotherapy services. We are a small group of clinicians based in still predominantly generic psychotherapy services. Although we have not seen consultant posts / services being increased, we have not seen the reduction of posts and change of services from generic into PD services. We believe this is a good
position so that services can continue to provide input to a wide variety of patients rather than becoming a service geared mainly to patients with BPD.

Scotland has managed to fill most of its ST4-6 psychotherapy training posts and these trainings have received very good feedback in national trainee satisfaction audits. Most trainees complete the Psychoanalytic Psychotherapy training which is registered through the BPC. We do have some difficulties with higher trainings in CBT and the dual GA / CBT ST4-6 posts have not been as attractive as the psychodynamic training posts. Further thought is being given to try to improve the uptake of these posts.

The Faculty Executive has also updated the website on the RCPsych webpage. We want to increase awareness of the good opportunities for training and working in Psychotherapy in Scotland. We are also keen to widen the awareness of meetings and conferences held in Scotland to try to encourage people to attend and contribute. So in essence although we are a small group of psychotherapists – we are optimistic about our services, determined to widen the application and access and enthusiastic to build closer relationships with colleagues nationally.

**National Workforce Planning**
The specialty continues to face difficulties in Scotland, with a peak (actually a long plateau) of retirements, with some recent difficulty recruiting to consultant posts.

Good news is that the North East Glasgow post has recently been appointed to, and interviews are in process for South Glasgow. There are further retirements to follow in West Glasgow and Forth Valley.

**Medical Psychotherapy Faculty Conference:**
A very successful collaboration with the Forensic faculty produced a lively and well attended conference in Dunblane in November 2015, with the title: "**Crossing the line - boundary violations in psychotherapy and forensic practice**".

The next conference will be on the topic of “**Hard to reach patients**”, with speakers to be confirmed. This is planned for 24/25th November 2016 in Perth.

**Faculty Executive Committee**
After a period of poor attendance at Exec meetings, we are delighted to welcome a number of new members on to the committee, with the hope this will energise some of our current strands of work, which are as follows:

- Update of census for medical psychotherapy in Scotland
- Improve input to NES MATRIX for psychological therapies
- Better engagement with faculty members
- Development of improved Medical Psychotherapy Scottish Faculty web page presence.

**Short Life Working Group on Borderline Personality Disorder**
I have been asked to chair this group, with representatives from the Medical Psychotherapy, General Adult Psychiatry, Child and Adolescent Psychiatry, and Forensic faculties as well as
representatives from the following groups: the Scottish PD Network, service users, Nursing, Academic and Clinical Psychology.

Emma Hargreaves
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**TRAINEE VOICES: MEDICAL PSYCHOTHERAPY TRAINEES SECTION**

Tiago Gandra

Welcome to the 2016 summer edition of Trainee Voices, a platform for discussion within the Faculty newsletter dedicated to training in Medical Psychotherapy.

In its endeavour to bridge different models of the mind, Medical Psychotherapy finds itself occupying something of a ‘transitional space’. Indeed, there may be something of a Winnicottian paradox hidden in the job description - to be and not to be a psychiatrist, to be and not to be a psychotherapist.

There is something uniquely rewarding about this freedom to integrate different discourses and approaches - and yet, I think it is fair to say that this can also be a lonely position to be in. Not only because of the comparatively small numbers of professionals - more than that, there is something fundamental about the nature of psychotherapeutic thinking that relies on a distinctive movement: being part of ‘something’, while simultaneously having to ‘step outside’ that very same thing – whether this a patient, a particular team or the NHS as a whole. In any case, inhabiting this borderland comes with unique challenges and anxieties. It also highlights the importance of creating the spaces and opportunities to come together and think about the work we do.

This is how I make sense of a distinctive feeling of ‘kinship’ which was felt by many at the Faculty’s Annual Conference which took place in Leeds earlier in April – a conference which offered an extraordinary run of high-profile speakers, with a particular focus on new developments of Attachment Theory. More recently, a number of us had the opportunity to gather at the Freud Museum for the Trainees and Trainers Summer Meeting, which took place on the 8th July – under the theme of The Patient, the Therapist and the Outside World. As a member of the organising committee, I would like to thank everyone who was able to join the conversation and participate in what felt like a thrilling and thought-provoking day.

Ultimately, it is also what this newsletter aims to do: to allow for an encounter and a conversation, not only within the Faculty but looking outwards, creating the space for this very particular way of listening and practicing both for ourselves and our colleagues from other specialties.
So we begin by celebrating the first series of *The Maudsley Lectures and Seminars in Psychoanalysis*, an exciting development particularly for those trainees who regret the unbalanced geography of psychoanalytic teaching - Greg Shields offers a personal account of his experience at the seminars this year, and reflects on the distinctive features of this programme.

Caroline Reed O’Connor follows with a playful inventory of various defence mechanisms junior doctors make use of to navigate the troubled waters of contract negotiation – defences which are often not as unconscious as would be convenient... Humour and a touching self-awareness again come to the rescue, in a core trainees’ recollection of her first session in the therapist’s chair.

Any clinician who is mindful of the central role of the therapeutic relationship is acutely aware of the shortcomings of our current model of care in mainstream mental health services. After his paper recently published in the BJP, Sebastião Viola concludes this edition of Trainee Voices with an intriguing reflection on the potentially harmful effect of current prescribing trends.

This is also my last contribution to the newsletter as editor of Trainee Voices. So I would like to thank everyone for their contributions and for the helpful feedback over the last couple of years. A big ‘thank you’ particularly to the editors Maria Eyres and Harriett Fletcher for their attention to detail and unconditional support. The next issue will see Anna Croxford and Alex Chatzgiorakis taking over this role - bringing new ideas, protecting the space for the different views and interests of our trainee colleagues and making sure the ‘conversation’ goes on. Welcome both!

In the meantime, please continue to send your contributions and suggestions, which are very welcome at any time of the year – submissions c/o stella.galea@rcpsych.ac.uk.

**Dr Tiago Gandra**  
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The Maudsley Lectures and Seminars in Psychoanalysis 2015/16 – A Review

Greg Shields

Psychoanalytic teaching has traditionally been associated with those revered organisations found north of the river, however in September of 2015 a series of lectures and seminars premièred at the Maudsley Hospital in South London.

Supported by the Institute of Psychoanalysis in collaboration with Maudsley Learning, and developed by psychoanalyst Dr Emma Hotopf, this series offered twenty-one weekly sessions delivered between September and March this year. Lecturers included well-known psychoanalysts with diverse backgrounds and interests, such as Margot Waddell, John Steiner, David Bell, and Stephen Grosz. They spoke on a variety of topics from narcissism to racism, psychoanalytic models, war and politics, and many more. Lectures were followed by forty-five minute small-group seminars facilitated by psychoanalysts.

The series was well-subscribed, although numbers of those attending dropped off after the first few weeks. Nonetheless there was a steady and sizeable core group that remained throughout both semesters, as well as some newcomers in the second semester. Applications were open to people of all backgrounds, and while the majority of students were either psychiatrists or therapists of some kind, there was a significant number from such diverse backgrounds as marketing, social sciences, and neurobiology.

The lectures were interesting and of a consistently good quality, with a few outstandingly good (and the occasional not-so-good) examples. This was not a beginners 'introduction to psychoanalysis' and a basic understanding of psychoanalytic concepts was assumed, so that the uninitiated may well have found themselves doing extra reading to keep up. Seminars varied in format between groups, and some students found these sessions more valuable than others. My own experience was a very enjoyable and stimulating one, enabled by our very capable facilitator who unobtrusively guided our musings into focussed and analytically-informed discussions.

The series differs from the Institute's well-heeled Foundation courses in that it does not provide a systematic approach to the psychoanalytic model, or to understanding human development from an analytic perspective. Instead it offers topics of broad interest to students wishing to dip their toes into analytic thinking, or those with some background in psychoanalysis who want to develop their knowledge base and analytic thinking skills. It felt more like an enjoyable evening class than a formal program of study. Depending on your perspective, this could be either a positive or negative feature. Speaking for myself, it whet my appetite to read more and to undertake further study in the future.

Overall, the Maudsley lecture series was a stimulating and enjoyable experience that left me wanting more. Moreover, it represents a resurgence of interest in psychoanalytic thinking south of the river, where biological psychiatry has reigned supreme for many decades. The second series is due to launch in Autumn 2016, and rumour has it that it will cover a new set of topics with different lecturers, so keep an eye out on the Institute of Psychoanalysis website for more details.

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**Strike defences**

Caroline Reed-O’Connor

As a Medical Psychotherapy registrar I've been thinking a lot lately about how we have been feeling about the Junior Doctors strikes and the psychological defence mechanisms we use to deal with difficult emotions...

I think I speak for many when I say, as a junior doctor, I have felt anxiety, fear, uncertainty, frustration, anger and many other difficult emotions.

There are the ‘healthier’ defence mechanisms...

**Humour:** how many comical posts have I read, song parodies, cartoons?... How I've loved those punctuated moments of lightness...

**Altruism:** the life-saving events on the picket line, the crowd-sourced funds appearing for those in financial hardship...

**Suppression:** I'll think about it later, for now I'll put on my badge, be polite and engage the public...

**Anticipation:** the planning for alternative careers, or moves to another country should imposition continue...

**Sublimation:** I think I'll take out my anger by pounding the streets as I go for a run... or maybe I'll channel that frustration into a strongly worded letter to my MP...

Then there are the slightly more neurotic defence mechanisms:

**Intellectualisation:** I think I'll write a post about the psychological defence mechanisms at play here...

**Rationalisation:** of course I'm angry I'm being treated like a child!

**Projection:** the government are scared and don't know what they are doing...

**Displacement:** if only my partner were more supportive I'd feel better... This computer is not listening to me!...

**Denial:** this doesn't really affect me...

**Repression:** well, this one is truly unconscious, so try some therapy and you may find out you're doing it?

**Reaction formation:** I'll be super kind to my MP and the government and my work colleagues and then they'll listen to me... Maybe I'll bake them some cakes...

And then there are the more psychotic defence mechanisms:
**Splitting**: the government is all bad, junior doctors are all good...

**Omnipotence**: of course the public should trust us, we are doctors, doctor-ness is next to godliness...

**Grandiosity**: I might get to go on TV!!.. I think I was born to wear a hi-vis orange jacket and lead my people to victory... the NHS will fall apart without me...

**Acting-out**: I'll just resign - that'll show 'em!!.. Or maybe I'll just turn up a bit late to work tomorrow...

Just some random musings from a typical healthy/neurotic/psychotic junior doctor...

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**My First Psychotherapy Patient**  
Anonymous

Entering the psychotherapy world is like being invited to join an alleged sorority group. It’s been given the approved nod and secret code to enter the door beyond.

I felt like an excitable puppy having opened the notes for my first psychotherapy patient. Hmm this could be interesting... she is from the same ethnic and religious background as I am. She wanted a female therapist...as I am! This is getting more and more curious. I look at my supervisor, hoping for some secret phrases, a hint of what I should say, equivalent to what I guess would be a secret handshake. Instead I got…’try it first’. Hmm ok. Still excited I imagine what wonderful ingenious interpretations I’d say to my patient, how she’d think I was clever indeed!

I send the appointment letter and the day arrives. I get to my room twenty minutes early, and sniff it out like a dog checking its territory. I sit on my assigned seat and get my pose ready. I cross my legs, then uncross them. I put on my glasses...yes that will make me look like a modern day female Freud I think. I finally find my psychotherapist posture: hand leaning on chin, head tilted, frowning slightly (obviously to look as though I have thoughts streaming around), and right leg crossed over left. And of course: glasses on. Satisfied, I then sit in the patient’s chair and imagine what she will find in her mind’s eye. She can see a painting of a watering can above my head. So possibly she will be thinking about nature when sitting here.

I move around the room, checking everything looks tidy. I recall my supervisor saying ‘try not making changes in sessions, keep it the same, don’t have your bag out’. Right! I move my things into the drawer. ‘Keep it the same’, these words echo in my head, did he also mean my outfit as well? Must I try to keep what I’m wearing the same? Of note, I wear the same outfit for the next 5 sessions with my patient, thinking that was the ‘correct procedure’ until my supervisor laughs when I tell him and comments that I am ACTUALLY allowed to change my attire....
I pace around waiting. The phone rings- she has arrived 5 minutes early. I rush to the door then stop myself. No. I must try to set boundaries, and wait for the assigned time. I make myself calm by looking at the painting, trying to get immersed in the colours- the brush strokes so evident on the canvas, the lines melting into one another. I glance at the clock almost in a trance. It is time. I go smoothly across the corridor as though I’m gliding. I go to the waiting area and see the back of my patient’s head. This is it I think; I am going to have my first psychotherapeutic relationship with this woman for 50mins every week for a year. I take a deep breath, almost trying to brace. She turns to me. There I am…a mixture of emotions...My patient. I have to control myself in wanting to share how much it means to me to have my first ever psychotherapy patient, and she is...looking disgusted! My heart drops. I introduce myself and ask her to follow me.

My thoughts race…why did she look like that? She doesn’t like me? Why? I look fine, I checked the mirror...

We enter the room and I think: Don’t be sensitive! … I realise this is my first countertransference I have ever experienced…or really been aware of.

We sit. She doesn’t take off her coat when she says: ‘you’re very young. Are you still studying?’ I laugh in my head, oh it’s because I look young! This is true, I have been mistaken for my sister who is in fact 15 years old and could possibly try to swagger a child ticket to the cinema if I so desired. I open my mouth to make my first remark and…. it begins!

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**Sickness Benefit Claims and Antidepressant Prescribing Trends: are we doing more harm than good?**

Sebastião Viola

Psychiatry has never been short of conundrums and enigmas from its very birth, and much research, energy and imagination has been used in trying to understand and address them. (In fact, some might argue, this is one of the reasons why psychiatry is so fascinating.) However, and somewhat paradoxically, conundrums can also come up when least expected, sometimes precisely when another was about to solved. This is what has happened with the most recent DWP data on sickness and disability benefits claims.

Dr Joanna Moncrieff (psychiatrist and senior lecturer at UCL) and I looked into the DWP data on sickness and disability claims from 1995 to 2014 and found that claims due to mental illness are now the leading cause for receiving these benefits¹. In contrast, research looking at similar data for the previous decade - from 1984 to 1994 – indicated that the majority of claims were due to musculo-skeletal disorders (principally back pain) and cardiovascular disorders, while mental disorders accounted only for 20% of the claims². Even more striking is that in the last two decades the number of people claiming benefits due to other medical conditions other mental disorders (including musculo-skeletal and cardiovascular disorders) fell by 35% - where the claims due to mental disorders increased 103%, reaching a staggering 47% of all claims in 2014. Significantly, within the mental disorders claims, the biggest proportion is due to mood and anxiety disorders (66.8%) and this proportion has remained relatively unchanged¹.
These figures cannot go unnoticed, neither can they leave us but wondering about their true significance. They have the potential to raise crucial questions about the current strategies we use to support people with common mental health problems, along with wider issues such as the impact of the economy on the mental health of populations.

One of the most pertinent hypotheses arising from this data, however, is the possibility that current mainstream treatments in psychiatry are not only not helping, but actually making things worse. This is not a completely new suggestion, and an article published in 2011 by the prominent American psychopharmacologist Rif El-Mallakh points in that direction. The fact is that the evidence continues to mount in favour of this hypothesis because alongside the increasing disability claims due to mental illness documented in our article, there is also a parallel increase in the number of antidepressant prescriptions, such as revealed recently by the Department of Health - over 61m prescriptions for antidepressants (costing £285m) were issued in England alone in 2015, a rise of 7% on the previous year and more than twice the figure in 2005.

The All-Party Parliamentary Group for Prescribed Drug Dependence met on 11th May at Westminster precisely to discuss the evidence of the link between the rise in disability claimants and the record level of antidepressant prescribing. The event was hosted by Paul Flynn MP and it included several prominent British psychiatrists, such as Dr Moncrieff and Prof. Alan Young, amongst others, as well as Robert Whitaker, the Pulitzer-shortlisted science journalist and author.

As a final note, it is worth adding that this problematic has crucial implications for provision of care. The over-medicalization of psychiatry and its repercussion on the therapeutic relationship has been an area of concern for some time, especially for psychotherapists and psychotherapeutically informed clinicians. But our study illustrates the need to raise the stakes to a different level altogether - as real harm could potentially be done to patients by allowing the current state of affairs to continue. At the very least an open and honest debate should be had on this topic.

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(5) Details of this very illuminating meeting and a live recording of the discussion can be found on the Council for Evidenced Based Psychiatry web page: http://cepuk.org/2016/05/11/politicians-experts-meet-explore-link-record-antidepressant-prescribing-disability/
EVENTS, NOTICES AND DATES FOR YOUR DIARY

Maturation and Ageing: An exploration of developmental processes in later life.
24 September 2016, St Pancras Hospital, London
This is a study day presented jointly by the Older Age Section of the Association for Psychoanalytic Psychotherapy in the NHS and the Squiggle Foundation to explore the use and value of Winnicottian concepts in work with older people. The speakers are Jane Garner, Angela Byers & Rachel Darnley-Smith (APP) and Adrian Sutton, Jennifer Johns and Tessa Dalley (Squiggle), with Sandra Evans as Chair.


Medical Student Psychotherapy Schemes in the UK 2017: Developing tomorrow’s doctors
20 January 2017, Royal College of Psychiatrists
A symposium organised by the Faculty Task Group on Medical Student Psychotherapy Schemes

YOUR CONTRIBUTIONS TO THIS NEWSLETTER ARE WELCOME!

We encourage you to contribute to the dialogue. Please send contributions for the next newsletter, which will be published in November/December 2016, to the email address below by 31 October 2016. You can also contact our sub-editors for international, trainee and academic matters.

We would also be very happy to receive photos for the front cover, with an autumnal or winter theme for the next edition.
Contacts...

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