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, Harriet Fletcher

A lot has happened since our previous Newsletter. The Faculty started the spring with another very successful London-based annual conference. The theme was ‘Trauma, Dissociation and Psychosis’ and we include reflections by our Academic Secretary, Mark Evans, as well as by Aakta Patel, one of our Service User Representatives, who talks about the experience of attending her first Faculty conference.

In an overarching sense, the theme of the conference was around the mind under pressure: how to keep thinking and making sense of things at the extremes of trauma, dissociation and psychosis.

The conference was eerily followed by a series of national traumas: the Westminster, London Bridge and Manchester terrorist attacks, and then the further tragedy of the Grenfell fire. After the Grenfell fire, both the Tavistock and the BPC (and no doubt other national psychotherapy and counselling organisations) received a large number of enquiries from therapists and other mental health professionals about how best to help survivors and the bereaved, as well as firemen and the wider community. Dr Jo Stubley, head of the Tavistock and Portman Trauma Service wrote a brief paper as an aid to that discussion and as editors, we felt that it would be useful to include this piece in this edition of the Newsletter. It contains some very useful reflections about how trauma and tragedy affect us all as human beings and how we can make sense of this in the context of strong urges to act and to help.

We are also very pleased to include a piece by our new International Editor, Tiago Gandra, who is currently working in Australia and has taken the opportunity to interview Professor Andrew Chanen, the leading researcher in the field of early intervention for young people at risk of becoming adults with a label of personality disorder. Tiago’s interview looks at some of the potential dilemmas involved as well as giving a fascinating overview both of Prof Chanen’s work and the award-winning service which he leads in Melbourne.

As always, the newsletter is also an opportunity to update you on things happening nearer home and we have reports from some of the Faculty Working Groups, as well as an article by Steve Pearce, Faculty Vice Chair about all the resources now available to members on the Faculty section.
of the College website. The Medically Unexplained Symptoms Working Group extends an invitation to Faculty members who have not yet heard about it to join their newly formed CPD group which met for the first time in June. This group joins the Neuroscience Interest Group as another way to meet other Faculty members and learn about new developments of key relevance to medical psychotherapists.

We apologise for the late publication of this edition: we aim to publish either just before or during the summer months but on this occasion life got in the way and we are (judging from the weather) well into autumn now. We were very pleased to receive a number of emails from readers with positive comments about the last newsletter. For us as editors, together with our growing community of associate editors who are adding increasing richness to the newsletter, is always good to know that people out there are reading what we put together and we look forward to hearing from you, with either positive or constructive feedback, in response to this edition. We also continue to welcome new articles and photos and will be working this year to a deadline of 30 December for the next edition.

Happy reading!

Maria and Harriet

Editorial Team

Editors in chief:
Maria Eyres, London
Harriet Fletcher, Sheffield

Contributing editors:
Alex Chatzgoriakis and Anna Croxford, Trainee Voices
Dan Beales and Andrew Shepherd, Book Reviews
Alison Jenaway, Members working outside Medical Psychotherapy
Tiago Gandra, International Voices

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As usual it is difficult to know where to start, as the Executive has been working hard on so many fronts. Best to start at the top, I think, with huge thanks to Simon Wessely who has offered us a lot of support over the past three years. One of his top priorities for his Presidency was to expand Medical Student psychotherapy schemes and Balint groups. His support together with a lot of work by Peter Schoenberg, Jessica Yakeley and James Johnston have led to an unprecedented expansion. Of the 32 UK Medical Schools in the country, links have been developed with 25 including two schemes established. The outcomes are being formally evaluated. This is probably the most significant contribution Medical Psychotherapy has made to psychologically minded practice in medicine and is a colossal achievement. Simon offered full support to many other Faculty projects, most notably the Medically Unexplained Symptoms (MUS) working group which he launched with Maureen Baker, President of RCGP, providing financial support to the development of the recently published JCP commissioning guide. He also formally endorsed the work of the Talking Therapies Task Force. As Dean, Wendy Burn was a great support to the Faculty so I think we have much to be optimistic about in the coming few years.

The clinical working groups continue to form themselves and become active in promoting development of clinical services. Their work includes; developing commissioning guidance, writing service standards and specifications, rewriting curricula and training materials for medical psychotherapists and psychiatric colleagues in the areas of personality disorder, Tier 2 psychotherapy services, primary care, MUS, historic childhood sexual abuse, psychosis, eating disorders and perinatal psychiatry. They are running one day training events at the College and other venues. These produce a steady income stream for the Faculty so that we now have some funds available to invest in priority areas.

The work of the Talking Therapies Task Force has just agreed funding for its first research project. This is a health economic evaluation undertaken with the Centre for Mental Health aimed at estimating the cost to the health and social care economy of offering ‘treatment as usual’ (most commonly no therapy), to people with severe and complex relational disorders. This is an essential first step in engaging wider interest in addressing the therapeutic needs of this population. The report of this evaluation is due to be completed in the spring of 2018. We are also involved with the new National Audit of Psychological Therapies which is going to measure therapeutic outcomes for people with anxiety and depression requiring inpatient care. These are important steps on the way to developing a national infrastructure for psychological therapies services for people with complex problems in secondary care services.
The Faculty and the Tavistock clinic have also been funded by HEE to develop e-learning in reflective practice for front line staff in emergency services and primary care.

The Faculty Neuroscience interest group has joined forces with the London Neuropsychoanalysis group, sharing events, publicity and jointly organising our programmes to provide more coherent CPD.

I am now in my last year as Chair of the Executive. An election for my successor will be held at the end of this year. Do consider standing for the Exec or Chair. It is one of the most interesting things I have done. At the very least, look out for the voting papers and cast your vote. We are making the sort of progress which will have a positive impact on jobs and services in the coming years, so maintaining our strong, capable Executive is of paramount importance.

Sue Mizen
Faculty Chair
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Message from the Academic Secretary

Mark Evans


The 2017 Medical Psychotherapy Faculty conference was held from 5th to 7th April at the Royal College of Psychiatrists headquarters in London and an adjoining neurosciences day on 8th April at the Tavistock clinic. As with the last three years, the conference team consisted of Jo O’Reilly, Jo Stubley, Sue Mizen and myself. Formal feedback suggested that attendees found the conference to be relevant, stimulating and at times challenging to our notions of what it is to be a medical psychotherapist (89% of attendees rated the conference as ‘good’ or ‘excellent’).

The conference title was ‘Trauma, Dissociation and Psychosis’ and was sponsored by the Talking Therapies Taskforce. This year, we continued to offer an expanded conference, with the option of pre-conference workshops on Wednesday afternoon prior to the guest lecture and offered an extra full day on Saturday coordinated by the Neuroscience interest group.
This year, the pre-conference workshops were both well subscribed and were entitled: ‘The nature of human suffering – an integration of psychotherapeutic and spiritual perspectives’ (Andrew Clark) and ‘Working with Transgender & Queers: Selves in Transition’ (Padakkara Saju). I attended the first of these two workshops and experienced an intriguing discussion about the nature of suffering and how it might be thought about from Christian, Buddhist, Taoist and psychotherapeutic perspectives. In the evening, the guest lecture was a talk by Earl Hopper entitled ‘Traumatic experience in the unconscious life of social systems’ in which he discussed the application of group and systems theory to wider systems, including an analysis of recent seismic geo-political world events.

The Thursday morning programme, chaired by Jo Stubley and Simon Heyland included lectures from Valerie Sinason, Ira Brenner and Richard Brown with the common theme of working with dissociation. Valerie Sinason stood in at short notice to give a very erudite and useful overview of the concept of dissociation with its origin in Janet’s thinking which had lost favour to a more dominant Freudian discourse and is only recently re-emerging to inform the debate around explaining symptoms seen in borderline personality disorder and Dissociative Identity Disorder (DID). Ira Brenner travelled from Philadelphia to talk about his work over many years, initially with Holocaust survivors and then with DID patients and was able to illustrate this with a case history and transcript. Richard Brown brought in another research-informed perspective and focused on the overlap between dissociative symptomatology and Medically Unexplained Symptoms coming from a Psychodynamic Interpersonal background.

The three speakers shared a lot of common ground but also brought out the challenges and differences including the potential for iatrogenic effects of naming separate states or alters. These issues were discussed in a full and informative plenary discussion involving the two chairs.

The Thursday afternoon workshops on offer were: ‘My fatal mistake – guilt, blame and the role of the psychiatrist in a patient suicide’ (Rachel Gibbons and Rob Hale); ‘A proposed continuum of dissociative disorders’ (Ira Brenner); ‘Trauma/dissociation and medically unexplained symptoms’ (Richard Brown) and ‘EMDR for the psychiatrist’ (Luiza Rangel).

In the final slot before tea, Valerie Sinason gave a talk on the issue of mandatory reporting in patients with trauma/dissociation. This is an extremely ethically difficult and hazardous area and Valerie did well to bring the issues alive in a clear and thought provoking way leaving the audience not necessarily knowing what to do but knowing better how to think about it.

The now well-established 60 second poster presentation plenary session was firmly chaired by Steve Pearce who kept strict time. (Nicholas Parsons would have been proud!) In this session, 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. The posters were later judged and the winners announced at the close of the day.

The afternoon ended with a plenary on suicide exploring its effects on psychiatrists and how these can be better managed within a ‘suicide group’ for consultants. William Burbridge-James, Rachel
Gibbons, Jessica Yakeley and Rob Hale presented and in the plenary discussion service user consultants, Stephanie Guidera and Aakta Patel joined in for what became a useful and informative dialogue with members from the floor.

The conference meal was held at Brasserie Blanc in Tower Hill, a short walk from Prescot Street. This was an intimate gathering in a downstairs room attended by Simon Wessely and enjoyed by all. Entertainment and after dinner singing was beautifully performed by Stephanie Guidera.

The first Friday morning panel comprised a theme of Open Dialogue and other Psychoanalytic approaches to working with Psychosis. Jaakko Seikkula presented his ground-breaking work in this area and outlined how the culture of services for Psychotic patients had completely changed in a historically highly morbid area of Finland. The importance of (particularly) Systemic ways of understanding and working with families was emphasised and Rachel Waddingham was able to bring in her experiences as a voice hearer and service user as well as her developing expertise as a trainee practitioner in Open Dialogue. Other Psychoanalytic ways of thinking and working with psychosis were summed up by Brian Martindale in a presentation that ended with a fruitful and challenging plenary discussion with areas of overlap and agreement established and some differences acknowledged.

In the second morning panel, Matteo Pizzo, George Robson and David Rogalski outlined their innovative service reaching out into primary care settings in a presentation entitled ‘practice-based meaning making’. There followed a talk by Tennyson Lee and Anne Ward who presented their interesting work using Transference Focused Psychotherapy. The afternoon workshops were entitled: **Open Dialogue and Psychoanalytic ideas: connections and disconnections** (Jaakko Seikkula, Brian Martindale, Rachel Waddingham, John Joyce and Adam Hutton); **Psychodynamic Psychiatry: The Medical Psychotherapist and the risk management panel** (Jo O’Reilly, Ian Griffiths and Peter Cartlidge); **Considering Psychosis in Reflective Practice** (Phil Osborne and Chris Douglas) and **Cognitive Analytic Therapy: a relational approach to medically unexplained symptoms** (Alison Jenaway and Carol Gregory).

After the tea break and further poster viewing, Tim Read gave the final lecture of the afternoon on **Expanded states of Consciousness**. This was a fascinating and challenging lecture which reviewed previous work using hallucinogenic and other substances to aid psychiatric recovery and also pointed towards a future reinvigoration of interest in this area with the refinement and continual improvement of brain scanning technology.

Our Faculty chair, Sue Mizen rounded off the conference by thanking all the contributors and by giving out the poster prizes. The winners were:

**1st Prize:** Dr John Gossa - A Part of Me: A newly developed integrated psychotherapy for adolescents with Autistic Spectrum Disorders and psychiatric co-morbidity

**2nd Prize:** Dr Sarah Dorrington - Family functioning, trauma exposure and PTSD in a middle income community sample
3rd Prize: Chloe Finamore - Evaluating the Effectiveness of Combined Psychoanalytic and Psychosocial Treatment for Severe Personality Disorder using the Borderline Personality Disorder Severity Index (BPDSI-IV): Preliminary Results from the Cassel Hospital

Saturday was dedicated to thinking about the neuroscience of trauma and dreaming and was led in the first morning session by Jim Hopkins, John Hook and Cynthia Fu. The papers discussed were:

T Fischmann, M O Russ, M Leuzinger-Bohleber (2013) Trauma, dream, and psychic change in psychoanalyses: a dialog between psychoanalysis and the neurosciences. Frontiers in Neuroscience

Earl Hopper then gave a clinical commentary on trauma and dreaming before Susan Mizen gave an attempt at a synthesis of the neuroscientific and clinical aspects of this subject area. The Neuroscience day ended with a group discussion about future developments for this interest group.

The 2018 Faculty conference will be held in Cardiff from the 25th to 27th April. 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 Specialty Advisory Committee (SAC)

William Burbridge-James

In my role as chair of the SAC (formally FECC) I have to attend a number of College committees, including the Education and Training Committee which is chaired by the President and Dean alternately, and is the most senior educational committee within the College, with overall responsibility for the formulation and ratification of educational policy.

I would like to feed back news that affects us from the committee to the wider Faculty membership. I am sure many of you are aware of the crisis in recruitment to Core training that psychiatry faced this August. In 2016 only 83% of Core Psychiatry Training Places were filled by a trainee and this year the fill rates were even lower. While London remains least affected, other parts of the country were struggling with some schemes attracting no new trainees. This has implications for current trainees in terms of rota and workload, and affects the overall quality of training. The fill rates for higher General Adult training are even lower, at about 50%, but again heavily skewed in terms of geography.

I think those of us who are trainers need to be mindful of this for our trainees and bear in mind the feedback from ‘Supported and Valued? A trainee-led review into morale and training’ published by the College this April from the work of the Psychiatric Trainees’ Committee (PTC) Supported and Valued. It is an excellent document and a tribute to those involved in bringing it to fruition. I draw readers’ attention to p.9 of the review where they found that ‘24% of trainees do not receive protected time for psychotherapy, and only 53% feel they receive timely allocation of a psychotherapy case.’ We need to be vigilant to make sure that trainees have the protected time they need and the opportunities to meet their psychotherapy training requirements.

The wider recruitment problems are addressed by Health Education England in ‘Stepping Forward to 2020/21: the Mental Health Workforce Plan for England’, which sets out ‘a high level road map and reflects the additional staff required to deliver the transformation set out in the Five Year Forward View for Mental Health based on best evidence to date’. Increasing the number of medical students is one aspect of this that you may have heard about in the news, and allowing psychology ‘A’ level to be given the same status as traditional science subjects. These initiatives may improve recruitment into psychiatry. Other aspects include an expansion of the Foundation year exposure to psychiatry, and creating incentives to improve the retention of psychiatrists, as well as to support the return to the NHS for those working in other sectors or as locums. As a Faculty, we need to make sure that our contribution to recruitment and retention is articulated and heard. This is already happening with the work of the Medical Student Psychotherapy
Summer 2017

Working Group, which aims that every medical school in the UK should provide Balint group experience for medical students during their training. Although the focus of this is not on recruitment, this can be a welcome outcome. Trainees are attracted to schemes where they have good psychotherapy experience, not because it is a mandatory requirement but because it brings psychiatry alive from a new perspective and engages their curiosity.

The other committee which I attend is the Curriculum and Assessment committee, where there are important changes on the horizon as all curricula will have to be remapped to fit in with “the Generic professional capabilities framework” that the GMC is driving forward across all specialties. Lastly, as I move into my third year in this role, I welcome the appointment of our excellent new Curricula and Quality Manager, Tony Roche, who manages the Curriculum and Assessment Committee and all the SACs. Now that Tony is in post we are making steady progress with our own SAC work that had previously stalled, and I will report on this next time.

William Burbridge-James
Specialty Advisory Committee chair
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Executive Committee Task Groups

Update from the Medically Unexplained Symptoms (MUS) Working Group
The MUS group is very active currently. It continues to meet quarterly and has recruited two new members. The group is currently working on several projects:

- An event with Professor Else Guthrie (on psychodynamic-interpersonal therapy) for late 2017 and a further event focused on non-clinical issues (service development, commissioning, consultant role etc) thereafter.
- A Faculty trainer-trainee day in 2018.
- Higher training curriculum amendment to include MUS.

The Talking Therapies Task Force MUS group has held its first meeting, with Prof. Helen Payne (British Association of Counselling & Psychotherapy (BACP) rep) joining us. The first task is to gather evidence around cost-effectiveness of interventions for MUS.

The Faculty MUS interest group held its first meeting at the Tavistock Centre, with case presentations and a talk from Prof. Simon Wessely about chronic fatigue syndrome. The next meeting will be held on 29th September.

Please look out for the book review in this edition of the new book about psychodynamic interpersonal therapy by Else Guthrie, Frank Margison and colleagues, which is required reading
for anyone with an interest in working psychodynamically with medically unexplained symptoms. The model has a strong evidence base in this area.

Simon Heyland
Chair, Medically Unexplained Symptoms working group
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Update from the Historic Child Sexual Abuse (HCSA) task group
The task group membership has expanded. We have collaborated within the Talking Therapies Taskforce to write a newspaper article on HCSA. We are planning our first academic event at Barts in November, in collaboration with clinical and legal experts in the field of HCSA. We have held a joint meeting with two legal experts, Victoria McCloud and Christopher Hodges, who wish to address the current legal system, including expert court reports for victims of HCSA taking their perpetrators to trial. This is part of on-going discussions.

We are taking the work of the task group to Council in October to present our current work, especially in relation to clinical care pathways and training around HCSA.

Jo Stubley and Maria Eyres
Co-chairs, HCSA task group
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Update from the Eating Disorders task group
The Eating Disorders group is doing some work on curricula and training and have reviewed the 2016 higher training curriculum and found very little about the subject. They are also exploring the possibility of developing a register of medical psychotherapy trainers with expertise in Eating Disorders who can offer placements to trainees, and also surveying people with an interest in eating disorders to gauge the level of potential interest in training events. The Eating Disorders Faculty is also involved in the revision of the College Report: Eating Disorders in the UK: Service Distribution, Service Development and Training. There is a joint training day being planned between the Faculties for mid-2018.

Anne Ward
Eating Disorders task group lead
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Faculty Executive Service User Representatives

Aakta Patel

In the previous edition of the newsletter we published an introductory piece by Stephanie Guidera. In this edition, we are pleased to introduce Aakta Patel, who works alongside Stephanie as the other service user representative for the Faculty Executive. Aakta and Stephanie are both now actively involved in the planning work for next year’s conference in Cardiff.

Conference reflections

I recently had the pleasure of attending my first Faculty Annual Conference since joining as a service user representative. This year’s theme was ‘Trauma, Dissociation and Psychosis’ and although not an area I previously knew a great deal about, I was looking forward to learning a great deal during the conference and meeting other Faculty members from across the professional spectrum.

A great deal of time and energy was spent on preparing for the conference by a dedicated Faculty sub-committee, so much so that planning the next conference usually begins shortly after the last one has finished! Another service user Stephanie Guidera and I, who both joined the Faculty about a year ago, were invited to participate in conference planning sessions. This enabled us to share our ideas and identify any workshops or plenary sessions we might wish to lead or participate in. This made us feel involved from the outset, with our thoughts and contributions very much valued.

The conference and plenary sessions were a good balance of clinical, scientific and psychosocial, catering to different psychotherapeutic sub-specialties and individual interests. I particularly enjoyed the psychosocial-based talks/breakout sessions, with a captivating talk by Rachel Waddingham, a passionate service user activist with a long history of psychosis who spoke powerfully about living ‘beyond the label’. I was also particularly interested in talks and workshops focused on the psychiatrist’s guilt after patient suicide and the impact it can have not only on the professional but the wider team and other patients, particularly in the inpatient setting.

Another highlight was the Faculty dinner at Brasserie Blanc, a short distance from the College. As service users, we were welcomed to share this lovely occasion with our Faculty colleagues, the dinner was amazing but we were also treated to a wonderful singing performance (with a touch of comedy) by Stephanie, which brought a tear to my eye. Brought together as friends by our Faculty work, I am incredibly proud of how far we have come over the past year, both individually and in terms of our Faculty achievements so far.

To summarise I joined the Faculty of Medical Psychotherapy as I wanted to make a contribution to the work of the College, and can wholeheartedly say I’m delighted that I did! I have had the
opportunity to make new friends and work alongside a dedicated group of professionals who truly value the service user voice and treat us as equal partners. I look forward to working with the Faculty for another 4 years and of course attending future annual conferences, the next in Cardiff in 2018. Look forward to seeing you there!

Aakta Patel
Service User Representative
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International Voices Special Feature

Tiago Gandra

Early Intervention in Personality Disorders - an interview with Professor Andrew Chanen

Perched on the south-eastern coast of Australia, Melbourne has long been known as the country's cultural capital. As is often the case, creative industries here flourished alongside an obsession with excellent coffee and artsy restaurants around every corner. Beyond cafe culture, Melbourne has also been at the centre of some momentous developments in youth mental health. Starting with Orygen Youth Health and its EPPIC clinic - which later inspired the development of Early Intervention Service in Psychosis in the UK and worldwide - Orygen is also the birthplace of the HYPE (Helping Young People Early) clinic, an innovative early intervention programme for young people with complex and severe personality disorders, with a particular focus on Borderline PD.

All things considered, it would be difficult to think of a better place for an 'out of programme experience’. Having been lucky enough to make Melbourne my home over the past few months, I took the opportunity to sit down with Prof. Andrew Chanen for a brief interview - looking into the work being developed in HYPE, the philosophy and the rationale for an early intervention service in Personality Disorders.

Andrew Chanen is Deputy Research Director and Head of Personality Disorder Research at Orygen, the National Centre of Excellence in Youth Mental Health and a Professorial Fellow at the Centre for Youth Mental Health, The University of Melbourne. He is also Director of Clinical Services at Orygen Youth in Melbourne, Australia. He established and directs the Helping Young People Early (HYPE) program, a clinical, research and knowledge translation program investigating the understanding of and prevention and early intervention for severe
personality disorder, particularly borderline personality disorder in youth. HYPE has been recognised with several awards for advancing healthcare. Andrew has over 100 scientific publications and a forthcoming book, ‘Early Intervention for Borderline Personality Disorder’, to be published by Cambridge University Press. Andrew serves on several Editorial Boards and on a number of expert mental health groups, including the NHMRC BPD Guideline Development Group. He is the Past President of the International Society for the Study of Personality Disorders (ISSPD) and the recipient of the 2017 Award for Distinguished Achievement in the Field of Severe Personality Disorders from the Borderline Personality Disorder Resource Centre and Personality Disorder Institute, New York.

In your view, what are the most distinctive features of the HYPE clinic? What is unique about this particular model?

HYPE is a programme that involves a service delivery model integrated with individual psychotherapy. What distinguishes it from other treatments for Borderline Personality Disorder (BPD) in particular is its nonexclusive focus on individual psychotherapy, a prioritisation of service delivery for everybody - and then individual psychotherapy for some, the majority usually - but with the recognition that individual psychotherapy is not the ‘be all and end all’ of treatment for BPD. The other thing that makes HYPE unique is that we have minimal exclusion criteria. Indeed, the only exclusion criterion is really based on other programmes at Orygen, reflecting a view that people with First-Episode Psychosis need a different tenure of care in the service, a different model of care. Everyone else is basically eligible, we don’t exclude people on the basis of antisocial behaviour, substance use, suicidality, any of the things that might traditionally exclude people from accessing services.

And the other thing that makes it unique is the age range, as we see clients up until the age of 25. HYPE is embedded within the larger youth mental health movement, which recognises that, from a developmental perspective, adolescence has changed across the latter half of the twentieth century. For social, neurodevelopmental and psychological reasons, the transition from childhood to adulthood is taking up a longer and less coherent period of time, that starts at puberty and runs to roughly the mid 20’s. So there is a recognition that, particularly in terms of what concerns Personality Disorders, nothing ‘special’ takes place at the age of 18. This is supported by findings from developmental neuroscience, which clearly indicates that brain development continues throughout the second and third decade of life, that personality development continues throughout that time, identity formation continues throughout that time.

Much of your previous work has focused on developing this concept of Personality Disorder across the lifespan, personality as a dynamic construct throughout the life-course rather than a condition that crystallises in adulthood. This carries some diagnostic implications particularly in the work with adolescents, and yet I think it is fair to say that in the UK there is considerable reluctance to make a diagnosis of PD so early in life.

I think there are two issues that are conflated here - one is the science, and the other to do with the social implications of the diagnosis of PD. I think it is the latter that usually gets in the way. The science is pretty clear, in that children and young people have personalities, and these can be, at
the extremes, abnormal. That, by definition, is Personality Disorder. Particularly with the strong evidence that PD is a dimensional and unitary dimensional construct – it is not that there are different personality disorders, rather there is this thing called Personality Disorder which is a unitary construct. And then you can describe individual differences. But essentially disordered personality can happen at any stage across the lifespan. What the science also is quite clear about is that just because you have a personality disorder at one stage does not mean that you will have it forever. Personality is more changeable than people previously thought. The science is pretty clear that on any measure, PD in young people stacks up against PD in adulthood – whether it is reliability, validity, outcome, structure of personality pathology. On any of those measures, PD in young people is just like PD in adulthood.

The difficulty is that when people make a diagnosis of PD they also have in their mind a very negative stereotype of PD, and many very caring clinicians are reluctant to make the diagnosis for fear that their patients will get worse treatment or rejection from services. They worry about the lasting implications of the diagnosis, even though we know that the diagnosis is only moderately stable - people will probably not meet the criteria later on. My answer to that is, if you look at who stigmatises people with PD, it is actually health professionals. The way to tackle the problem is not to avoid the diagnosis, but to tackle bigotry and discrimination among health professionals.

Is there a need to change the perception of PD, from a diagnosis that is seen as lifelong and enduring, to a condition that is eminently treatable? Because that might go a long way in addressing the burden of stigma and the sense of hopelessness that comes with the diagnosis.

Absolutely. And also, the perception of the diagnosis as being illegitimate and second rate. So, I think that indeed we need to rehabilitate the diagnosis. And that is no different to Schizophrenia – when I was a medical student, Schizophrenia was a dirty word and now it is a legitimate and accepted diagnosis, even though its diagnostic validity is partly questionable. But you can change things, and I think that to not diagnose Personality Disorder now is actually discriminatory - because there are treatments available, which are empirically supported and which have shown to be effective. To not diagnose is to deny people access to those treatments, and also to send them down a pathway of potentially inappropriate or harmful treatments – particularly with the use of substitute diagnoses such as depression and bipolar disorder.

The advantages of increasing the sensitivity of a diagnosis of Personality Disorder in adolescence would be much clearer if we could count on a reliable provision of care after that. Now, we know that the early intervention model in psychosis has gained a lot of traction in the UK and worldwide, but we are yet to see a similar development in the field of Personality Disorders. In brief, how would you make a case for early intervention in this particular patient group?

The science supporting the rationale for early intervention in Personality Disorders is quite strong now I think, and actually this is not particularly around a narrow focus on BPD. There is good evidence now to indicate that BPD is just a proxy for severe Personality Disorder, that it actually captures what is the general severity component of Personality Disorder. And the importance of severe PD in young people is not focused around a narrow diagnosis, but what it actually means for their development and prognosis. So, severe or Borderline PD is a red flag for a group that is
likely to do very poorly in life. My interest in Early Intervention is not because I narrowly want to stop people from developing BPD. What we know is that the BPD diagnosis is a gateway to a whole range adverse psychopathological outcomes, an array of different mental disorders – depression, anxiety disorders, other personality disorders. And it is also a red flag for vocational impairment, physical health risks, sexual health, substance use – so this is the group that goes on to develop severe and enduring problems. It is for those reasons that we should target this group. We cannot be certain who is going to reach those adverse outcomes, but the science of prevention is that you try to narrow the focus to find the group at highest risk.

That is why I have argued against universal prevention, that is targeting the whole population – or even selective prevention, which would be targeting those with some risk factors but who do not have any visible problems. In terms of efficiency, the best bang for our buck, we should think of indicated prevention - targeting those individuals who are beginning to show signs of borderline pathology, and intervene at that point.

At a time of dwindling resources and relentless pressures in the public sector, the issue of cost-effectiveness is inevitably a very topical one. In regard to Early Intervention in personality disorders, where does the evidence lie at present?

There is emerging evidence around the cost of illness – and Borderline PD is expensive, something which it really shares with other severe mental disorders. If you have a disorder that starts early in life and goes on for a long time, then it is likely to become very costly. These are expensive disorders because they strike people in the prime of their life, and the majority struggle with some disability throughout their lives. What is interesting is that, when you think of BPD, you think that this is a costly condition because patients spend a lot of time in Emergency Departments, intensive care units, hospital admissions. Actually, the reality is that the majority of the costs associated with BPD are indirect, work-related costs. So one of the untold parts of the story with BPD is vocational disability. Patients often do not complete education, and often they do not hold jobs or hold meaningful working lives. In fact, BPD patients make up for a sizeable proportion of people receiving disability pensions – I think the numbers indicate that around 42% of people with a diagnosis of BPD will be on disability pension at some stage. So this is a disorder that is very disabling, and even if some features of the disorder might attenuate in their 20s or 30s, one of the most stable features is the functional impairment. So people might not be self-harming or presenting to ED very often, but they are unlikely to be functioning very well. Again, that is another reason for Early Intervention – once that pattern of disability is entrenched, it is very hard to shift. Once their social networks have evaporated, their families disintegrated, and they have missed out on educational and vocational opportunities, it is very hard to ‘uns scramble that egg’.

You began by saying that one of the distinctive features of the HYPE clinic is that it does not assume that all clients will be ready to engage in psychological treatment. And yet, one of the more striking aspects of my experience in HYPE has been the way that the whole team relies on a specific model, that of Cognitive Analytic Therapy. The language of CAT seems to permeate the whole team, and I was struck by the unifying role of this framework. In your view, what is it about CAT that lends itself to this particular way of working?
What we wanted to provide when we designed the service was a service for all people, not necessarily just individual psychotherapy for those who were willing to engage. What attracted me to CAT was that it offers both a model of development and psychopathology, as well as an individual psychotherapy. And then the other central ingredient is that, in order to run a service for complex patients, you need to have people singing from the same song sheet. Disunity is poison for services trying to treat complex patients. My experience of training in psychiatry is that you go through these programmes where often no two people in the service would actually agree on the model, and so much energy is spent arguing about the model and arcane points about treatments, rather than focusing on the patient. I think that too often services are focused on therapy as an end in itself, whereas HYPE views, and I personally view, psychotherapy as a means toward an end. Also many models are quite restrictive about entry. One of CAT’s features is that psychological mindedness is a goal of therapy, not a prerequisite.

CAT relies on a very pluralistic approach to psychotherapy, particularly I think because of the influence of Vygotsky and the idea of the ‘zone of proximal development’, the idea of staying within the capacities of the individual. It allows you to offer something to a broad range of people. You might have to shift your expectations of what you can offer them, but CAT gives you a model that can offer something to everybody, and serves as the lingua franca of the whole programme. So even if you never offer somebody a session of individual psychotherapy, you can still have a psychological approach to their problems, and a unified model shared among the team that has some depth and also allows you to weather the pretty substantial storms that you get when you collect all these patients into one team.

**Looking into the future, in which direction do you expect Personality Disorder services to develop? Can you give us a sense of the theoretical developments you anticipate, and some practical implications to technique and service design?**

I think that the paradigmatic shift, at the moment leans toward Early Intervention. I think it is getting some traction with the developing of an alliance - called the Global Alliance for Prevention and Early Intervention for BPD. It is hard to overestimate the task of shifting toward an Early Intervention model, because you’ve still got the struggle of early identification, in order to offer time-limited interventions. That is a paradigmatic shift, to get people to think that way. I think the other novel things that might develop, and which will probably develop as part of Early Intervention in youth mental health, is the emergence of novel platforms for delivery of services. Not to say that there is going to be an ‘app’ for treating BPD, but novel ways of delivering treatment for people who are hard to reach. This means using technology in a more creative way, to be able to access people who previously we could not reach, or who could not reach us. Also, developmental neuroscience will help to inform the development of treatments.

I think the other paradigmatic shift that needs to happen is the mainstreaming of Personality Disorder treatment, which still does not have the legitimacy it deserves. When we, Orygen, were starting the Early Intervention in Psychosis movement, the thing that psychosis did not have was a crisis of legitimacy. Everybody knew that psychosis was a legitimate and severe problem, and there was never a question that this patient group needed treatment - whereas severe Personality Disorder suffers this legitimacy problem. I think that this is the big shift that needs to happen. I do
hope that changes to the DSM, and the removal of Axis II might lead to that - that Personality Disorder might be seen as just another disorder in the DSM. There is certainly some discussion around the removal of Axis II, but I also think that there needs to be a more active campaign to change services, to turn this into a legitimate focus. I think that these are the kind of proximal developments that we can anticipate.

Tiago Gandra
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Contemporary Practice

The unpalatable truth of childhood sexual abuse, and what we have to do to address it
Joanne Stublely and Maria Eyres

As the news of the Manchester bombing, the London Bridge attack and the Grenfell Tower fire continue to haunt the nation, more attention than ever is currently being given to how we can protect our children as a society.

While it is vitally important that we learn how to shield our young from external terror, we equally need to learn how to better protect them from other forms of pain, an issue brought to the fore
by the recent BBC1 series “Three Girls” which explores the sexual exploitation of young girls in Rochdale and the inexcusable lack of response to it. The BBC1 documentary on the subject that followed, “The Betrayed Girls” featured the testimonies from the victims and the shocking truth from those who spoke out and were met with professional and organizational silence.

Unfortunately, the ongoing tragedy of the reality of childhood sexual abuse and its impact on lives and mental and physical health seems to be difficult to tackle and the urgent reaction it requires from health, social care services and society in general, continues to be turned away from, denied or remains unacknowledged. This is despite a growing recognition of the widespread nature of child sexual abuse and exploitation evident in recent history.

In 2012, the Jimmy Savile scandal led to Operation Yewtree and the subsequent “Giving Victims a Voice” joint publication from the Metropolitan Police Service and the National Society for the Protection of Cruelty to Children (NSCCP), with evidence of over 450 complaints spanning 55 years with a victim age range from 8-47 years. Multiple police operations followed including Operation Whistle (Jersey), Operation Midland and the Wiltshire investigation into Heath.

In August 2014 Professor Alexis Jay published a review of child sexual exploitation in Rotherham. The report said: “organized child sexual exploitation had been happening on a massive scale over many years”. The government’s response was to produce the paper ‘Tackling Child Sexual Exploitation’ published in March 2015. It states clearly; “Child sexual exploitation affects all our communities. While the full extent of this crime is still unknown, we do know that it is not confined to one area. Any local authority or police force that denies that it has a problem, or thinks that it is only happening elsewhere, is wrong. As discussed in the Jay and Casey reports, a child that has been sexually exploited is likely to require long-term, specialist help. This help ranges from basic support to rebuild their self-esteem and resilience, to interventions that tackle more serious psychological and mental ill health on an individual and family basis.” The paper also promised some additional funding to support victims and to provide specific training over the next two years in services working with sexually abused children.

In 2014, the Independent Inquiry into Childhood Sexual Abuse was established, with aims of exposing past institutional failings and making future recommendations for child protection measures. The inquiry included in its scope the Roman Catholic and Anglican churches, local councils including Rochdale (portrayed in “Three Girls” and “The Betrayed Girls”) schools, the BBC, the armed forces, hospitals and charities. The inquiry has been plagued with difficulties, perhaps unsurprisingly when one considers the nature of its investigation and the powerful emotional pulls that are inevitable in this arena.

In 2013, the Department of Education published a paper entitled “Working Together to Safeguard Children”. It was stated that safeguarding guidance was crystal clear and no significant changes needed to be made.

However, this was challenged following the high profile events of Savile and Operation Yewtree, as well as the Child Sexual Exploitation findings. In 2014, an Amendment to the Serious Crimes Bill was brought before the House of Lords. It was withdrawn and the government began a
consultation process on the use of Mandatory Reporting (MR). Under MR, specific groups or professionals would be placed under a legal duty to report suspected cases of child abuse and neglect to the proper authorities. Failure to report reasonably held concerns would result in criminal sanctions. The consultation, which included the “lesser” option of “Failure to Act” is ongoing.

The Children’s Commissioner Report on Childhood Sexual Abuse published in 2016 estimates 450,000 cases of sexual abuse in children in England between 2014 and 2016. In the same period, only 50,000 cases were known by statutory agencies. This serves to highlight the ongoing concern of what remains hidden, perhaps only coming to light in adolescence or adulthood when significant distress or functional impairment may become evident.

Recent studies suggest that around 50% of people receiving mental health services report abuse as children: one review found that “on careful questioning, 50-60% of psychiatric inpatients and 40-60% of outpatients report childhood histories of physical or sexual abuse or both” (Read 1998). Others have concluded that: “child abuse may have a causative role in the most severe psychiatric conditions” (Fergusson et al 1996: Mullen et al 1993).

A history of child sexual abuse is commonly seen in a wide variety of disorders from Depression, Anxiety, Post-Traumatic Stress Disorder, Substance Abuse and Dependence, Eating Disorders and Personality Disorders, particularly Borderline Personality Disorder. The psychological evidence of the impact that maltreatment during infancy and early childhood has is increasingly clear. The repercussions into adolescence and adulthood can be significant and widespread with the NSPCC saying in 2010: “The impact of child maltreatment includes a wide range of many complex social and economic problems, with an increased likelihood of mental disorders, health problems, educational failure and unemployment, substance addiction, crime and delinquency, homelessness and an intergenerational cycle of abuse and neglect. “ There has also been evidence that childhood abuse is linked to physical health problems later in life which could include heart disease, obesity, liver disease, cancer and chronic lung disease.

Although adults with a history of childhood sexual abuse may present to services with multiple medical and psychiatric symptoms and diagnoses, it is rarely the presenting complaint due to associated shame, guilt and stigma.

This is confounded by a lack of recognition within health service staff of the potential presence of such a history and the need to ask. A study by Read and Fraser in 1998 demonstrated that 82% of psychiatric inpatients disclosed childhood trauma when specifically questioned whilst 8% volunteered disclosure without being asked. A further study (Felitti and Anda 2014) showed a 35% reduction in doctor’s office visits and 11% reduction in casualty visits if adults were asked about adverse childhood experiences as part of a standard medical assessment.

So what does all of this tell us about what needs to change in this difficult and emotional area? Firstly, there needs to be a significant shift in health and social care in relation to current and historical childhood sexual abuse. Much of this mirrors the recommendations in relation to children as cited above, particularly the need for work across usual boundaries within an
integrated network, an active and open approach to the possibility of disclosure in all settings, management that is patient-centred with good leadership and governance.

In relation to training of health care workers, there is an urgent need to update training curricula to ensure a level of sensitive and confident interviewing skills leading to making appropriate diagnosis and signposting to treatment provisions for victims as well as perpetrators to stop the cycles of abuse.

We need to map existing clinical services that support victims of current and Historical Childhood Sexual Abuse to identify gaps as well as to recommend the best practice and care pathways from primary to tier 4 specialist care to inform commissioning. The current emphasis seems to be on child protection and safeguarding, less on treatment or prevention especially in relation to adults with historical child sexual abuse.

There is also a need to influence the direction of research into current and historical childhood sexual abuse starting with updating its definition to incorporate recent developments in digital technology. The reported prevalence is wide ranging, the current evidence base is poor and treatments are often not adequate or long enough. Child sexual abuse inevitably impacts on attachment, capacity to trust, to relate to others and form long term healthy relationships and yet the few available treatments often fail to address the need for relational intervention.

Finally, what frequently gets missed out of this kind of discussion is the need at a societal level, as well as a therapeutic level, to seriously address the issue of perpetrators. What leads to so many of our children being sexually abused or exploited? What happens in the wider fabric of our society that leads to the “creation” of abusers and what can be done in the realm of prevention and treatment of this group to begin to impact on the frightening statistics we are beginning to consider?

It is only through a willingness to face this difficult subject that we may begin to bring about some of the changes recommended and a collaboration within society to address the underlying issues which may contribute to childhood sexual abuse.

**Dr Joanne Stubley and Dr Maria Eyres**  
**Co-chairs of the Historical Child Sexual Abuse**  
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An update on the electronic resources available to members on the Faculty Website

Steve Pearce

The member support page of the website has been updated, and placed behind a password. So to access this area, go to the college website, log on, then visit the Medical Psychotherapy Faculty website and navigate to the member support pages at the bottom.

The member support pages now include links to some resources that may not be known to some Faculty members. Chief among these are the Faculty email list, a closed list which faculty members can join. This list is used to discuss current issues, request support, and advertise jobs. Similarly, trainee members can join the trainees email list at Faculty of Psychotherapy ST4-6 trainees and this link will be going up on the website as well.

There are a number of documents available to encourage innovation in supervision and consultation, including descriptions from members of their work facilitating (or in some cases being a member of) ward groups, Balint groups, Schwarz rounds, Risk groups, structured clinical management, and consultant case discussion groups. If any members have been involved in other initiatives that might benefit other members, let me have them and I will put them on the website. There are also documents providing evidence for effectiveness of interventions and advice on tackling threatened cutbacks and closures, and we have plans to put up business cases for those members involved in developing services. There are links to support services for doctors generally, and psychiatrists in particular, and to Faculty regional representative resources.

We receive fairly regular feedback that it is difficult for Faculty members to connect with, or feel supported by, other members; we hope this resource represents a start in addressing this. Members are welcome to get in contact to suggest additional resources, or to send documents they feel might be of benefit.

Steve Pearce
Vice Chair
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Grenfell Fire

Jo Stubley

This has been a very painful and difficult trauma for the wider community of London, coming so soon after the Manchester bombing and the two terrorist attacks in London (Westminster and London Bridge). The societal and political implications and ramifications of this particular disaster are considerable and add to the emotional impact. As the lead of the Tavistock Trauma Service I have had many therapists contacting me wondering how they might be able to help. I have also heard about voluntary registers of therapists being set up to offer help to survivors and bereaved, as well as therapists going down to the community and offering therapeutic help in the immediate aftermath.

It is an understandable response, fuelled by perhaps many different reasons. Trauma by its very nature impairs symbolic capacities and stirs up very powerful, primitive emotions. Our ability to think is inevitably impaired, and the push to action is very powerful. One common form of action is through identification, generally within the various positions of the traumatic scenario. As bystanders to this event, many of us may have felt propelled into action, especially in the role of rescuer (a common position for people working in the helping professions). The wish to get involved may also be fuelled by a manic excitement, a vicarious pleasure seen in the slowing down to view the accident on the side of the road. There is also, inevitably the wish for reparation, often fuelled further by guilt – survivor guilt and in this instance the guilt linked to the socio-political context. All of this can help to explain why there has been such a propulsion into action. However, this wish to help in the early stages often needs to be carefully considered so that precipitous action does not actually make matters more difficult.

There is a process of responding that is built upon experience of previous events and the current evidence base. NICE guidelines are clear that in the initial phases after a major trauma the following needs to be held in mind:

1. Many people will experience trauma symptoms in the early phases but this does not require expert intervention. It is best managed with “Watchful Waiting” – a combination of psychoeducation and encouragement to use one’s usual supportive network.
2. Debriefing is not appropriate as a general rule and indeed some studies suggest it may be harmful.
3. One needs to attend to the “hierarchy of needs” – a safe place, food, clothes etc are the priority.

Watchful Waiting is the term coined by NICE guidelines to describe the most appropriate response in the first month or so. At its heart is the recognition that the majority of people who are involved in a traumatic event will not go on to develop Post Traumatic Stress Disorder (PTSD). With straightforward psychoeducation, traumatised individuals can understand that the usual response
in the early days after the event is to have a variety of symptoms that are likely to settle over time. These symptoms may include nightmares, vivid images or thoughts of the event, trouble sleeping, irritability, low mood, feeling numb or cut off from others, tearfulness, temper outbursts, avoidance of any reminders and so on. For most people this is normal and with support and care will gradually resolve. The best care involves support from one’s usual social and familial network, good basic self-care around eating well, not using alcohol or drugs, keeping to a reasonable routine and getting back to life’s usual pattern as soon as possible.

There is a higher risk of PTSD developing if someone is socially isolated and doesn’t have a good support structure around them, if they have a previous history of trauma or mental health issues or there is a history of trauma or psychiatric illness in the family. A history of childhood trauma can also significantly increase the risk. Some demographic factors may also increase risk – female gender, low socio-economic group, minority status and low educational attainment. The severity of the trauma and the degree of loss also increases the risk. Any of these factors especially if there are a few present, may suggest a closer eye should be kept on that individual to ensure their symptoms settle over time. They may require intervention earlier or from a more specialised service if there are concerns.

Local services are already responding to setting up appropriate pathways for care. For this event it is Central and Northwest London NHS Trust. They are likely to institute a “Screen and Treat” approach which will include gathering data for research as was done after the London 7/7 bombs by the Traumatic Stress Clinic. One of the findings from their research was that less than 30% of survivors went on to develop PTSD and for the emergency service personnel involved the figure was much lower (2%). The pathway on this occasion will be local (including NHS and voluntary services as appropriate) and will be a tiered response as only a few will need specialist services.

This event may also precipitate individuals who have a history of traumatisation to experience more symptoms, to have their own traumas, reactivated by this current, very public event which has been so pervasive in the media. Studies from 9/11 demonstrated the potential for vulnerable individuals to be traumatized by repeated exposure to the event through the media and it can be helpful to think with patients whether they need to protect themselves from this kind of media overload.

As a final note, it is also important to remember there can be a ripple effect, with friends and family as well as workers involved with survivors also potentially experiencing vicarious traumatisation. The need for a supportive, containing network is also vital here and staff may need to find supervision or other forms of reflective practice to consider the impact of the work. The need to consider whether we should take action and in what form requires a capacity to reflect, to consider our motivations, both conscious and unconscious, and to take time to allow survivors and bereaved to recover within their usual supportive networks. As therapists, it is important we recognize that our skills may not be most helpful early on but we may as fellow human beings offer attendance to the hierarchy of needs – a safe place to sleep, food and comfort. This was, for me, what was most impressive in the early stages after the fire – the capacity for ordinary Londoners to offer what was needed in such a time of crisis. It is a basic requirement of containment, the blanket around the shoulder of the traumatized individual, that is the essence of
early care following a disaster. For the therapist wishing to help perhaps the hardest task is to not act but to be available in a reflective capacity until action may be required.

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**Trainee Voices: Medical Psychotherapy Trainees Section**

Anna Croxford and Alex Chatziagorakis

Welcome to the 2017 summer edition of Trainee Voices, a space for discussion within the Faculty newsletter dedicated to trainees with an interest in Medical Psychotherapy.

This edition brings a variety of articles from a number of trainees from diverse training backgrounds, and stages and locations in their training, highlighting the broad application of Medical Psychotherapy in various Psychiatric specialities and also the current opportunities and commitments some trainees make to exploring psychotherapeutic ways of thinking and working within their everyday clinical work.

A real sense of interest, enjoyment and appreciation of the importance of psychotherapeutic techniques, including applied approaches and thought, is evident including the commitment trainees make to ensuring the community have various spaces to get together to continue their interests and valuable work.

We are warmly reminded of some of the events run by the Faculty and trainees since the last edition, and would also like to mention the summer Trainee-Trainer Medical Psychotherapy Conference, which was hosted in the Exeter Psychotherapy Service on 7th July 2017 and was a very well received, thought provoking and emotionally touching one day Group Relations Conference.

Attendees were grateful to Annabel Walmsey, Psychotherapy trainee in Exeter, who organised the day, and to the Exeter Psychotherapy department and facilitators who hosted the day, and also to a number of the department who attended. The facilitators provided a safe environment for attendees from a range of professional backgrounds and experiences to explore often touching emotional responses during the day and were very much appreciated. We would like to take the opportunity to further thank the facilitators Dr Murphy Ford, Robert Plant and Maureen Wright all of whom are from Exeter, and also Anna Motz who made the journey from Oxford.
The Winter Trainee-Trainer conference is scheduled for 26th January 2018 and will provide trainees with an opportunity engage in an experiential day at the Cassell Therapeutic Community in Surrey.

**Trainee Articles**

Dr Zabelle Aslan warmly reminds us of this year’s interesting and enjoyable RCPsych Medical Psychotherapy Faculty Conference from 5-7th April 2017 entitled ‘Trauma, Dissociation and Psychosis’, and how important this event is to trainees. She takes us through her experience and understanding of the event via a summary of the main speakers’ presentations and also of the workshops she attended.

Dr Alex Chatziagorakis highlights the value of Student Psychotherapy Schemes, thinking about his own psychotherapy experience during his Psychiatric training that seems to echo the reports of research studies discussed at the recent ‘Medical Student Psychotherapy Schemes Symposium’ and also of medical students who have taken part in Student Psychotherapy Schemes.

Dr Charles Le Grice shares with us his thoughts around the use of social media in Psychiatry, in particular for psychodynamic therapists, and the conflicts that can arise between maintaining therapeutic neutrality and the possible benefits of using social media. His article raises a number of questions for the individual to consider.

Following Dr Tim Reid’s lecture proposing the possible benefits of psychedelics at this year’s RCPsych Medical Psychotherapy Faculty Conference in April 2017 and also a resurgence of research in the field, Dr Jonny Martell presents evidence that suggests psychedelics may prove to be a tempting future treatment modality alongside psychotherapeutic techniques.

Dr Kathleen McCurdy gives us a synopsis of the well-received spring term of the Maudsley Lectures in Psychoanalysis run by the Institute of Psychoanalysis at Denmark Hill. For those inspired to attend the seminars this year, she includes the structure and richness of the seminars highlighting specific application to her speciality and also wider social and political contexts.

In contrast to Dr Chatziagorakis’ piece on Student Psychotherapy Schemes, Dr Parvinder Shergill presents her emotional experience and conceptualisation of being a Balint group attendee, highlighting the importance of having a space to think about emotions in the doctor-patient relationship and the relief that this can provide.

Dr Tessa Sloper Talbot and Dr Roberts Klotins bring alive our memories of the varied psychotherapeutic perspectives discussed at the Winter Trainee-Trainee Medical Psychotherapy Conference entitled ‘Art and the Psyche’ and held at the Wellcome Collection Gallery in London. They also offer valuable tips for future trainees organising this bi-annual trainee led conference and also an analysis of the attendees’ experience of the conference.
As always, we look forward to seeing you at other upcoming events (mentioned at the end of the newsletter). In the meantime, please continue to send your contributions and suggestions for the next newsletter - submissions c/o stella.galea@rcpsych.ac.uk.

In particular, we look forward to reading about trainees’ experiences of the Summer Trainee - Trainer Group Relations Conference in Exeter in the upcoming winter edition of this newsletter, and encourage further additions to this piece which is in process.

Without your contributions the conversation would not continue!

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The Pursuit of Preservation
Zabelle Aslanyan

Trauma, Dissociation and Psychosis
The Royal College of Psychiatrists Faculty of Medical Psychotherapy Annual Conference, Weds 5th – Fri 7th April 2017.

The busy schedule over the three-day conference consisted of panel discussions, lectures and numerous workshops, all with plenty of audience participation. These workshops allowed smaller groups but ran in tandem meaning I selected one of two or more options during each slot.

My conference started with Dr Padakkara Saju’s workshop entitled ‘Working with Transgenders and Queers: Selves in Transition.’ He spoke about his work running a gender clinic and introduced us to the ‘Genderbread Person’ made up of their parameters in Gender Identity, Gender Expression, Biological Sex and Sexual Attraction. It was interesting to hear about the changes in the way the NHS manages and views these individuals as their involvement with mental health services has gone from Compulsory in their pathway to hormone prescription and surgery referrals to Optional, and in the future the ‘diagnosis’ of transsexualism will be classified under Endocrine Disorder rather than Mental Disorder. He also spoke about the higher representation of individuals with Autistic Spectrum Disorders in the gender service and the considerations this requires.
Wednesday finished with Dr Earl Hopper speaking about ‘Traumatic Experience in the unconscious life of social systems.’ Bion outlined the three basic group assumptions of Dependency, Fight-flight and Pairing; Dr Hopper spoke about a fourth assumption of Incohesion – with varying socio-cultural states termed Aggregation and Massification. A state of Aggregation was paralleled to a bowlful of boiled potatoes, encouraging individuals, experimental behaviours and sometimes isolated individuals. However, if this state is threatened or experiences trauma then it can shift to Massification in a search for safety. Massification was paralleled to a bowl of mashed potato where people can be anonymised and homogenised. He talked about groups, such as families or societies, shifting between the two states as neither seems to be able to be sustained.

Thursday was themed around dissociative experiences, with Dr Valerie Sinason and Professor Ira Brenner speaking about Dissociation and Dissociative Identity Disorder (DID), and Dr Richard Brown focussing on Medically Unexplained Symptoms in a plenary session and his workshop I attended. Dr Sinason summarised methods of dissociation from abuse and trauma as going Mad (psychotic), Bad (forensic), Sad (depressed), Sick (somatised symptoms) or Suck (addiction) in an unconscious act of avoidance or to protect a ‘broken’ abusive attachment. They spoke about the rise in interest and acceptance of DID as a diagnosis and how the lack of credibility in DID by professionals seems to echo the frequent denial of the trauma or abuse the individual endured. Dr Brenner invited us to read his interaction with a patient with dissociative symptoms and discuss how he engaged him psychotherapeutically.

Dr Brown spoke about his success in working with individuals with non-epileptic seizures using psychodynamic interpersonal therapy. He argued that the term “dissociation” should be used more carefully and explained the sub-categories of detachment and compartmentalisation, with emotional numbing and depersonalisation falling under the former, and conversion and somatisation disorders falling under the latter. These distinct conditions need to be worked with in different ways and these definitions can guide research in therapy.

The day finished with a focus on suicide; the theoretical psychoanalytic basis behind an individual ending their life and Dr Rachel Gibbons speaking about the value of running a ‘Suicide Group’ for consultant psychiatrists to support one another after the tragedy of a patient suicide and the aftermath of institutional scrutiny.

The last day considered psychosis and the search for meaning behind what is often considered a bizarre presentation. Professor Jaako Seikkula and Rachel Waddingham spoke about using Open Dialogue approaches in psychosis; the former speaking about the strong evidence base in Finland for this relational therapy described as a cross between family therapy and psychodynamic psychotherapy, and the latter speaker giving a service user’s perspective on being given a diagnosis of psychosis and now training to be a therapist in Open Dialogue. They spoke about dialogue being the essence of life and each individual starting their dialogue at the moment of birth, and how this naturalistic approach means that sessions should be structured by their content and not by the agenda brought by therapists. Ms Waddingham spoke about the importance of the language used in defining psychosis and the term itself, and how giving labels to ‘elements of psychopathology’ take power way from the individual’s self-expression.
Dr Brian Martindale spoke about traditional psychoanalytic theories in psychosis and how it can be thought of in terms of a disintegration of a whole and a dispensation of reality in order not to suffer it. Dr Phil Osborne and Dr Chris Douglas then led a workshop showing how a simple Balint approach to reflection can be fruitful in understanding the relational and individual experience of psychosis.

There was also an interesting presentation about a possible future model of community psychiatry led by Dr Matteo Pizzo, whereby consultant psychiatrists, psychologists and psychiatric pharmacists are resident in GP practices to reduce psychiatric referrals and help manage complex mental health patients whom GPs find challenging. This was followed with a presentation about the successful application of transference focussed psychotherapy in Narcissistic Personality Disorder by Dr Tennyson Lee and Dr Anne Ward.

The conference ended with Dr Tim Read speaking about ‘Expanded States of Consciousness’ and the exciting new role psychedelics and other currently named ‘recreational drugs’ could play in broadening psychotherapeutic experiences in the not so distant future.

Many of the speakers over the conference spoke about dissociation and psychosis being a result of trauma ‘fragmenting’ a personality and an identity and the subsequent search for survival. In a final thought, this seems to me to mirror Harry Potter’s Tom Ridley splitting his soul by enduring traumatic acts and placing these parts in separate Horcruxes to preserve his survival. The presence and easy acceptance of such ideas in popular culture seem to indicate these psychotherapeutic concepts reconnect with a more intuitive understanding of these conditions.

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Medical students and psychotherapy: Reflections on the Medical Student Psychotherapy Schemes Symposium.
Alex Chatziagorakis

As a medical student, Medical Psychotherapy was possibly the only medical specialty that I knew almost next to nothing about. Neither had I met a psychotherapist before, nor had I had any idea what a psychotherapy session was like in real life. Coming across the world of Balint as a Core Trainee in Psychiatry, I began to realise the wider applications of psychotherapy beyond the consultation room (for example, when discussing complex cases from a psychodynamic perspective). Fast forward five years later, as I near the completion of my training as a General Adult Psychiatrist, I am in a position to say that I have acquired some experience in psychotherapy. Not only I have been a member of Balint and other reflective practice groups, but I have also delivered psychotherapy in several modalities (psychodynamic, CBT, group therapy) and I have
become an accredited Balint group leader. It is from this standpoint that I believe that medical students may benefit if psychotherapy elements are further integrated in the undergraduate curriculum. This is exactly the reason why I attended the Medical Student Psychotherapy Schemes Symposium at the Royal College in January 2017.

Listening to medical students and/or recently graduated doctors from Bristol, London (UCL) and Leeds reflecting on their experience either from Balint groups (Bristol, UCL, Leeds) or from student psychotherapy schemes (Bristol, UCL) reinforced my belief that psychotherapy has something valuable to offer to (at least some) medical students. I was particularly interested in learning about the UCL Student Psychotherapy Scheme, the first scheme of this kind to be established (back in the 1960s) to provide a selected number of medical students the opportunity to deliver psychodynamic psychotherapy. I was also particularly interested in Professeur Philippe Jaury’s lecture on his research on Balint groups for French medical students; he claimed that participation in Balint groups may increase students’ ability to demonstrate empathy and enable them to better handle difficult clinical situations, such as those presented by borderline personalities. This finding echoes those of other researchers, who found that participation in Balint groups increased students’ understanding and effectiveness in the doctor-patient relationship. For example, Levenstein found that participation in a Balint group increased students’ understanding and effectiveness in the doctor-patient relationship\(^1\), whereas Yakeley et al. found that participating students demonstrated increased knowledge of the doctor-patient relationship compared with a control group\(^2\).

These presentations in the Symposium also echo my own observations as a medical student Balint group leader. Balint groups appear to be well-received and well-regarded by the medical students. Most students value the opportunity for an open group discussion on interesting, difficult or sensitive issues, as well as the contribution of their peers. They recognise the value of Balint groups as a tool for reflection and the potential role these could play in their professional development. They also recognise and value the opportunity to consider, understand and discuss about feelings evoked by patients, as well as specific issues related to the cases presented. At the same time, I am the first to admit that my views may be biased; perhaps a number of students may not benefit from any exposure to psychotherapeutic ways of thinking.

However, in light of the existing evidence (whether this comes from research, our own observations as psychiatrists and medical educators, or simply listening to the students’ reflections in the Symposium), I personally embrace the College’s initiative to develop UK-wide medical student psychotherapy schemes with the aim to enhance the emotional literacy of nascent doctors and the empathic foundation of future doctor-patient relationships.

References


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The Information age, Privacy and Psychotherapy
Charles Le Grice

It is a principle of psychodynamic psychotherapy that the therapist is neutral, allowing the transference to develop as the patient projects their own feelings onto the therapist. This principle guides the interaction between therapist and patient within the consulting room. However, the consulting room is not the only space where the patient can form ideas about their therapist. For any therapist with an online presence, this may also inform the fantasies that the patient develops. I am not aware of any research into the proportion of patients who search for information about their therapist online. However, the ease with which an online search for a name can be carried out, and the curiosity that patients feel about the health professionals that they meet, mean that I suspect this is common.

My own experience as a clinician is that patients often do use online searches to try to learn more about those who treat them. On one occasion a patient began to ask about the abstract of a research project that I had presented. The topic related to mental health in the military and led the patient to identify me with the armed forces. On another occasion a patient formed an idealised view of me informed in part by a belief that I am a poet (a belief based on the fact that I share my name with a little-known poet).

There are ways we can limit the potential for disclosure of personal information to our patients. Social media sites have privacy settings that limit what can be seen by those who have not been approved as friends or followers. We can avoid any online interaction with patients and make clear the ways that we would prefer patients to contact us. In online environments that are publicly accessible we can limit what we share to the purely professional.

However, I wonder if there is a tension in rigidly preserving our professional identity on social media. Social media is a place where people discover ideas that have the potential to change lives, it is where they form relationships and share memories. If we only use social media to share research papers and Royal College of Psychiatrists updates, then does it feel as if we are denying every aspect of ourselves that is not our professional identity? However, if we adopt a different strategy and reveal a glimpse of our own full life on the internet, then that information may
determine our patient’s response to us. Perhaps a suspicion of social media also means that we are at risk of missing out on the potential benefits. As the GMC recognises, use of social media by doctors can have a number of benefits, including “engaging people in public health and policy discussions” and “facilitating patients’ access to information about health and services”\(^1\). Twitter is alive with psychiatrists who are using the platform to promote the interests of our patients and our speciality. If medical psychotherapists do not contribute, then our viewpoint risks being overlooked.

I wonder also if my suspicion of social media contains a luddite element. If a patient finds out that you are married online, is this really different to wearing a wedding ring at work? Is identifying a place of birth from a psychotherapist’s social media really different to correctly identifying an accent? Nonetheless, it does seem to me that there are key differences between a patient forming beliefs about a psychotherapist during an appointment and information shared on social media. The first is that when a patient forms an idea about a psychotherapist during an appointment, this can be taken up and discussed and the meaning of that idea to the patient can be interpreted. There is no potential for a contemporaneous transference interpretation when a patient draws conclusions about a psychotherapist from an internet search conducted at home (although of course they may bring their thoughts or feelings to the next session). Moreover, the ideas that a patient forms about their therapist during an appointment are speculations that need not be confirmed, but information gathered online is taken to be fact. Finally, social media has the potential to reveal the life the psychotherapist lives outside of the therapeutic relationship, and as such could limit the ways in which that relationship develops.

In conclusion, in our use of the internet there is a grey area between unacceptable and unprofessional disclosure and remaining a pure blank slate. Where we should position ourselves within that grey area is not always clear; both participation in and withdrawal from the online world are associated with costs.

Reference

1 General Medical Council (2013) *Doctors’ use of social media: Guidance*. London, GMC

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Medical Psychotherapy and the Psychedelic Renaissance.

Dr Jonny Martell

At the recent annual Medical Psychotherapy Faculty Conference in London, Dr Tim Reid envisaged a near-future where psychiatry trainees might be expected to have taken psychedelics as a training requirement. His talk was entitled ‘Altered Stated of Consciousness.’

I’m unsure what psychiatrists concerned at the difficulties recruiting into the specialty would feel about such a training requirement. Or how the public at large would feel at the profession’s adoption of a rite of passage more in keeping with shamanistic healing traditions. However, as his talk made clear, there is a resurgence in psychedelic research. Cultural attitudes are likely to shift, perhaps partly in response to the more sober and respectable vanguard of today’s researchers than those characterized by the excesses of Timothy Leary’s more revolutionary and countercultural call to arms. Dr Reid rightly drew attention to the book ‘The Psychedelic Renaissance - Reassessing the Role of Psychedelic Drugs in 21st Century Psychiatry and Society’ written by psychiatrist Dr Ben Sessa. This surveys terrain flourishing once again after years of being laid fallow by the moratorium imposed on psychedelics research by the Nixon administration.

Later this year at Imperial College London a trial is to explore the potential of psilocybin with psychological support for treatment resistant depression. This is a follow up to an earlier study that demonstrated preliminary support for its safety and efficacy. Led by Professor David Nutt (sacked by the Blair government for pointing out that riding horses is more dangerous than ecstasy) and Dr Robin Carhart-Harris, the study is supported by the Beckley Foundation. This is a think tank and NGO dedicated to pioneering psychedelic research and driving evidence-based drug policy reform. The lifting of the prohibitively expensive Home Office schedule 1 license required for such research is an important priority. In the US, the Multidisciplinary Association for Psychedelic Studies (MAPS) is the key player, notably securing recent FDA support for Phase 3 trials of MDMA-Assisted Psychotherapy for PTSD, for which therapist training programmes are running.

Alongside clinical studies, there is a wealth of neuroscientific research exploring brain function during the psychedelic experience. In another study from the Imperial team, healthy volunteers given LSD underwent brain imaging. The results revealed the manner in which the greater communication between different brain networks might underlie the profound altered state of consciousness or ‘ego dissolution’ that many people experience when under the influence of psychedelics. Research in Barcelona is shining a light on the much talked of ‘after-glow’ that people experience after taking ayahuasca, a psychedelic brew used ritually in the Amazon. The change in connectivity was found to correlate with an increase in traits associated with mindfulness and the marked antidepressant effects noted in the days and weeks afterwards might
represent an important window of opportunity for psychotherapeutic intervention. As psychedelic research throws new light on the architecture of consciousness, new hypotheses are being generated that might revitalise psychoanalysis.

Twenty years after Freud first proposed his structural model of the mind in ‘The Ego and the Id (1923),’ the Swiss chemist Albert Hoffmann cycled (quickly) home having intentionally ingested 250 micrograms of lysergic acid diethylamide (LSD), his normal sense of self starting to unravel. Once home, his family doctor was called who could find no serious cause for concern. He sat with him, but of course had no experience himself on which to draw to guide the chemist on his at times terrifying journey. In psychedelic clinical research settings, there are normally two ‘guides’, one male and one female and as Dr Reid mentioned in his talk, they should have personal psychedelic experience. He correctly impressed on the audience that should psychedelic research continue to show its early promise and revolutionise psychiatric treatments, it should be more psychologically- minded clinicians whose assistance patients might most need. As per the allegory of Plato’s cave, those emerging out in to the sunlight can be dazzled by what they see. Research consistently points to a correlation between the degree to which the experiences are felt to be spiritual or numinous and efficacy of treatment. Meaningfully integrating these experiences is as important, if not more so, than the experience itself.

History has a tendency to judge psychiatry’s latest wonder-discovery with opprobrium. The horrors of insulin-coma therapy or lobotomies spring to mind and more recently there appears to be a closer scrutiny of the potential harms of long term antipsychotic use. Psychedelics have been around for millennia and their safety profile amongst traditional societies who continue to use them ritually or medicinally is without question. As they would know, set and setting –or mindset and the physical/ social environment- is all important. Careful management of these parameters with the correct dose are consistently showing psychedelics to be a safe treatment for a wide variety of disorders. Beyond their safety, two authorities on psychedelics and psychopharmacology research offered ‘tempered optimism’ and ‘upbeat pessimism’ in a recent circumspective of the therapeutic potential of psychedelic drugs, past, present and future. Should their hopes for psychedelics’ cost effectiveness be realized, the demand for adequately trained and experienced clinicians will need to be met. As Dr Reid’s talk made clear, medical psychotherapists might want to consider their role in rising to this challenge.

References

Dr Jonny Martell


3 http://beckleyfoundation.org
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Dr Martell is joining the Psychedelic Research Group at UCL in January 2018 for a year as a study doctor and guide.

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**The Maudsley Lectures in Psychoanalysis: Reflections of a Forensic Psychiatry Trainee.**

**Kathleen McCurdy**

2015-2016 was the inaugural year for a new series of seminars on psychoanalysis held on the Maudsley Hospital site in Demark Hill organised by Emma Hotopf, and run by Analysts from the Institute of Psychoanalysis who made the journey south of the river Thames to present a series of weekly lectures and discussions. Following much success, 2016-2017 saw a return of the format with a host of fresh topics and I was lucky enough to be able to attend the Spring term. The lectures were wide-ranging in scope; covering subjects as diverse as borderline states, the interface with Forensic Psychiatry, psychotic phenomena in groups and the music of Bob Dylan.

Pre-course reading was distributed prior to the course and provided a mix of reading around core concepts and additional clinical cases building on what was spoken about in the lectures. As someone with limited experience of psychoanalytic thinking this was useful to bolster my understanding of the core themes before they were expanded on in the lectures. The lectures
were held on a Monday evening and consisted of an hour-long lecture followed by a facilitated discussion within a small group setting guided by a highly-experienced Psychoanalyst focusing on that evening’s topic. The diverse participants in the seminars; from practising therapists, to junior doctors, to public health practitioners and those who worked in the arts and media sector, allowed for a range of perspectives on the material beyond what I have perhaps become used to as a psychiatrist. Questions and reflections on the material from group members gave the lecture material added richness and opened up new ways of thinking about my everyday practice and the work I do within a wider context.

As a Forensic Psychiatry trainee, I found the two evenings focusing on violence, Ronnie Doctor speaking about a clinical case of patricide and Don Campbell speaking on “Gangs, Guns and the Absent Father”, particularly relevant. The exploration of the meaning of the violent act can sometimes be overlooked in the secure environments in which I am used to working where often the threat of imminent violence looms and thinking about extreme and violent acts can be daunting. Ronnie Doctor provided an exploration of the interface between analysis and psychiatry through a case study and enabled me to reflect on how analytic thinking can enrich our understanding of our patients and potentially offer some insight into risk and treatment. Don Campbell provoked consideration of the violence in the wider social context; focusing on the disenfranchisement of young black men, the function of “gang culture” and its stereotyped construct of manhood by focusing on clips from the film Bullet Boy. It certainly made me reflect on the critical role perceived disrespect and shame plays in the presentations of many of the young men I work with. It has helped me rethink how our interactions, both personal and as a profession, can be perceived and left me hopeful of the prospect of positive change in people’s lives.

However, beyond the obvious forensic aspects, I found many of the other sessions as stimulating, and perhaps even more so, because they provoked thought about topics that are less commonly talked about in my milieu. Lectures on traumatic experiences, both individually and in groups, not only stimulated thoughts about the high levels of trauma that many patients in the forensic setting have experienced (and may be unacknowledged) and the institutional trauma evident in these services, but also more widely in other settings and at a population-level in the wake of terrorist attacks and following gross political upheaval in the UK and abroad.

Unsurprisingly, consideration of the current American political environment and the election of President Trump over Hilary Clinton also dominated lively group discussions following a thought-provoking lecture on the roots of misogyny by Jan Abram.

I look forward to seeing what the future holds for the Maudsley Lectures in September 2017; the balance of topics this year between core psychoanalytic concepts and their application to both clinical material and wider contemporary society and culture has certainly been well-received. The easily accessible structure of the course and the inclusion of contemporary issues viewed through a psychoanalytic lens has opened up the topic to a wider audience, holding something of value for those, like me, just discovering the field as well as a few gems for more experienced Analysts and trainees. Certainly, the structure of the series, with new topics each semester and each year, maintains a particular freshness and I’m sure will see returning attendees year after year. It
certainly has piqued my interest in exploring the world of psychoanalysis and how it can enrich not only my practice as a Forensic Psychiatrist but also my understanding of current society.

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To Balint or not to Balint, that is the question: A trainees Reflection on Balint Group.  
Parvinder Shergill

Balint group echoes a sense of varied emotions among the trainees, and I wish to explore why this is the case. I am a CT2, having been a member of a Balint group for two years within my psychiatry training.

Balint group is meant to examine and explore the feelings developed between the doctor and patient which in turn should help the doctor understand the patients experience by the reflection of the emotions arisen from themselves. Hopefully, this process will be beneficial to the doctor in helping to better understand their own emotions, and thus help in how they treat the patient.

At work, I have found myself immersed in the weekly ritual of Balint, something of which I find myself thoroughly enjoying and dare I say it almost feeling as though it’s a psychotherapy session for me alone as the patient. However, why do I find some trainees not eagerly awaiting the next session unlike myself? Perhaps it is the realisation that as doctors it is of being under the spotlight instead of the patients. As psychiatrists, we are content with being the ones that delve into the unconscious of our patients, their inner ticking, their layers of personality, and vast landscape of fears and dreams. But if we were to turn the tables round, how do we as clinicians handle this possible infiltration of facing one’s deepest emotions whilst in a room of fellow psychiatrists? The tables have indeed turned.

Personally, I relish Balint, as it provides me with an opportunity to discuss my work and realise the interpersonal dynamics between my patients and myself. I welcome the experience to understand and learn that going through this journey of understanding with one’s patient and the impact of this unique relationship that has on my own emotional wheel. It is the most crucial to me. It is true I don’t yet have the most extensive experience in a wide variety of therapeutic interventions, apart from Cognitive Behavioural Therapy (CBT) which I have done professionally and personally, and psychotherapy professionally. However, I find myself extremely drawn toward Balint group more so then psychotherapy and CBT. I think it is because in a short amount of time in one session of Balint group, I find myself more aware of my own psychological feelings as well as blind spots. It helps me understand different views of my interaction with my patients and how I interpret my
emotions compared to others. It is a space for me to delve into my reflections, helping me to better understand my own doctor and patient relationship. However, the most important is that after each Balint I feel as though I have just done a boxing class with my mind: I feel as though I have combatted my emotions, lost any self-criticisms I had about my interactions with my patients, and feel utterly refreshed. Possibly it is the same experience those get in a mindfulness class, or an interpersonal therapy session. Whatever therapy session works for each of us, the outcome is one we want the same: to be feel more relieved and better for it. For me that is Balint group.

However, among the sceptics that are my psychiatry colleagues, I wonder why they are in fact at times dismissive of Balint.

As I reflect on this, I think perhaps it is the very reason as to why I cherish Balint in viewing it as an amateur psychoanalytic session of myself, that other trainees feel uncomfortable with. Perhaps the realisation of having to face difficult understandings of our own emotional content in the context of our patients is unbearable to some. Could it be the stir up of emotions that as doctors we are trained to control in medical school, that are now live in action in Balint could be in fact too uncontrollable for even us to make sense of? Perhaps the abrupt ending at the end of rotations with the abrupt ending of Balint group within the jobs make trainees feel inconclusive, and in a way abandoned after such an intimate setting of discussing our delicate intricate mind’s eye. Could these anxieties that are evoked upon trainees be the reason why Balint is not spread to other specialities such as surgical rotations where the surgeons are taught to cut a patient, but would find it unbearable to be cut emotionally themselves in Balint?

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Tessa Sloper Talbot and Roberts Klotins

Together we organised this year’s Winter Medical Psychotherapy Trainer and Trainee Conference - a national conference open to all psychotherapy trainees and trainers across the UK. It was held on 13th January 2017 at the Wellcome Collection Gallery in London.

We think this is truly a conference for all medical psychotherapy trainees. Ours is such a small speciality that all of us would not only attend several of these, but also would be in the position to organise one or more. Two very important questions when organising this conference were - can we fit it in our schedules and who are the organisers; can we work together? Tessa’s thought was about bringing in Art; Roberts suggested that the second focus of the conference would be on
Summer 2017

Neuroscience. The most fun bits in organising these conferences is that you can invite speakers on the themes you really are interested in.

The conference theme was ‘Art and the Psyche’. Tessa chose this theme because of her background and interest in the arts and her wish to ‘cross pollinate’ these two areas. How can one inform the other? Can creativity be a form of catharsis? Is the creation of an artwork similar to the creation of the transitional space between therapist and patient? Is the ability to appreciate beauty and the aesthetic a sign of mental health? Are there more pathological uses of art? Is there a role for art in therapy? Tessa wanted to explore these themes from a number of different perspectives and organising a conference was a great way to do that. We were able to bring together speakers from different schools of practice (Kleinian, Jungian, Neuropsychoanalytic) united on an exploration of this theme. We chose the Wellcome Gallery as it is a wonderful venue that has long explored the relationship between art and medicine. The conference room displayed ancient pottery which was very much on theme (art as a container). The conference coincided with the Wellcome Gallery’s exhibition “Bedlam the Asylum and Beyond” which displayed art works from both patients and staff at the Bethlehem Royal Hospital. There was a guided tour of this exhibition at the end of the day.

In terms of the structure of the day, our first speaker was Margot Waddell – Psychoanalyst, Consultant Child Psychotherapist and Author of the widely acclaimed book Inside Lives. Margot took us through her paper: Art and the Psyche: The containing function of meaning which explored “Art’ as encompassing, on the one hand, sources of creativity - whether in painterly, literary, carved, staged or cinematic form, and, on the other, post-Kleinian theory and psychoanalytic practice, mainly stemming from the work of W.R. Bion and Donald Meltzer. The art object, like the mind, can function at once as a generator, receptor and transformer of raw emotionality into feeling states, ones that acquire meaning where none had been. Such acquisition is central to the building of an experience of aesthetic reciprocity which lies at the heart of psychic development”.

Our next speaker was Katherine Killick - Jungian Analyst and Art Therapist whose talk presented a Jungian perspective on the part that art can play in the psychotherapy of extreme / psychotic states of mind. “Art making, and transactions surrounding images in the therapeutic setting, constitute a field of activity that exerts a gentle but effective challenge to the prevailing tyranny within the psyche, and over time this can revolutionise the patient's capacity for thinking”. It was a rare opportunity to be able to follow the progress of patients in art therapy through the evolution of their art works. It was also helpful to explore the theme of container- contained rom a Jungian perspective.

Following Katherine, we had Susan Steinberg- psychotherapist and award winning film director. Susan took us through her film ‘Mirrors to Windows’- a film that follows an international cast of three generations of women artists and their negotiation between art and life. This allowed for the perspective of the artist to come through and it allowed us to compare and contrast the different ways art can be used.

The conference concluded with Prof Jim Hopkins from University College London (UCL), who gave us a Neuropsychoanalytic perspective on ‘The Free Energy Principle and its relation
to Art and Creativity’. Jim’s talk explored Freud’s structural model at neuron level. Reminding us also of just how much perception is based on one’s internal model of the world as opposed to just external stimuli.

We concluded with a guided tour of the Wellcome Collections’ Bedlam exhibition which gave us an opportunity to further consolidate what we had taken in. Of course, there was then a trip to the pub and this happily lasted until closing time. Overall it felt a wonderfully stimulating day as supported by the feedback we received.

We thought in organising the conference it was important not to over-do it. We all have busy schedules with commitments to the patients, our own analysis, teaching, external teaching, groups, you name it. From our experience the rational structure of what we did was:

- Advertise, advertise, advertise. But this is precisely what we did not do, procrastinating until a month was left and we regretted it. If you have a list of participants early you can be so much more comfortable with the subsequent items of your programme. And not be very anxious.
- Have a venue - there is usually some venue that you might find more readily available (e.g. in London that would be the Royal College); once you have identified that then you can think of something extra - like the Wellcome Gallery.
- Talk to your prospective speakers. Do not forget to mention this is a trainee event and you might not be in the position to offer much of a payment. Nevertheless, this is truly a fun part. If you are enthusiastic about the topic / speaker, chances are your speaker will be too about your event.
- Have an idea about food and coffee during the day.

This is it really. The above will give you the budget that the Royal College expects you to have. The College is very helpful in that you can organise all the money flow through them, so that you do not have a headache about it. There is no administrative fee from the College.

For us this event meant to work together in a way we saw was good-enough to keep the whole thing moving forward.

We thought it would be good to know what people thought about the conference. It can be really cumbersome to deal with paper feedback. Roberts happened to have an easily accessible Limesurvey installation, so we organised the feedback collection and feedback report production electronically. It is quite satisfying to know your work has received an interesting response and the feedback you receive may be helpful to the next organisers.

We asked participants to leave textual feedback and rate the level at which they enjoyed the conference or found it useful. Participants needed to move a slider between 0 and 100 to indicate on the familiar 100 % scale their agreement with the statement “I felt the conference was:” “very bad” (indicated by 0) and “excellent” (indicated by 100).
One of the most encouraging comments was: “I enjoyed talks of all 4 speakers, there were some brilliant inspirational ideas discussed but at the same time it created much room in my head to explore things even further outside of the conference. Well organised and managed. Very inclusive and open atmosphere. Great choice of topics.” Because the feedback collection and making a report about it proved so easy, we decided to make the same feedback mechanism available to the future organisers for the same price we paid - for free.

Another great thing that you notice when organising the feedback collection is how people come to your event from various backgrounds. Apart from our specialism trainees there were Core trainees who are thinking about Psychotherapy, Consultants who have come to like your choice of topics, psychologists who are interested in how psychiatrists think about psychotherapy and more. This is a very interesting and democratic conference for all, including potential trainees.

I suppose our message to all Medical Psychotherapy trainees is - if you are thinking about organising one of these conferences - don’t overthink, just do it. It is quite easy, it brings lots of likeminded people together and it is great fun.

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TRAINEE CONTRIBUTIONS TO THIS NEWSLETTER ARE ALWAYS WELCOME!

We encourage you to contribute to the dialogue. Please send contributions for the next newsletter to Anna and Alex c/o stella.galea@rcpsych.ac.uk
Book Reviews

Dan Beales and Andrew Shepherd

Psychodynamic Interpersonal Therapy – A Conversational Model

Michael Barkham, Else Guthrie, Gillian E Hardy & Frank Margison

As the authors of this valuable book indicate in their preface, a challenge arises in the broad range of experience and conceits held by any potential audience for this work: The difficulty in developing an appropriate voice for this communication (perhaps an irony for a book considering a conversational mode of therapy) is highlighted by the authors in their opening discussion.

The book is presented in three sections: - First, underpinning theoretical structures and empirical support for the psychodynamic interpersonal therapy (PIT) model are presented. The second section outlines introductory, intermediate and advanced concepts in relation to therapy delivery, as well as a consideration of the way these concepts can be ordered within a chronological therapy. The final section presents information relating to the development of an on-going PIT practice before closing with an epilogue discussion relating to the life and work of Robert Hobson, on whose legacy the PIT model builds.

The theory underlying PIT could be considered ‘mid-range’ in that it does not speak to the aetiology of any specific underlying distress or disorder that an individual may experience, or that may manifest as symptom – but instead considers the way underlying distress links to its social manifestations through an impairment of interpersonal communication. The development of a therapeutic rapport therefore becomes essential in the development of a safe-space in which the therapist and client work together to support a ‘feeling language’, while avoiding an over-reliance on ‘thing language’ [‘it’s my “depression” causing this…’ as opposed to an acknowledgement of emotional content] – Hobson’s metaphor of ‘jam-jar language’ is drawn on here for clarity; although, at least for me, this is a curious analogy since does anyone not have some form of emotional association with jam-jars, or at least their contents? The theoretical claim made then is that in facilitating the maintenance of an emotionally literate ‘feeling language’ an individual is supported in maintaining clear forms of interpersonal interaction, leading to a lessening of personal distress.

The ‘practical’ section of the book is admirably clear and well-structured which, together with the appendices detailing means of auditing the therapist’s adherence to the model, supports the authors’ claim regarding the transparency of the model to audit and research. This links to the section of the book in which empirical claims are made for the efficacy of the therapy in relation to a range of presenting difficulties for clients. Such empirical claims are essential for any therapy seeking to succeed in a climate of ‘evidence-based practice’ but the presentation of such claims in
a work such as this is almost always problematic since the absence of a structured, or systematic, search strategy for the identification of research leaves the author open to a possible charge of partiality, or cherry picking.

Perhaps the greatest concern, for me, in this book’s presentation is perhaps the way it moves between the identity of the PIT model and the ‘conversational model’ – feeling almost as if an effort is made to cast off the ‘psychodynamic’ legacy that is still so clear. Thus, for example, the therapist’s emotional response and feelings are acknowledged as a resource to be employed, but without a firm acknowledgement of the way positive and negative aspects of this countertransference can be addressed; an area of discussion readily addressed in many modern considerations of psychoanalytic theory. In this manner, the theory’s position at the ‘mid-range’ perhaps risks losing many of the strengths of the legacy on which the book draws, sometimes in a seemingly uncomfortable manner.

Such criticisms are voiced solely as a point of discussion however since this book clearly offers a valuable position and succeeds in many of the challenges which it sets itself in approaching its broad potential audience. Its success in this regard is sufficient to recommend it as a point of reference and discussion for almost all clinical practitioners.

Andrew Shepherd
Book reviews editor
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Events, Notices & Dates for your Diary

Second in the Medical Psychotherapy Seminar Series 2017: Psychodynamic Psychiatry: Psychosis, Suicide, Trauma and Violence – Psychoanalytic Perspectives takes on Thursday 2 November 2017 at RCPsych, London. Further information can be found on the event website

The Winter Trainee-Trainer conference is scheduled for 26th January 2018 and will provide participants with an opportunity engage in an experiential day at the Cassell Therapeutic Community in Surrey. Further information will follow.

The Faculty of Medical Psychotherapy Annual Conference 2018 takes place between Wednesday 25 – Friday 27 April 2018 at the Radisson Blu Cardiff Bute Gate, Cardiff CF10 2FL. Further information can be found on the conference page of the website.

The Medical Psychotherapy Faculty Medically Unexplained Symptoms Special Interest group is holding its second meeting on Friday 29th September 2017, at the Tavistock Clinic in North London. Contact the organisers c/o of stella.galea@rcpsych.ac.uk
Your contributions to this Newsletter are welcome!

We would very much like to have more of a dialogue with our readership, and we are always grateful for any comments and contributions. We are currently publishing the newsletter twice a year, with Spring/Summer and Autumn/Winter editions. The deadlines are respectively 31st of December and 30th of June. Please send any articles or photographs to the editorial team via stella.galea@rcpsych.ac.uk.

We look forward to hearing from you.

Maria and Harriet

Contacts...

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