



Faculty of Medical Psychotherapy Executive Committee

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Editors' Welcome

Alison Jenaway



This is the last Faculty Newsletter that I will edit and it has a focus on the impact of Covid 19 on all of us. The articles range from thoughts about some of the social and political effects of the pandemic, to personal experiences of how training and clinical work has had to be adapted. As I am now semi-retired and have only been working one day a week for the NHS in a voluntary capacity, I have felt particularly disconnected from my team while working online, a bit like an astronaut floating out in space with only a crackling radio to communicate to the mother ship. How much worse must this feeling have been for many of our patients who struggle with isolation and loneliness? As I write, there is

a glimmer of hope on the horizon with the announcement of several vaccines which look effective and safe. The thought of being able to meet again in person, perhaps as early as next spring, is a welcome one. Thanks to all of you who have sent in articles during my time as editor, including those who have contributed to this issue. I hope that the newsletter has also helped people feel that communication and sharing one's experiences is still possible, even in these challenging times. The next editor will be Pamela Peters who is also based in Cambridge and who will no doubt be in touch to call for articles for the next edition. The deadline will be at the end of April 2021.

Editor in chief:	Current contributing editors:
Alison Jenaway, Cambridge	International voices: Charles Le Grice
	Trainee Voices: Alasdair Forrest and
	Michael Milmore
	Book reviews: Daniel Beales and Andrew
	Shepherd

Message from the Chair of the Faculty of Medical Psychotherapy

Steve Pearce



Dear Faculty members,

It has been a long summer, and it promises to be an even longer winter.

Most of our services have moved either entirely online, or into hybrid models of mixed online and face-to-face work. As many of you will know, this is causing complications for training, in particular in long psychotherapy cases that started face to face and have had to move online, but also in some places resulting in trainees having difficulties accessing training cases.

The closure of many services very early in the first wave of the pandemic, when it was perhaps anticipated that the demand for acute services would be higher than it in the end was, has not been repeated. We have had to get used to working from home with sometimes difficult and demanding patients. We have seen an increase in workplace-based stress and symptoms of burnout, and when people have been able to move back to the office, been reminded of the importance of physical contact with colleagues.

This makes the second lockdown doubly disappointing, with face to face work stopping again, and many people having to work from home again having moved back to the office, and when able go to the office finding it sparsely populated or deserted. It has also been disappointing for many of us that after a period of increasing face-to-face work, including for some people group work, most of this has now had to come to an end, we hope temporarily.

There have been some upsides. Many were sceptical in the early stages about the usefulness of remote therapy and assessments over video or telephone, and have been pleasantly surprised at how effective it appears to be, particularly once patients have got used to the new medium. Approaches that perhaps seemed least likely to be satisfactory, such as phone therapy, video group therapy, and even group phone therapy, have proved in some circumstances to be surprisingly useful and containing.

So we have all been learning new skills. We have also been learning the meaning of phrases such as “zoom bombing“, how to chair video meetings, how to deal with patients storming “out“ of a video consultation or video group, and how to handle suicidal patients and patients displaying disturbed behaviour remotely.

After an initial flurry of productivity to deal with the rapidly changing situation, the Faculty executive, and the College more widely, have settled into a more routinised way of coping with the challenges posed by the pandemic. All courses and conferences have moved online, at least until late Spring 2021, but this has not dampened the enthusiasm for psychological thinking among our colleagues. The Psychodynamic Psychiatry day conference on November 13th had almost 500 delegates attend, the highest number for a remote College event so far. Next year’s conference will also be online. Meanwhile, Chris Holman and Diana Menzies have been facilitating a monthly large group on Zoom, a spin off from the cancelled 2020 conference, to try to replicate as far as possible the large group experience of the conference, while simultaneously providing a resource to Faculty members over the period of the pandemic. This is an excellent place to connect with other Faculty members during this difficult time, as is the Faculty email list.

Best wishes

Steve Pearce
Chair, Faculty of Medical Psychotherapy
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Message from the Academic Secretary

Maria Eyres



I am writing this at the beginning of the second national lockdown, thinking about the strange way 2020 unfolded.

Unfortunately, we were not be able to host our annual conference in April due to the pandemic and the College was not able to offer us a virtual platform in the autumn, as their event calendar was already full. This feels like a real loss as the Conference offers us both intellectual stimulation and an opportunity to come together as a profession, renew old links and forge new connections, creating a support system that sustains us throughout our careers.

Many thanks to Andrew Williams and Saju Padakkara who helped to organise the 2020 conference but had to leave our conference committee this summer due to other commitments. I am very sorry that the conference we all worked so hard on remained only in our minds.

Luckily, a couple of our conference speakers, Jo Stublely and Sue Stuart-Smith, together with Jo O'Reilly, the lead author of the College COVID guidelines on organisational dynamics, agreed to contribute to the Medical Psychotherapy COVID 19 webinar on the 25th of June, entitled *Trauma, Containment and Recovery*. The webinar had some great feedback and for those interested who didn't have a chance to see it, it is still available by following the link [Free webinars | Royal College of Psychiatrists \(rcpsych.ac.uk\)](#) A big thank you to all our brilliant speakers!

Another legacy of the conference that didn't happen in the way it was planned but metamorphosed to something different, and no less helpful, has been a large group online experience. Very kindly, the group facilitators Diana Menzies and Chris Holman agreed to run 6 monthly large groups on zoom. The group has now been extended to take us through to our virtual 2021 conference in April.

The group was initially set up as a support group in the face of the consequences of the pandemic but has since unfolded as a place to reflect on the wider issues in our external and

internal worlds. The group is for the jobbing consultant medical psychotherapists and for senior trainees in medical psychotherapy. The aim of the group is to give us an opportunity to come together as a profession to discuss what is on our minds and to hear from each other, to hopefully feel more connected, supported and strengthened by this experience. I tend to think of the Faculty as my professional spiritual home, so I found it helpful to be able to connect with colleagues in this uncertain time.

I would very much like to encourage you to use it.

As for the 2021 conference, we know that it is going to be a virtual one. Parveen and I were joined this autumn in the conference committee by Vikram (a very warm welcome, Vikram) and we have started our work. Our two new experts by experience, Grace and James expressed interest in our work too and we are looking forward to future meetings with them. We decided to keep our conference title *Survival and Development; Exploring our Internal and External Landscapes*. We will explore three main themes, the pandemic, the issues of race and a climate change. They all seemed to us equally urgent to think about, the theme of climate change being a legacy of this year's "lost" conference which acquired an additional dimension in 2020.

And last but not least, the *Psychodynamic Psychotherapy Conference* in November attracted almost 500 delegates and goes from strength to strength, growing every year. Congratulations to Jo and Rachel!

Maria Eyres
Academic Secretary
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Message from the Chair of the Specialty Advisory Committee

William Burbridge-James



As I write I am aware of the emotional impact and pressure that the pandemic continues to have on trainees and their psychiatric and psychotherapy training, alongside the effects of separation for trainees working away from their families and home countries.

When we think about providing a setting for psychotherapy we usually think of the constancy of the regularity of the time, and place; the same room with the same layout, and same time each week for the sessions. This is to provide a secure base for psychotherapy to unfold, and the establishing of a working alliance. However it is also the state of mind, and well-being of the therapist, and their ability to tend to the environment and be in a receptive state of mind where they are open to the verbal and non-verbal communications of the patient. It is the job of the organisation, supervisors and trainers to support trainees in this endeavour and help contain their anxieties so that trainees can in turn do this for their patients.

Feedback from colleagues has validated that it has been helpful for the Faculty and the College to have clear guidance that it was considered to be too complex for trainees to start working remotely with new patients; although it may be more suitable for some psychotherapeutic modalities. Trainers have then been able to work at an organisational level to ensure that trusts meet their responsibilities to provide COVID assessed secure settings for in person therapy, even if this is having to work with additional PPE and behind masks. The latter is an added dimension where eye contact becomes the predominant form of facial contact in the absence of the totality of the face, especially our mouths.

I am also aware that other colleagues have also been initiating remote therapy for trainees under guidance and the Faculty produced their own helpful guidelines for remote working in May. [Faculty of Medical Psychotherapy Remote Therapy Guidelines](#)

The ground is constantly shifting: - we moved back into a national lockdown in early November and now into the tiered system, with the prospect of the vaccine imminent. Uncertainty is all around, while we need to continue to ensure that we provide secure bases to help our trainees feel contained, and to progress in their training, developing as psychotherapeutic psychiatrists and help their patients.

The SAC will be undertaking a survey to assess the impact that the pandemic has had on psychotherapy training and trainees' experiences.

The work of the SAC has continued and in October we submitted out higher training curricula, along with all psychiatric specialities to the GMC curriculum assessment group (CAG) and we are awaiting their feedback.

Please contact me if there are specific training concerns related to medical psychotherapy.

Wishing colleagues a good Christmas and 2021.

William Burbridge-James
Specialty Advisory Committee chair
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THE DYNAMICS OF A GLOBAL PANDEMIC

Some circular thoughts in response to the pandemic

Kate Dufton

What do the current awakenings of the climate destabilisation, the [Covid pandemic](#), [Black Lives Matter](#), [Michael Marmot on inequality](#) and [the strain and stress in the NHS](#) have in common?

They have certainly gained attention in the health community as a whole in a way that feels different. With the pandemic it was inevitable as a major health emergency, but this autumn in the RCPsych alone there has been a South Asian History month, an African and African Caribbean Psychiatry Online Conference and two half days on “How to be a Preventative Psychiatrist”.

So, I am expecting with the invitation for the newsletter to share experience of the transition to working online, that there may also be responses to the way the pandemic has brought issues of inequity and the symptoms of ecological strain to the fore. After all, while these issues are huge threats; the biggest [threats to global health](#), they also present [health opportunities](#) - ways to make it better.

Psychotherapy has suffered from an industrialised efficiency mindset, with the best of intentions, as much as has the rest of medicine and of course we want to do the best with the least. But an industrialized monoculture is only one way, a way that is likely to be part of how things will be, but not the only way. The metaphors here are about gardening and farming and echo the question which has been asked of our farmers – can farmers be engaged in a reciprocal regenerative relationship with the soil, the land and its creatures or do farmers in fact need to be a kind of miner extracting resources without replenishment. And in health care can we have a regenerative, relational psychiatry or do we work to protocol, extracting maximum efficiency and possibly heading for diagnosis by computer and medication delivery by drone, as I heard described by one very busy CMHT consultant at a conference last year. And as the tide could be turning for farming, so it could in health care with a growing and necessary emphasis on the reciprocal needs for the wellbeing of health professionals who cannot do a good job if they are resource depleted.

Some years ago, because I was doing a teaching session on formulation, comparing different approaches, I tried comparing the different ways of formulating our difficulty responding to the climate crisis – or actually in even thinking or talking about it at that point. I found myself facing into the relationships of entitlement and exploitation which underpin these issues and how these are rooted into our childhoods as individuals and our colonial past and our exploitation of each other – I was reminded of a particularly ghastly version of this while watching a World War One film last night. With CBT I found myself facing the opposite of “unhelpful ways to think” that lead to depression – a kind of manic denial and dismissal. The problem here became a binary with its risk of splitting - minimisation or catastrophism, me or them. And thinking how these binaries maintain each other, I was struck by how my collie dog when faced with conflict runs in circles. These formulations led me to a circle of thinking which was more reciprocal and regenerative between my work and the ecological stress and risk. I really got the Lancet and others on how this is an opportunity as well as a tragedy. How in psychotherapy we may have a bit of the jigsaw puzzle in working with the difficulty of making change and we may learn from those who are working at this particular need for change. Explaining to others I found myself saying we know we have a problem, we have solutions. The problem is the gap between the two and in there must be the psychologies and psychotherapies of change along with politics and social action.

So this led me to the kind of work William Burbridge-James summarised in his review of Roger Duncan’s *Nature in Mind: Systemic Thinking and Imagination in Ecopsychology and Mental Health* in the last newsletter. If I could bet, I would, that ecopsychotherapy and understanding how nature connection is critical for our wellbeing and can be part of curing and healing, will be an important frontline in coming times. And I mean both the science on how, for example, soil microbes may help prevent inflammatory conditions but also how a [nature “metaphoray”](#) gives us structures for thinking and relating which are inherently human and good for us in a way that machine and factory production, and military models may never be.

It was more than my collie dog that highlighted the importance of circular thinking. I found it again in [Kate Raworth’s Doughnut Economics](#). Finding a zone of working between impoverishment and overshooting planetary boundaries and her chapter on the benefits of a new visual framing; a doughnut rather than a growth line pointing upwards as our picture of a healthy economy (unchecked growth is cancer). Perhaps we might have a “doughnut of tolerance” rather than a “window of tolerance”, which perhaps leads to different thinking about what is outside the zone of tolerance?

The circles are also about reciprocity and regeneration in our relationships. I remember in my second job in psychiatry when I found out about transference and how in a very stuck relationship with a patient it provided a regenerative source of ‘what next’.

This, I think, links to this year's Faculty conference which couldn't happen but which Maria Eyres enticingly described in the last Newsletter – *“Survival and Development; Exploring our Internal and External Landscapes. While the body has become more visible in the consulting room in recent years, thinking about our patients' spirituality and the external reality outside the consulting room, including the physical environment, might be less present”*. Our spirituality and external reality outside the consulting room can be part of a turning of attention and an inspiration but this requires quite some working through.

This is the last slide from Peter Byrne, RCPsych Lead for Public Health, at the *Preventative Psychiatry* conference.

What do we need to do?

1. For trainees New Curriculum; influence other groups
2. At consultant level, refocus SMI health: cigs, other Pv?
3. Every MH Trust needs PMH leads: protected PA(s)
4. Leadership on Prevention within every faculty
5. Single, unifying RCPsych stance on Poverty-Inequality
6. RCPsych leadership on resourcing Prevention, because it works, and “following the science” – we cannot wait for NHS-D, PHE, ONS to package data
7. New leaders: PMH + Sustainability = Prevention

The [Climate Psychology Alliance](#) brings together, in a community of enquiry, psychotherapists and psychosocial researchers and others interested in exploring how the depth psychologies can help in “facing difficult truths” and free up thinking and feeling and help us “through the door” from our consulting rooms but also in our rooms in working with the impacts of it all. It is notable how CPA members often still describe feeling alone with these concerns – and certainly that has been my experience. It looks like the spiral of silence is turning the other way now.

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Society and COVID- using some psychoanalytic concepts to understand group dynamics

Alina Vaida

There have been many discussions about how the COVID crisis is going to impact the population's mental health on an individual level but I also find fascinating the impact on society as a whole and how different nations used different defence mechanisms while facing the same threat. By using the psychoanalytic understanding of groups' dynamics, it can help us make sense of the powerful processes at play. This paper is based on my interpretations and reflections, it is not meant to be a scientific truth.

My reflections involve the lived experience in the UK and the lived-from-a-distance experience in Romania, as most of my family and friends are there. I also kept in mind the impact on other countries, for example USA. I will shortly summarise the impact on different countries and what sense I made of it.

The situation developed quickly in Romania. When only eleven people were confirmed COVID positive out of a population of 20 million, gatherings of more than 50 people were forbidden and, shortly after, the schools were closed. Here in the UK, the message about "many more families will lose their loved ones" came at eleven COVID deaths but it took a few more days to actually start some significant restrictions.

We all know what happened next but what I found interesting was how different countries reflected different group dynamics in dealing with the crisis.

Romania closed the borders quickly and instated an institutionalised quarantine for everyone coming into the country. There are more than a million Romanians living in Italy [1] and with the crisis unfolding there, many headed towards "home". However, "home" wasn't home anymore as people from inside the country quickly perceived the threat and became very vocal, on the verge of aggression towards anyone trying to go back. This was fuelled by the media with the complicit participation of the politicians who were transmitting desperate messages "please don't visit for Easter". From very early on I could see a subgrouping organisation, between "insiders" and "outsiders". Then followed a split between the "infected" versus "non-infected" as many cases of infection were public in the early days. When the whole of Europe was shut down the rhetoric of the emigrants coming back started to die down but only to be replaced by another societal split, between Romanians and the Roma minority. With a complicated history of slavery and discrimination, the Roma community is poorly integrated, with high incidence of poverty

and societal segregation, many of them living at the cities' peripheries; many Romanians (68% according to an opinion poll in 2010) [2] perceive the Roma's criminality rates as being disproportionately higher. The themes in the media and online were about Romanians following the rules whilst "gypsies" (derogatory term for Roma) were gathering in large groups, not respecting restrictions and "recklessly infecting everyone". It was the same theme of splitting but the 2 subgroups changed. Then it was the old versus the young, with young people complaining that they were staying in to protect the elderly, while the elderly were shamed for being outside, "enjoying the sunshine". Another splitting followed between the church goers who benefited from some exemptions from lockdown at Easter versus the ones who didn't value the religious rituals. It felt like a long string of subgroupings and splitting between the "good" versus "bad", with constant tension and anxiety and a sense that anger can get out of control. The fight didn't seem to be so much against the virus and its consequences, but against the infected and the groups they belonged to. This resonates with a paranoid schizoid state of mind [3] when everything is split between good and bad, while omnipotently rejecting the bad - the threat of infection in this case- and projected into the "other", "the infected". The ones who follow the rules are idealised, become the good objects while the ones perceived as reckless become the bad objects. The death instinct is reactivated by the actual death threat represented by the virus. In terms of group understanding applying Bion's theory, it resembled a fight – flight organization, stuck into continuous fight. [4]

In the meantime, I was going through lockdown in my life here in the UK with my immediate family. Initially things were progressing very slowly but when it started, it felt like a rollercoaster. The initial denial of the threat with the plans to "mitigate" rather than "supress" [5], alongside the repeated mentioning of the plan led by science and its "world leading scientists" created the idea that we had a specially designed, made in the UK plan, rather than just a copycat of other successful countries. Now, looking back it seems an infantile narcissism [6], created both by self-importance but also accentuated by the surprised gaze of the whole world looking to see what the rebel child of (non) Europe was doing. After the initial shock of the plan change mid-crisis, I was pleasantly surprised to see that the developing narrative was that "we are all in this together". The outpouring of support for NHS, the clapping, Captain Moore, many freebies and discounts for NHS staff contributed to a positive message of hope, resilience and fight against the virus. The rhetoric was about the war against this "terrible virus", "the disease". It seemed that the badness was projected onto the virus and the population was left feeling good, heroic and capable of sacrifices. We were all the "good British people" following the rules and protecting our NHS. It was like every rule followed equalled a life saved. It was beautiful and enlightening but also terrifying as I could feel a paralysing anxiety. What surprised me throughout was the high compliance with the rules without strict enforcement of the law. Although it seemed to come with a renouncing of judgement and almost robotic rule following. On many social media platforms people seemed to beg for more and more rules;

many comments stated requests like “we need a longer lockdown”, “please, don’t open schools”...There were sad stories of people dying alone in hospitals as visiting was not allowed although this changed in many trusts during the pandemic. But it felt like people renounced the need to say goodbye, to have close human contact, all in the name of the fight against the virus. Was it worth losing the human aspect of dying? It is a rhetorical question but what was obvious was that many people made sacrifices which are very hard to comprehend in other circumstances. Arguably, they were needed but for people who didn’t have the chance to hold their dear ones before they passed, maybe it is worth having a public discussion to help future planning.

What makes a society unify rather than divide in subgroups? Was it the history, the sense of duty, the analogy with the war, the fact that we have a Queen as the head of state under which we can all stand together regardless of political inclinations? The death anxiety was amplified by the rhetoric about the war and all badness was projected onto the virus and people became good and heroic. The sacrifices were more for the other rather than self, because to do otherwise would mean to be murderous. If we apply Bion’s theory to understand the society as a group, it resembles a dependency group, when the group is passive and acts as if the leader is omnipotent. Although Boris Johnson was representative of the “leader” for many people, for others this role was more ambiguous, being taken by the “scientists” or the NHS. The population was given very specific prescriptions about their daily lives and the majority accepted it as a public duty; we were all in a regressed state of mind and thinking about the measures in place was not necessary and not desirable. Or perhaps it resembled Hopper’s massification, when the group behaves like a “mass”, replaces thinking with slogans and subgrouping is not possible by definition. [7]

Things started to change in late April – May, with more and more media articles about government failures, lack of PPE and the very high death toll; the resentment and anger towards the government were increasing. It felt that people started to have different versions of reality. I remember a statement on social media from the early days of the lockdown, with someone asking, “why can’t people just stay in their gardens?” This sums up the problem with the lockdown as it is a luxury for the middle class but not an easy task for the deprived or less fortunate. It turned out that it wasn’t only increasing the poverty gap but disproportionately killing more people from BAME backgrounds. The “we are all in this together” proved to be an illusion. [8]

So initially there was unity, the fight of good people against the deadly virus; the badness was placed on the virus but gradually also on the government for not acting soon enough. The anger towards the government was intensified following the Dominic Cummings’ story [9] when the unresolved trauma of making very difficult decisions came to light. How was it possible to follow “common sense” when we all sacrificed everything without questioning? It felt like an awakening from a hypnotised state with more anger and distrust surfacing.

Interestingly, in the US there were different group processes at play. There was lack of trust in medical authorities and the science about the virus. We saw protests in several cities quite early in the pandemic, with people asking for “freedom”. Part of the population complied with the restrictions in place but there was not a sense of unity, at least as it was portrayed in the media [10]. Conspiracy theories were rife and some crossed the ocean leading to 5G masts being set on fire [11] and the anti-vaccination discourse came to the fore. There, the “badness” seems to have been placed on the perceived authority that was described as malicious, perverted, following their own interests.

In summary we have seen the same threat leading to different group dynamics in different countries. In Romania, there were several subgroupings, with societal splitting between “good” and “bad”; the badness was placed on the “other” carrying the virus. In the UK, we saw an abandonment of thinking and strict rule following, the badness was projected onto the virus and later also on the government. In the US, the badness was projected on a global conspiracy and the medical authorities (including pharma, Bill Gates [12]). For Romania, a possible explanation is long history of lack of trust in others resulting from communist practices of people spying each other. Here in the UK, it tapped into the analogy with a war situation and the desire to save and help others. In the US, it may be due to their more extreme capitalisms, with a higher tendency to see reality through its monetary value.

How did it evolve? Did we shift from dysfunctional organisations to healthier ones? Not yet. In Romania, the shift was from fight to flight around June, with reports of large crowds enjoying the sunshine at the beach and a temporary sense of victory. But by July the number of cases and deaths started to rise more than during the initial wave. The organisation reverted to the “fight” mode, with some people being seen as “responsible”, who follow the guidance and others as “conspiracy theorists”, mainly corresponding to the political spectrum, right leaning versus left.

In the US and UK we saw the anti-racism protests and a different organisation of groups, initially towards massification [7]. There were no apparent subgroupings initially as everyone seemed to come together for the same cause, at least as a discourse. According to complex theory, we need some anxiety (or tensions) to make changes happen. Too little leads to a stilted non creative status quo, too much leads us to “chaos”; the desired position is “at the edge of chaos” [13]. In the UK we saw many organisations taking a stand against racism and committing to change. In the meantime, some US states saw long term protests without apparent resolution. [14]

Another important observation is about mask wearing. In Romania and the USA it seems more of a political statement rather than a strictly epidemiological measure; if you don’t wear one in the USA, you are more likely to be a Trump supporter or, in Romania, you risk

being called a supporter of the populist party. Both countries have had or are due to have elections this year and the main media outlets are perceived as leaning towards one or another political end of the spectrum. In this way, the fight organisation is intensified and people are labelled as belonging to one camp or another without any middle ground.

What I think that the UK did very well (although many would struggle to see positives) in terms of society dynamics, is that we managed to avoid juxtaposing a fight organisation on top of a political divide - the fact that the Opposition supported the measures in place indubitably helped. Having the BBC also helped cohesion, holding a more balanced view with a focus on keeping people together, rather than channel TV news that are known for their political leanings (CNN versus Fox News [15]). Different scientific views are better tolerated in the UK (eg Prof Gupta, [16]) and not immediately branded as “denial”, which opens the door to conversation. The difficulty now is that we moved from the initial “we are all in this together” to more nuanced and diverse opinions and preferences. The unification against the virus doesn’t seem possible at this stage; a healthier strategy is continuous dialogue and negotiation, without tipping the balance too much towards fear or denial. There are more and more voices asking for a more personalised approach, indicating that people are not willing to renounce their thinking ability anymore. The main risk is a shift towards a fight organisation, between people who are worried and support lockdown measures and people derogatively called “deniers” who prefer a life closer to the pre-COVID “normal”. The initial “togetherness” in action needs to be transformed into togetherness in thinking and negotiation. It is still a long way ahead of us.

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This essay was submitted for the Zoonia Nazir Memorial Prize and received a commendation.

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CONTEMPORARY PRACTICE IN MEDICAL PSYCHOTHERAPY

Masking over: Reflections from primary care on the effects of COVID-19

Matteo Pizzo

‘Don’t come here, we’re all going down with it’, said a GP in her email to me, when I asked about popping in to speak with the staff about how they were managing. It was the end of March. That same week I pushed on the door of another of my regular GP practices and found it was firmly shut. I called to the reception window: no answer. At yet another practice we were asked not to attend for what eventually turned out to be almost three months. What had happened to all the hard work of building numerous relationships at the GP practices we have links with? What about all those room spaces we’d negotiated, the familiarity we’d built with the receptionists, the nurses and doctors, with the kitchen spaces and corridors?

Little by little, as we headed into summer, the doors began to open a crack and we slipped back in. It was a huge relief to see many of our GP colleagues face-to-face again. But this was not primary care as we knew it. As I was leaving a GP practice, in the glow of my return to clinical work there, I was confronted with a man standing outside the entrance, yelling his

date of birth and prescription request into the intercom. He looked angry and humiliated. A few members of the public at the bus stop nearby raised their eyebrows and they overheard the fraught exchange. I knew the reception room to be empty, the staff working behind a tall Perspex screen. Would it not have been possible to invite this man in for a calm conversation at the desk? I was left feeling very uneasy, thinking to myself: 'what kind of experience is this?'

There's been a relentless deluge everywhere of 'keep out', 'steer clear', 'go away'. These invocations to non-existence are familiar to many of our patients. Most have early life experiences of neglect, indifference, and hostility, a kind of 'I wish you were not here', 'your presence is toxic' communication. These are often replicated in life 'out there', with housing evictions, benefits docked, and forever-lengthening waiting lists. Now it seemed as though this culture of 'go away' had properly infiltrated 'health' and 'care' services. What has emerged is the 'cult of coronavirus'. Of course, it's got precious little to do with a virus. Coronavirus has become the reason to enact hostilities whose power I had underestimated. At the core is an attack on being human. There are all sorts of things that are disturbing about being human: we have bodies that can become sick and die, we host viruses and bacteria, we have bodily fluids, we have need of one another for care and comfort, and we want and need to touch one another. With coronavirus as the reason, we've embarked on a quest to render ourselves and one another as little human as possible.

How can we do our work in the midst of all this? Indeed, what is our work about? I see my primary task as making contact with others (patients, colleagues, systems), in order to see what meaning can be made from discomfort and suffering. I had taken my primary tool to be my mind. However, over the past seven months I have understood that just as important in this task are my body and face. Being physically present and sharing space with others enables the proper metabolism of the embodied experience of suffering. I may not touch my patients, but for them to be able to see, hear and (hopefully not too often) smell my body offers them a reality-orientating experience: we are here, in this moment. I may feel like your hostile mother, but I am not she. I can see your tears. You can see my mouth.

A few months ago, in a joint consultation with a GP, a young woman came to see us. For some years she'd been afflicted by persistent bodily pains. She began telling us her story. After a few moments, looking at my (bare) face, she asked if she could take her mask off. I nodded. Almost simultaneously the GP also removed her mask and all of a sudden we were three human beings in the room, our faces available for the work before us. The young woman told us the very painful story of having been captured by the Taliban some years previously. Her (masked) captors abused her. We heard her out and made some gentle links between what she'd experienced and her current state of suffering in body and mind. I thought this work was possible thanks to the witnessing and containing presence of bodies and faces in the room.

In another joint consultation with a GP, another young woman began to tell us about her suicidality. There was a sterile, inhibited, two-dimensional quality to what she was bringing. I asked her why she thinks about ending her life so much. She looked up, and asked to remove her mask (having noticed that the GP and I were not wearing one). In floods of tears came her account of childhood sexual abuse. This was the first time the GP, who has known the patient for years, heard this harrowing story. It would not have been possible by video consultation, or by phone.

The risk of transmission of coronavirus can be reduced by taking up seats with sufficient physical distance, keeping the window open for ventilation, making use of tissues should we need to cough or sneeze. Even though the task of reducing the risk of coronavirus is important, I do not believe it is our primary task. Our primary task, as far as I understand it, is pursuing a messy, unpredictable and relational meaning-making endeavour, which involves bodies and faces as much as minds. Safety (understood only in relation to coronavirus transmission) has taken up a perverted position of power in our society and organisations. Human contact, and the development and negotiation of relationships, is not safe, and nor should it be. It involves risk, which leads to the possibility of change and transformation.

Not having human contact and not being able to see one another's faces also involves risk, sometimes so much so that it contributes to terrible isolation, to mental breakdowns and suicide. A patient known to our team recently took his own life in a horrendous, shocking and violent way. As I was mulling it over it struck me that the patient did not know what the faces of clinicians he had met (in person, with masks) looked like, and they did not know what his face looked like. What is it like to have been in the room with a patient who later commits suicide, and not to know his/her face?

I've heard relatively little from psychiatrists and psychotherapists about the dehumanising effects of lockdown, of mask wearing, of (anti)social distancing. Guidelines about working online emerged very quickly, and there's been quite a lot of praise about 'new ways of digital 'working''. It's all rather rushed to me, perhaps a defence against knowing the enormous losses incurred when human beings are no longer regularly in the room with one another. Is it time to begin to talk about it more openly?

In the face of too many 'go aways', might we bring back 'come here', and 'you're welcome'? If so, how?

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Virtual containment in a time of chaos: Reflections on facilitating Balint groups remotely

Rebecca Cunningham, Emma Fisher

Prior to COVID there most likely would have been a lot of resistance to any suggestion of doing a Balint group remotely. We now find ourselves thrust into this way of working without choice. Thinking about this as a polarised good versus bad debate is therefore probably not helpful. What we did feel was helpful however, was reflecting on the challenges and benefits of facilitating Balint groups online and trying to learn from our experiences as we adjust to this new online world.

When lockdown initially commenced, weekly teaching for trainees and other doctors within the trust stopped for a period of time, before being re-established several months later online. Perhaps this was congruent with an initial immobilisation of psychological resources in the face of a global pandemic and the threat to our personal existence. Some juniors were redeployed to acute hospitals and emergency care was prioritised. This meant that opportunities for trainees to meet were reduced and there were concerns about the impact this may be having, including increased isolation.

Although face to face Balint groups had to stop, it was quickly realised that Balint and other reflective practice was more important than ever as we faced the trauma, distress and uncertainties that COVID brought with it. Immediately, the existing Balint groups for psychiatry core trainees were shifted to an online format and an online Balint group for higher trainees in psychiatry was established in April 2020. In the trust, there had also been recent demand from foundation doctors for a Balint group. As two higher trainees; one with formal Balint facilitator training and one with a special interest in psychotherapy, we agreed to start a group for foundation and GPVTS doctors, supervised by a medical psychotherapist. As our decision to start a group coincided with the beginning of COVID, we decided to set up an online Balint group and we have now co-facilitated two 8-week online groups for foundation doctors and GP trainees together.

The virtual effect

We have found many benefits of the online format. It certainly feels more inclusive. An in-person group would mean choosing one site within quite a large geographical area for the group location and so logistically and practically, would have excluded participants on distance and travel time. A 'virtual' distance however, seems at times to inhibit a natural flow of conversation from one participant to another and can feel more like stilted turn taking. Non-verbal communication and cues are difficult and, as facilitators, we often found

ourselves working harder to keep the conversation going and pick up these nuances. Of course, this is added to working with (or rather against) the technical hinderances that can seriously impede communication.

Holding the frame of the group has proved challenging. There are obvious aspects of a traditional Balint group which just cannot be recreated online (at least not without some serious creativity!). Having an empty cyber 'space' just isn't the same as the empty chair. Anyhow, even knowing who was missing at times often felt hard to keep track of for several reasons. Firstly, we found that several participants seemed to prefer having their cameras switched off, and, particularly in our second group, we found that people felt it ok to pop in and out (even during sessions) and the stability of a core group never really felt established. One particular session comes to mind when we had a doctor who joined and left several times. Later this doctor wrote his apologies in the 'chat box' and explained he was conducting a clinic at the same time. Meeting online definitely makes it easier to multitask and I'm sure we can all put our hands up to this, but in a group setting that relies on the presence of its members, this felt far from ideal! We found that our numbers fluctuated quite significantly, ranging from 2 to 12. This felt quite different from our own experience of being members of Balint groups and facilitating prior to COVID, which we agreed had been more consistent.

Cyber embodiment

Our juniors did not have the luxury of their own trust laptops as we perhaps took for granted as higher trainees. We found that as a result, participants often shared a computer. When cameras were off or unavailable this made it hard to get a feeling of the group size and establish individual identity. Consequently, we struggled to hold group members in our own minds. When cameras were on and people were sharing screens, it created quite a peculiar dynamic. We observed how these pairs would often seemingly unwittingly join forces and almost merge to become more dominant and we wondered about the effect this may have had on those sitting alone. Seeing these pairs turn to look at each other felt like a reinforcement for the rest of us of this loss of non-verbal relating and created a sense of mourning of the loss of being in the room as a whole group. We found ourselves wondering to what degree online working may have on unconscious communication and reflected a feeling of being detached and distant at times. Alessandra Lemma recently spoke about online working from an analytical perspective during a conference (*The Disrupted Frame*, Confer, October 2020). Here she spoke about how we embody space within the therapeutic setting when in the room with the other and the altered experience of this online. This certainly relates to Balint groups and although we are still embodied online, it seemed to us that certain elements of the importance of embodiment were taken for granted until lost during the switch of frame.

When cameras were turned on, they gave us many insights into the personal lives of our participants who were joining from home. This created a sense of inequality and potentially evoked envy in those who were donned in scrubs and stethoscopes, running from the wards to the communal coffee room, who had to look at those in comfortable clothing lounging on a sofa, or even bed. A private space can easily become contaminated with one's personal lives including their possessions and significant others. This leads us onto another very important point, that of confidentiality.

Holding environment or leaky container?

In a traditional Balint group, the room acts as so much more than just that. It is a safe container where, as facilitators we encourage our group to share not just clinical case material, but also to brave exchanging with each other countertransference reactions. To a junior doctor who is new to Balint, this can feel quite alien and exposing. In an article that predates COVID with the opening part of the title *Any room won't do*, (Elisabeth Punzi and Christopher Singer 2018) the authors explore the meaning of the psychotherapeutic room and one conclusion drawn is the importance of spatial stability in holding and containing. The question we found ourselves asking was, Can the online environment be a suitable replacement for the room? And if so, how can we ensure maximum stability? Of course, Winnicott writes quite prolifically about the *Holding environment* (Winnicott 1960), in which he is referring to both the physical and psychological importance of the environment. We wondered what he would make of the new cyber environment!

In our reflections, the term 'leaky container' took on several meanings including the leakage of confidential clinical material to outsiders by the lack of the physical four walls as well as concerns over the psychological containment of our group members, which felt very different online. Despite our encouragement that group members find a private room and our offer to book rooms for them if needed, there were still instances when communal areas such as the junior mess or coffee rooms were used. Consistency of the setting invariably adds to the sense of safety in a group. This was definitely disrupted and the variety and change in backgrounds and settings of our members was striking.

Despite these confidentiality concerns, we found that material brought to group was varied, interesting and allowed plenty of reflection and rich discussion. We both agreed that a move to the online format hadn't particularly affected this aspect of Balint. Often there were quite long silences when asking who had a case, and we wondered if presenting online felt more daunting and unfamiliar. However, the general experience was that once a case was identified and presented, things warmed up. The themes were often topical and included aspects of working during COVID. However, this was not always the case and the material brought often felt very familiar. This familiarity was probably a reflection of our group members wanting to retain some normality or vent their difficult feelings evoked in working within psychiatry, COVID or not.

Guardian of the boundaries

Being guardian of the boundaries is arguably the most important task of facilitating a Balint group in any setting. We both agreed that this was much harder online. Whilst we were mindful that maintaining the overall structure of the group was of great importance and generally possible online, we found other boundaries more difficult to maintain and the group became more chaotic. This included eating and drinking in sessions, arriving late or leaving abruptly, not sending apologies and generally less of a sense of commitment to the group.

Working online can sometimes be felt by both clinicians and patients as being less formal or inferior to meeting in person. Although we felt that some of this came directly from our group members, we were also mindful of our own conscious and unconscious biases that we may have acted out. For example, on one occasion we both had other commitments come up last minute and had to cancel a session. Without thinking too much about this at the time, we later found that for a few weeks after group numbers were low and members sent late apologies or just didn't attend.

With the aims in mind

None of our members in either group had experienced Balint previously and so this online experience is the only Balint they have known. Perhaps it is our own experience of both in person and online groups and the contrast that has led to some of these aspects discussed above becoming evident. Our feeling that at times, our group members were being short-changed, may not have been shared. The feedback obtained was positive and to quote one trainee directly; *"This was my first experience of Balint and I feel it has been so helpful in allowing time for reflection, consideration of my colleagues and patients perspectives and developing my own resilience. I have really enjoyed being pushed to consider the psychological considerations behind the circumstances discussed and to develop this analytical thinking. I would definitely advocate for the group continuing for future foundation trainees rotating through Psychiatry and can see how beneficial it also could be across all specialities of medicine."* This feedback and others received was reassuring in that we felt that the overall aims of Balint group had still been achieved without too much obvious detriment of the online setting from the perspective of the group members. Another trainee commented in their feedback *"It has been reassuring to me that my peers have experienced similar difficulties and frustrations to me. I have also had useful insight into difficult patients or interactions and how to effectively manage them but not to personal detriment"*. The importance of knowing that we are not alone in our experiences or struggles is even more crucial during this pandemic, as feelings of isolation are all too common.

Now as a second lockdown hits us and no obvious end to the pandemic in sight, the trainees' feedback has given us the drive to push on with online Balint groups. However, we will be sure to learn from our experience so far, as we feel our way through this virtual new training experience.

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REFLECTIONS ON PSYCHOTHERAPY TRAINING DURING COVID-19

Pandemic Psychotherapy – a COVID poem

Anna Crozier



When life as we once knew it changed almost overnight,
Our feelings were conflicted, poised ready for a fight.
Where's Jung when you need him? Maybe *he* could shed some light
On our Collective Unconscious as we navigate this plight.

Please stop Idealising the Maternal NHS.
When Good Enough stopped being good enough I got depressed.
I need someone Preoccupied with my internal mess.
Winnicott Hold *me* through Freud's Return of the Repressed.

'Splitting and Projection; they suit me' I told Klein.
'That soothing Omnipotence that occupies the mind.
I Denigrate Play Therapy'. She stopped me to reply
'Those Primitive defences, fail all of us in time'.

What I wouldn't give for some Containing Function now.
A Basic Assumption is that *Bion* will know how
To support our Group Mentality when we are breaking down.
When his Reverie brings forth the Nameless Dread we'd disavowed.

Freud's instincts and libido have *died* with him it seems.
My Id is freed from those interpretations that he gleaned.
My Super-ego's grieving but my Ego's quite relieved.
He'd have a field day with the latent content of my dreams.

So don and doff your PPE and cleanse with anti-bac.
Dispel COVID deniers and rabid anti-vaxs.
In surviving as your mental health's assaulted and attacked,
Take comfort in the knowledge that the College has your back.

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Psychodynamic therapy training during COVID-19 – a trainee perspective

Ellena Sheldon

I am a core trainee in psychiatry working in Cornwall. I work less than full time and returned from maternity leave just prior to the first 'lockdown' in March 2020. I have found the impact of the COVID-19 pandemic a challenge, but there are definitely positives to reflect on as well.

I have been fortunate that during COVID our training has continued. All our teaching, clinics and meetings were swiftly moved online and we use Microsoft Teams for teaching and meetings, and Attend Anywhere for clinics.

On reflection, I have really enjoyed having teaching and training online at home. It has meant I can take a proper break, for example, watering the tomatoes in the garden. It has also meant I can finish on time and we have more family time in the evenings. I think the quality of the teaching has been maintained. Although I have noticed an impact on the group dynamics among the core trainees.

We are a cohort of 11 core trainees in Cornwall and we are often joined by Foundation Doctors and GP Trainees for our training sessions. This means we form close working relationships, and friendships too. I have really missed seeing my colleagues face-to-face, and hearing about their latest job rotation or simply how things are outside of work. This impact has been felt greatest among the cohort of new core trainees who started in August 2020. I still have not met either of them face to face. This means we have missed out on a lot of the usual informal induction and welcome. One of the trainees is hoping to arrange a meal for us all, when it is safe and legal to do so and I think this will be really important.

The uptake of using *Attend Anywhere* for clinics took a little while to establish. I was an ambassador among the junior doctors and found the experience really positive. Anecdotally there have been fewer patients missing their appointments. Although this is yet to be verified with an audit! We know there are pros and cons to working online, but as a working mum myself, I can appreciate the fact that an appointment online can take a lot of the stress out of travelling to a medical appointment; especially in a county which is geographically spread out like Cornwall.

The training delivered over Microsoft Teams has been excellent. One of the most impressive things has been the continuation of psychotherapy training. Interestingly, Balint group works very well online. I think this is because the person presenting can physically mute their microphone and sit back as the other trainees discuss the case.

I have found meetings over MS Teams a little more challenging and they are somehow more intense and tiring. Furthermore, there seems to be less of an even spread of conversation among trainees. It's harder to read body language and pick up on some of the cues that would enable a more natural conversation flow. I think over time, this has improved as everyone has adjusted to meetings online. I am pleased that there is a culture of having the video on in Cornwall, and I think this is important in maintaining engagement within the team.

I started psychodynamic psychotherapy with a patient at the start of lockdown. All our work has been online. This has been a learning curve. Some of the positives include being able to be on time for every session, as I have not had the challenge of Cornish traffic prior to an appointment. I believe that has helped in the process of containment. Furthermore, I have been able to attend more sessions than I otherwise would have done i.e. after an online mandatory training course. I think that it took us both a couple of sessions to adjust to meeting online, and perhaps the start of therapy was a little slower than usual. However, we've discussed this in supervision and my supervisor feels this has not had any lasting impact on the therapy.

I am seeing a young adult, and during our supervision, we have discussed the impact of the patient attending therapy within the family home. It has allowed my patient to present themselves in a vulnerable state, for instance in their pyjamas, which would not happen in a clinic. I have been able to see their home environment and gain a greater insight into their life than I otherwise would have. However, it has also meant the therapy is always within the presence of their parents. Occasionally my patient has whispered things they would be embarrassed about their parents hearing. I feel it's symbolically important for the therapy to happen outside of the home, when safe to do so. This is because the work with young adults often involves working through the challenges of the separation phase, or Jung's archetypal event of leaving the parents. We hope to meet face to face soon and I believe this will have a positive impact on our therapy going forward.

Towards the end of the lockdown, there was a feeling of relief but there was also a lot of fatigue among staff. I often heard nurses reporting that it was like working a 'Christmas Season' every day. The on calls got significantly busier and the turnover of patients was much greater than usual. This was helped by the positivity and support offered amongst staff, and by management. The trust was very supportive. We were fitted with the correct PPE, and adjustments to working patterns were made in good time. Furthermore, we had a free lunch everyday as a token of gratitude. This did wonders for team morale and really boosted everyone's spirits at a time of great uncertainty

I found the increased demands at work, with the increased demands at home very challenging. There was a considerable period of time where I was working from home (I work 60%). My husband was also working from home full time and our little boy's childcare had closed. The alternative childcare provided by the council was a large 'hub' in West Cornwall. As he'd only settled into childcare a couple of months before lockdown, we decided against another change for him. I am grateful for my knowledge of attachment theory and the understanding around early years stability and love. This was a big sacrifice for us as a family but I know it was the right decision. Luckily the weather was good, so we would tag-team looking after our little boy, usually in the garden, while the other person worked. It meant working most weekends and evenings. However, we made wonderful family memories and we were spoilt with more time as a family than we would have otherwise had. Although, it's fair to say we were all ready for the childcare facility to reopen when it did!

I think understanding what colleagues have been through during lockdown is really important. Lockdown was different for everyone I know. For some, it meant immense social isolation with a period of quiet rest. While for others, uncertainty about the future of their partner's job - would they have to sell their home and move? A couple of colleagues were shielding, and others felt frightened going to work as they had relatives who were shielding. Many parents found themselves being a teacher, cleaner, cook and employee. It was an incredibly difficult period but people got through with the love and support of family, friends and colleagues.

As we enter the second wave, and are midway through the November lockdown I am reflecting on how different it feels this time. Thankfully the schools and childcare facilities are still open. There is more of a feeling of adaptation to the new normality; we have all already made the majority of adjustments needed for working from home so it feels less stressful. Unfortunately, the optimism is not the same and there is less team spirit. Staff members are tired from the first lockdown and there appears to be less support this time; the clap for carers has finished and there are no free lunches.

I'm proud that we have been able to adapt throughout the COVID pandemic. I am grateful to have been a part of a service that has continued to provide mental health care, as well as brilliant training for core psychiatry doctors. I remain hopeful that the positive attitude that carried us through the summer will continue through what may be, a very challenging winter.

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REFLECTIONS FROM CONFERENCES AND EDUCATIONAL EVENTS

Reflections on Medical Psychotherapy online large group

Richard Duggins

Along with learning to cook and watching Hamilton, attending the Medical Psychotherapy Online Large Group has been one of my positive experiences of lockdown. After attending an awful large group experiential day as a trainee many years ago, I was rather cautious when an invite came from Maria Eyres and Simon Heyland to join a new medical psychotherapy large group. I am pleased I was brave and attended because Chris Holman and Diana Menzies facilitate the group so well, allowing an open and creative space.

Why am I enjoying the group? The connections are wonderful; getting to know my colleagues, understanding some of their perspectives, and people becoming much more than a name on a distribution list or a newsletter. As a result, I feel much more part of the Faculty, which my projections had placed as a rather exclusive clique in London, far away from my home in Newcastle upon Tyne. A sense perhaps of belonging, and perhaps potentially contributing. The wide range of voices in the group is stimulating; difference in ethnicity, geography, seniority, and psychotherapy orientation to name a few. My feeling is that this group may be a disruptive innovation, forming new and vibrant connections that could benefit our Faculty.

The Group runs the fourth Thursday of every month from 5.30pm – 7pm using Zoom. It is an open group for Consultant Psychiatrists in Medical Psychotherapy and senior trainees. If anyone would like to register to receive an invitation, you can contact Maria Eyres c/o stella.galea@rcpsych.ac.uk

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TRAINEE VOICES: MEDICAL PSYCHOTHERAPY TRAINEES SECTION

Edited by Alasdair Forrest and Michael Milmore

A qualitative exploration of the psychiatric trainees' experience in Balint group

Alexandra Gabrielsson

Introduction & Aim

Balint groups are weekly groups run for psychiatrists in training to support understanding of the emotional exchange that takes place between patient and clinician during a consultation. By listening to others in the Balint group, people can recognise the relevance to their own experiences.

In Hertfordshire Partnership University Foundation Trust Balint groups run on a weekly basis for junior doctors. This qualitative work aims to explore the experience of the trainees in the Balint group, through semi-structured interviews.

Context of the study

This study took place across Hertfordshire Partnership University Foundation Trust and included trainee psychiatrists of different grades who were or had recently been attending Balint group on a regular basis.

Method

Trainees were approached individually and semi-structured interviews were carried out over the phone. All answers were transcribed into written form by A.G in real time.

The questions (appendix 1) were put to all trainees and follow up questions posed according to responses and to seek clarification where needed.

A total of 10 trainees took part, of which 6 were women and 4 were men. Amongst the trainees were 3 CT1s, 4 CT2s and 3 CT3s.

The duration of experience in the Balint group ranged from 4 months to 2 years, with the average being approximately 1 year's regular attendance.

Of the 10 trainees who participated, 3 had not started a psychotherapy case, 2 had completed both a long and a short case and 5 were preparing to start a case.

Analysis

Analysis of the data gave rise to 7 main themes. Direct quotes from the transcripts have been included in italics to illustrate the personal experiences of the trainees (Thanks to those trainees for their consent to share their comments).

Theme 1: SHARING EXPERIENCES IN A SAFE SPACE RELIEVES THE BURDEN AND PROVIDES A WELCOMED BREAK

Trainees described Balint group as a space that felt free of judgement, where information and encounters could safely be shared. Anxieties about their own performance as doctors seemed to dissipate as experiences were shared and normalised in an environment that allowed for self-compassion and acceptance.

Trainees looked forward to attending Balint group as it provided a rare opportunity to meet and share outside of the normal working environment.

"Sometimes I might feel like the only one facing a problem, but then in Balint group you realise that others are having the same problems...it sounds strange to say but it helps me feel better knowing that"

"I am not alone in facing these difficulties in my work, it happens to others too...feels nice to know"

"Everybody seems happy to be vulnerable in there...there is no judgement"

"It is a welcome break to the week... to just sit down and think about stuff for an hour"

Theme 2: "GROWING UNDERSTANDING OF PATIENTS AND SELF THROUGH EMOTIONAL EXPLORATION"

Trainees described Balint group as a space to explore the psychological aspects of the doctor-patient relationship. It helped them bring another dimension to their understanding of complex clients and allowed them to explore situations with more compassion, tolerance and sympathy.

"I used to struggle a lot with patients with personality disorders...I just couldn't make sense

of the behaviour... I feel differently now, I can understand better why it is difficult for them at times and it helps me feel less annoyed by certain behaviour."

"I have learnt to feel and show more empathy through Balint group. I feel like a different doctor now. I always used to take people at face value, but now I can understand people in a deeper sense.

"Balint group helps me gain a deeper understanding of a person's presentation and how it links with their past experiences... like attachment issues, childhood"

Theme 3: INCREASED GROUP COHESION THROUGH SHARED EXPERIENCES

The majority of trainees felt that the experience of being in the Balint group positively impacted on the relationship between colleagues both inside and outside of the group, overall leading to a better understanding and acceptance of fellow trainees.

"There is a sense of unity in the group."

"I understood a lot more about my fellow trainees in that group and it made it easier for me to understand where they were coming from and why they were acting like they did. I got closer to the cohort I did it with in that small group"

"I see colleagues in a more human light ...I connect with them better..."

"Yes...it creates another bond...very positive...I feel closer also outside of the group"

Theme 4: IMPACT OF GROUP SIZE AND TRAINEE TURNOVER

The matter of group size seemed to have some importance, and smaller groups which were regularly attended by a few trainees facilitated sharing.

High turnover of trainees around changeover time seemed to destabilised the group and cause some disruption to the process.

"Size of the group really matters... I attended two of different sizes. First one was small and intimate and the second one larger and more impersonal... I found group sharing quite hard in a big group, I would not want to bring a case there....also I don't like answering questions in a big group when I don't know everybody"

"There is a high turnover of trainees at times and when the group is too big it can feel difficult to engage as I would like"

"It helps to have an even number every week...otherwise when the group is too small I can

sometimes feel pressure to present a case which I feel uncomfortable with. Sometimes the group possibly feels too big, and the room feels absolute packed and maybe really impersonal in a way”

Theme 5: BEING IN THE BALINT BUBBLE

Although trainees were very understanding of the practical difficulties of colleagues always attending on time, frustration was expressed over late arrivals and the effects this had on the group and what was being shared. It was almost as if by opening the door to invite latecomers in, the therapeutic and comforting atmosphere was at the same time allowed to leak out.

“Sometimes there are people running late and trickling in...which means lots of repetition and it does feel like you’re interrupting when come in late... like you’re breaking the bond and feel of the session in general.”

“People can pop in half way through, then they join in the conversation without full details of the scenario which usually means they misunderstand and misinterpret. If I do come late I tend to try to stay quiet”.

Theme 6: BALINT GROUP AS AN EYE OPENER

Most trainees felt that Balint group played an important part in introducing them to a therapeutic way of thinking. For many it was the start of considering psychological aspects of their patient encounters. Those who had started psychotherapeutic cases felt it was helpful preparation in managing cases individually and found that they could build on their Balint group experience in their individual cases.

“Yes, it opened my eyes to psychotherapy and the importance of this as part of a considered approach...especially since not all of us will have the chance to have a psychotherapy post I think that’s important”

“I think Balint group was good preparation for working on cases.. I sort of got a sense of what I needed to do”

“It helped me to start thinking in psychological terms”

Theme 7: IMBALANCE IN THE GROUP

Sometimes sessions felt dominated by one participant in the group, and this brought frustration from the trainees.

“One person was very dominant in the first small group I was in. We would talk about the same thing every week and this could have been better controlled by facilitator”

“Sometimes some people dominate the group – I feel like this should be controlled somehow but I am not sure how it could be”

Theme 8: TRYING TO PLEASE

It seemed as if trainees at times got caught up in wondering what may be expected by the facilitator. This could influence what they brought to and shared in the group as they ended up in a state of trying to please.

“I worry sometimes that I am being analysed by the facilitator...it affects what I say in the room...not too much but I am aware”

“Sometimes it feels like the facilitator is trying to get us to think in a way we are not capable of...then people start saying anything, like guessing, and it feels like we lose the plot a bit.

Summary and discussion

The data generated suggests that Balint group is a place where busy psychiatry trainees can come to offload and share challenging experiences from their everyday work. Thoughts which have not had a chance to be aired elsewhere find a place in Balint group and frustrations can be left behind.

To have the weekly Balint hour set aside for “thinking” rather than “doing” seems like a needed break in the week of the trainees, standing in contrast to the often busy and demanding daily clinical work. An atmosphere is created in the Balint group which is positively described by trainees in various ways using words such as “feel”, “bond”, “atmosphere” and “process”, and trainees disliked disruptions such as late comers or dominant group members, suggesting that this space feels important and meaningful. Trainees who had been attending Balint group for a longer period appeared to be more sensitive to disruptions, suggesting that perhaps with prolonged attendance and experience in the group the awareness of the importance of keeping the atmosphere intact is heightened.

A known and practiced way of setting boundaries and protecting the atmosphere in the group is to not allow latecomers into the sessions. Whilst this might improve punctuality and serve the intended purpose, it would likely interfere with the trainee’s ability to achieve required attendance and may cause undue stress for those who have to travel far from their daily place of work. Perhaps raising supervisor’s awareness of the importance of attending Balint group (and attending on time) would be the best way of supporting trainees in this matter.

Since the collection of this data the local Balint group has temporarily moved to Microsoft

Teams due to the COVID-19 pandemic, and it is likely that this has enabled more punctual attendance.

A few trainees described a feeling of being very aware of the facilitator during the session. One trainee mentioned a worry about being constantly analysed, affecting what they said to some extent, and another trainee felt that at times there seemed to be confusion about what was being asked by the facilitator (at which point the session sometimes deteriorated into a guessing game).

One trainee felt that this more commonly happened when a new cohort of junior doctors joined, suggesting that perhaps there is an anxiety (driven by uncertainty) about what is supposed to happen in Balint group.

The matters of trickling in of latecomers and heightened awareness of the facilitator may go hand in hand and highlight a more general feeling of uncertainty about what Balint group is actually about and what to do in the group. An introductory session could help in addressing these points but would come with some challenges in itself as new core psychiatry trainees join twice in the year. A solution might be to include a brief presentation on Balint group and its purpose into the induction programme, as this should be attended by all doctors at time of entry into the trust.

Junior trainees in the cohort studied felt that Balint group helps them improve as clinicians. It was clear from the data collected that this sentiment stuck with the trainees through their training, as more senior trainees agreed and in addition felt that Balint provided them with useful skills in managing therapy cases during the latter part of training. Trainees described their practice as more well-rounded following a longer period of Balint group experience. They felt they were better able to consider the emotional life of their patients and reflect on how previous life experiences may affect their presentation and support needs. There was a general feeling from the senior core trainees that continuing Balint group attendance beyond the required number of sessions would be useful, however trainees acknowledged that this was unlikely to be practical as other work commitments take over.

The matter of group size brought up some different views, but seemed to be important.

Several trainees felt that when the group was too big, the atmosphere and intimacy was lost and they felt uncomfortable sharing. For those trainees who were able to elaborate further on this, their reluctance to share seemed related to feeling self-conscious in large groups and a worry about judgement. We found no difference between junior and senior trainees in this respect.

Some trainees pointed out that when the group is too small this can also lead to difficulties.

One trainee felt compelled to present a case when the group was small, even if they had not intended to do so to begin with.

Some trainees felt most comfortable in groups of around 8-10 people, whilst others did not specify numbers but rather felt that who was participating was more important – those trainees felt more comfortable if the group was attended by trainees they had an established positive relationship with. It seems that whilst group size and participation is a complicated matter, which has some influence on how trainees behave and share, the very nature of Balint group and the varied opinions on what makes the perfect group makes it challenging to offer a simple solution. Perhaps facilitator awareness of the phenomena is important to help address these concerns in sessions as they arise.

In summary, the Balint group was described as a welcomed feature in the core training programme. It offers an opportunity for trainees to regularly come together and improve group cohesiveness and relationships. The importance of a Balint group should not be underestimated, particularly in the current climate which has forced us to adapt quickly to new ways of working and added new pressures. In the long term this kind of support will likely result in better mental wellbeing of the trainees, boosting confidence and resilience and helping them build new skills. This is also likely to improve the clinical care of the patients they care for.

It should be mentioned that this qualitative exploration is not a completely objective or external look at the process of Balint group. My acquaintance with all of the trainees and their awareness of my role in the psychotherapy team is likely to, in some part, have influenced their answers and ability to speak freely about their experience.

Appendix 1

Qualitative exploration of trainee's experience of Balint group

- Level of training?
- Duration of experience in Balint group?
- Have you also started/completed any psychotherapy cases?

1. What have been your experiences of being in the Balint group? Any positives/negatives?
2. Do you think attending Balint group has been an important part of your training? How?
3. Do you feel that the Balint group has helped further your own development as a doctor/psychiatrist? If so how?

4. Do you think that the Balint group affects the relationships between the junior doctors as a group? In what way?

5. Have you ever felt uncomfortable about sharing an experience in Balint group? How and why?

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BOOK REVIEWS

Editors: Dan Beales and Andrew Shepherd

Polyvagal exercises for safety and connection. 50 client centred practices, by Deb Dana

Forward by Stephen W Porges. Published by Norton Press

Reviewed by Carol Gregory

Stephen Porges' polyvagal theory has an important place in the trauma research and therapy world. Though not without its serious critics, Porges polyvagal theory provides a neuroanatomical and neurophysiological basis for the way therapists work with their clients to help them tolerate emotional distress. Additionally, it has facilitated the development of an increasing number of techniques and interventions for managing emotional dysregulation. It has also found a role as a simple and convincing psychoeducational tool for clients.

The title of Deb Dana's *Polyvagal exercises for safety and connection* and her introduction, clearly spell out her intentions in writing this book. She states her position that 'fundamentally clients come to treatment suffering from a compromised ability to regulate their autonomic response' and her goal that 'the exercises in this book give the therapist

ways to teach clients to safely listen to their autonomic stories... to invite discovery about their autonomic nervous system in session.. and to encourage mastery between sessions.’ Polyvagal theory is her starting point and her launch pad to a diverse range of exercises devised to manage autonomic dysregulation. She writes clearly, succinctly and her passion for her subject shines through.

The book is laid out in four sections. The first two sections are an overview of the polyvagal theory and an introduction to the ‘BASIC framework’ that Deb Dana has devised. The third section contains personal progress trackers for clients’ use, while the final section repeats the ‘polyvagal exercises’ contained earlier in the book. Throughout, the book is very well referenced to both recent neuroscience and well-being literature.

In the first section the three organising principles of the polyvagal theory, autonomic hierarchy, neuroception and co-regulation are explained. For those less familiar with the theory, or for the purposes of teaching or psychoeducation, it provides a clearly written, accessible and bullet-pointed list of the features of each of these principles which are then each fleshed out in a chapter of their own. The validity of the polyvagal theory is taken as read and the author does not at any point address the academic criticisms of this theory, which I think would have been useful to explore. These theoretical chapters contain ‘mini-exercises’ for the therapist to use to explore their own autonomic hierarchy. It was interesting and informative to take the time to complete these exercises, to consider, through a polyvagal lens, my own day to day emotional fluctuations and experiences of more major emotional dysregulation.

Part two of the book introduces the reader to the BASIC framework; Befriend, Attend, Shape, Integrate and Connect, which Deb Dana has formulated as a way of working with her clients. It is intended that the therapist will teach the client the mnemonic and work through each of the exercises associated with each heading. Practice between sessions and reporting back on progress is expected. This highly formulaic way of working did not resonate with the way I practice, valuing as I do the ability to be flexible and responsive to the material that arises.

The third section is a short appendix containing ‘personal progress trackers’, to assist in noticing early successes, referencing learning theory to support this technique.

The final section lists all the exercises contained earlier in the book. And while the purpose seems to be to make it easier for therapist to locate particular exercises it seems to be unnecessary repetition.

So what does this book bring to the table for therapists? As a cognitive analytic therapist and psychodynamic psychotherapist, who uses EMDR, I see both extreme and more

nuanced trauma as a central part of my work and working with problems of emotional dysregulation as core to this. Any book exploring techniques for helping with this problem has to be welcomed, and the author provides many interesting, creative and personalised exercises. For someone beginning to move into the trauma world, it provides a well written review of Stephen Porges theory, and it is clear that the author is passionate about her way of working. Although I would not use this book in the structured way that Deb Dana envisages, which seems to me to be too formulaic, it is a useful resource to have on your bookshelf. There are certainly some exercises that I believe will resonate with particular clients. I intend to try them out.

Reviewed by Dr Carol Gregory
Consultant psychiatrist (retired),
Trained in Cognitive analytic and Psychodynamic Therapies
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Call for future book reviewers and contributions

The book review section is a recent addition to the Faculty newsletter. Thus far, the section has been somewhat ad-hoc but we are hoping it may be possible to grow and develop it further in the future. For this to happen, we need contributors and fellow bookworms. We have a number of ideas on how this section could be developed – two examples of these are review series addressing a theme or debates. We are therefore keen to hear from you - either if you have an idea for a review, a series for discussion or other contributions to make? We have made contact with a number of publishers in the field and are able to negotiate access to review copies in many cases.

Please therefore, if this is something you are interested in helping to take forward, send an email and get in touch.

Andrew Shepherd and Dan Beales
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EVENTS, NOTICES AND DATES FOR YOUR DIARY



Faculty of Medical Psychotherapy Annual Conference 2021

Survival and Development; Exploring our Internal and External Landscapes

Date: 21 – 24 April 2021, online

[Event webpage](#)



In our Future Archives competition, we want YOU to write history.

As we leave an eventful 2020 behind, the RCPsych prepares to celebrate its 180th anniversary in 2021. Anniversaries are not just for celebration, but also for reflection and contemplating our past, present and future.

We want everyone, yes, everyone (patients, carers, junior doctors, consultants, psychologists, nurses and anyone else interested in mental health), to send us their perceptions and experiences of psychiatry and mental health services at the present time. All entries will be preserved in the RCPsych archives, creating a holistic mosaic of psychiatry in 2020/21 for future generations. You'll also be competing for iPad prizes and a chance to speak at the College's next international congress!

Competition now open

Find out more: [Future Archives Competition](#)



Coroner surveillance study of COVID-19 associated neurological and psychiatric conditions

Dear Colleagues

Please support The Surveillance Study of COVID19-associated Neurological and Psychiatric Conditions. The RCPsych is one of several organisations supporting a programme run by Benedict Michael (NIHR Health Protection Research Unit for Emerging and Zoonotic Infection, University of Liverpool). The programme seeks cases of neurological and psychiatric syndromes associated with suspected or confirmed COVID-19 infection.

Please report cases via this [RCPsych web portal](#) – it is very brief and will take < 5 minutes.

No patient identifiable details will be needed. The Health Research Authority have reviewed and approved the collection of these data for health surveillance. The data being collected is a very brief survey with four questions: the patient's SARS-CoV2 status (COVID 19 virus), their psychiatric status and their neurological status if known to you.

Please keep your own record. Before you click 'Submit', please print the completed page and keep it alongside a note of the patient's medical record number, so that you can provide more details when Dr Michael's team contacts you, as we will seek more details on these cases in the fullness of time. We will remind members about this form via our weekly COVID-19 email, until there's no need for continued surveillance.

Thank you for your support.

Dr Adrian James (President)

Dr Mike Dilley (Neuropsychiatry Faculty Chair).

Benedict Michael (NIHR Health Protection Research Unit for Emerging and Zoonotic Infection)

On behalf of:

NIHR Health Protection Research Unit for Emerging and Zoonotic Infection Programme Study Management Group: Rhys Thomas, Rachael Kneen, Ian Galea, and Sarah Pett.

RCPsych Group: Alan Carson, Tony David, Mike Dilley, Tim Nicholson, Tom Pollak, Valerie Voon.

YOUR CONTRIBUTIONS TO THIS NEWSLETTER ARE WELCOME

We encourage you to contribute to the dialogue. Please send contributions for the next newsletter by the deadline of April 2021 c/o stella.galea@rcpsych.ac.uk

CONTACTS

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