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FACULTY OF MEDICAL PSYCHOTHERAPY

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## Editors' Welcome

**Alison Jenaway**



The contributions to this newsletter seem to reveal a desire for those passionate about psychotherapy, and medical psychotherapy, to reach out beyond their traditional roles and bring calm and compassionate thinking into areas that other specialities cannot reach. The work that has gone into the new publication of the leaflet "The Role of the Medical Psychotherapist", announced by both Steve Pearce and Sue Mizen below, may have prompted some of this thinking, but it is clear that many of you are seeking ways to influence both physical and mental health teams in positive ways. From reading Richard Duggins account of his involvement with Schwartz Rounds, Matteo Pizzo's interesting experiences with the new "GP at Hand" Service, and a report by Shameel Kahn of introducing Balint Groups into a teaching hospital in Pakistan, it feels as if there continues to be a hunger for the kind of thinking that psychotherapists are able to facilitate. We have several conference reflections too, including one from the first joint conference between the Eating Disorders Faculty and the Faculty of Medical Psychotherapy, organised by Parveen Bains. This is another exciting example of reaching out into new areas of work, and a similar joint event with the Perinatal Faculty has also taken place. Do send in any comments about the articles in this newsletter, new thoughts about your own work, conference reflections or book reviews for the next issue by the deadline of 28<sup>th</sup> February 2020.

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| <b>Editor in chief:</b><br>Alison Jenaway, Cambridge | <b>Current contributing editors:</b><br><b>International voices:</b> Charles Le Grice<br><b>Trainee Voices:</b> Alasdair Forrest and Michael Milmore<br><b>Book reviews:</b> Daniel Beales and Andrew Shepherd |
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## Message from the Chair of the Faculty of Medical Psychotherapy

Steve Pearce



A number of important events that are significant for Faculty members have occurred recently - or are about to.

The revised CR224: Role of the Consultant Psychiatrist in Medical Psychotherapy has now been published. This has taken a long time to progress through the College processes, and during its construction we have fielded a number of concerns from members, in particular worries about the way the psychiatric aspects of medical psychotherapy consultants' jobs are described. Some Faculty members were concerned that Trusts would use the descriptions of prescribing, section 12 and emergency work, and consultant responsibility for patients, to require them to move away from medical psychotherapy work towards general psychiatric duties. We constructed the wording carefully to reflect these concerns, while retaining the central point that medical psychotherapists are fully capable psychiatrists, who are trained and competent in prescribing, emergency psychiatry and the application of the Mental Health Act. This breadth of capability is central to the specialty, differentiating it from non-medical psychotherapists and psychologists.

The College Personality Disorder position statement will shortly be published. In anticipation of the prominent place given to Personality Disorder in the implementation plan for the NHS Long Term Plan, which sets out how the NHS will develop over the next 5 years, an interfaculty group was convened under joint Medical Psychotherapy and General Adult Faculty leadership to set out the College view on how Personality Disorder services should develop to best serve population needs. A more detailed account will be given in a subsequent newsletter. The working group has set out the very high levels of morbidity and mortality present in this group of patients, and a stepped approach to severity according to tiers of service provision. Tiers 1 (primary care and IAPT) and 2 (outpatient and non-specialist services in CMHTs and AMHTs) are suitable for mild and moderate Personality Disorder, Tiers 3 (community based specialist services) and 4 (residential specialist placements) for severe Personality Disorder. The distinction between the levels of provision and need will become increasingly important as Integrated Care Systems are implemented (successors to New Ways of Working and linked to Sustainability and Transformation Partnerships), in which local providers will form collaboratives to deliver services they think appropriate to their local population. As ever, personality disorder services are vulnerable to neglect during re-organisations, due to a combination of the particular stigma attached to

the diagnosis, campaigns to change or abandon the concept, and the difficulties of working productively with the patient group.

At the conference in April 2019 the most striking element of the large group discussions was the absence of competitiveness (formulated as envy by one of the convenors) between groups and models. There was a general feeling that this was new, and a welcome development. Talk of a lost purity, when members of the Faculty practiced a pure form of (psychoanalytic) therapy unaffected by psychiatric concerns (the comment was in respect of dual training) or integrative models, received robust push back. The sense, in particular from the younger faculty members, was of a flexible approach, making use of the various models in which they have received experience, and importantly, incorporating their psychiatric background. The days of medical psychotherapists operating as if they were not psychiatrically trained are, rightly, now behind us. An integrating approach also accords well with research that shows that the more senior the psychotherapist, the more likely she is to practice eclectically, taking methods and understandings from a range of traditions according to what is most likely to help her patient at the time.

Finally, a comment on consultant posts and vacancies. From time to time trainees complain to me that there are very few vacancies for consultant medical psychotherapists. Certainly, small specialties like ours require some waiting for posts suited to candidates' skills and working preferences. However, this complaint is striking when set against the difficulties filling posts outside London, both full time and part time. Recently posts around the country have been advertised and remained unfilled, strikingly in the North and West, including attractive posts as part of a well-resourced team. Competition for other posts outside the South East has been light at times, sometimes attracting only one qualified candidate. This situation is likely to be related to a preponderance of trainees wanting to remain near where they trained, often London. Although this is understandable given the time of life when doctors become ready to take up consultant appointments, it is worth clarifying that there is no shortage of consultant posts in the speciality; STs who are prepared to take on a challenge might find moving into a less well-resourced area a rewarding long-term career move.

**Steve Pearce  
Faculty Chair**

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## Message from the Academic Secretary

**Maria Eyres**



I will start with Reflections from the Faculty's Annual Conference held in April 2019 at the Royal College of Psychiatrists; Creative and Destructive Forces in Groups; Clinical Settings, Organizations and Society

This year's conference was my first as an academic secretary and I am very grateful for the support of the Conference Committee; Jo O'Reilly, Haroula Konstantinidou and Matteo Pizzo who have been wise, diligent and a joy to work with; it wouldn't be the same without you.

The conference opened on Wednesday evening with Professor Eric Vermetten from the University of Leiden who gave us an overview of the development of concept of psychotrauma and how it led to the development of the diagnosis of PTSD. Eric then examined the research into its treatment over the last 30 years and discussed the promise of medication-enhanced psychotherapies to treat it. He spoke about the promising use of psychedelics, specifically of MDMA. Psychedelics have become something of a regular topic at our conference over the last three years, attracting a range of reactions. This year I had a sense that the tide is turning in favour of restrained enthusiasm and away from scepticism.

He was followed by Dr Neil Kitchner who spoke about PTSD research in ex-military and civilian populations in Wales. His video of the veteran walking on a treadmill towards his recovery wearing a harness while watching the images associated with his traumatic experiences was very moving and stayed with me for a long time. Neil is also a keen photographer. His presentation was peppered with photographs of abandoned landscapes of mental asylums by Matt Van der Valde and Christopher Payne. These brought an eerie beauty to the evening.

Morris Nitsun opened Thursday proceedings with his talk on the dialectic of creative and destructive forces in groups. He described them as circular rather than linear processes, linking them to the binding function of the life instinct and the unbinding one of death instinct. It is the oscillation between adhesive and separating forces in the group that gives

it life and can either promote or impede progress. Taking this idea further, Nitsun contrasted the more collaborative, constructive strengths of the group as seen by Foulkes versus more defensive, regressive group potential as described by Bion. He then spoke of his concept of the anti-group, which he described as having antagonistic and disruptive aspects, bringing Foulkes' optimism with Bion's pessimism into a dialectic. Groups can be both, cohesive and fragmented and the creative moments often emerge when they come together. Nitsun illustrated those concepts with some material from the group, which brought them to life.

The title of Dr Eliat Aram from the Tavistock Institute of Human Relations' talk was *Understanding Group Processes; The Art of Possible*. She spoke of Group Relations conferences as a necessary way of learning through experience and drew links between them and contemporary theories of groups, including complexity theory. It was her description of the social dreaming event her organisation held to commemorate their 70<sup>th</sup> anniversary which evoked much interest in the delegates and caught my imagination to the point that we are planning to include it at the next year's conference.

After the coffee break, Gabriella Rifkind gave a fascinating talk anchored in geopolitics. She feels strongly that the culture and the politics of the land where we are born shape our psyche. Gabriella also highlighted that while politicians might be allergic to pure analytic ideas, they may be more amenable to the applied psychoanalytic thinking and she raised the question of our responsibility and the need to get involved.

Thursday lunchtime provided us with much needed space to find friends and colleagues and exchange reflections from the morning. It was followed by large group, facilitated on both days by Dr Earl Hopper and Dr Jale Cilasun. They had been invited to do so by John Hook who the conference committee had asked to oversee this part of the conference (see John's account later in this newsletter).

Dr David Bell very kindly agreed to stand in after our original Thursday afternoon speaker had to withdraw at short notice for which we are very grateful. His talk was entitled *Neoliberalism is Bad for your Mental Health*. Dave spoke of the manic triumphalism of capitalism following the fall of Blair/Brown government with its freedom to compete and the Darwinist survival of the fittest. When in such primitive states of mind, one is only able to examine reality from a rather dualistic and horizontal viewpoint (good schools, hospitals etc will survive, the bad ones will die), neglecting the question of the vertical/historical investigation of why. He spoke about the hate of dependency and destructive narcissism which confuses ordinary human need and dependence with a malignant process and about the difference between the welfare state with its strong nurturing femininity and how the term 'nanny state' represents an attack on this. He ended his speech with a call to keep alive different types of thinking and to support each other.

The conference dinner was, as usual, a jolly affair with old friendships being nurtured and the new ones struck. We were entertained by our after-dinner speaker, Jon Goldin who shared some anecdotes from his media work on behalf of the College and by the beautiful singing of Stephanie Guidera.

Friday morning opened with Dr Az Hakeem who outlined gender dysphoria and gender identity on the basis of his work in the specialist psychotherapy service which offers assessment and therapy for these patients. He illustrated his work with material from the group he had run and promoted his book on the subject in between the slides of his presentation. Sexuality is something that we would like to explore further in the future conferences, so it was good to start opening it up with this complex subject.

The next presentation by Jan Birtle, Pippa Hockton and Rachel Collins White spoke of the barriers that prevent people on the outskirts of society accessing and engaging with therapy. Jan opened the presentation speaking of the projections society can lodge in this group of people and how it serves a purpose of getting rid of what is uncomfortable/unbearable; the unwanted parts of society becoming disowned and disavowed. Rachel spoke about the charity “Unseen” which works towards abolishing modern slavery and helping its victims. Pippa described the process of engaging prostitutes through the work of the charity *Street Talk*, illustrating it with clinical examples and describing a very different model of therapy to the way we work in the NHS. This was an inspiring and moving session which linked in my mind with the Dave Bell talk, and how there is very little space in our services for those needing a different, slower and more tailored approach to engage.

This session made me realise how grateful I am for the speakers for sharing their innovative approaches and for helping us to connect with those projected out of the society.

Steve Pearce and Adam Dierckx took us into the very different territory with their talk *The Use of Democratization to Empower; Lessons Learned from Democratic Therapeutic Communities*. After summarising the essence and culture of the therapeutic community and the use of democratisation, they discussed the importance of responsible agency as a necessary vehicle for change to achieve recovery and live a good life. The conclusion of their talk was that democratization and communalism in therapeutic communities serve two purposes; to promote empowerment and responsible agency and to contain ‘psychotic’ and destructive elements of large group process.

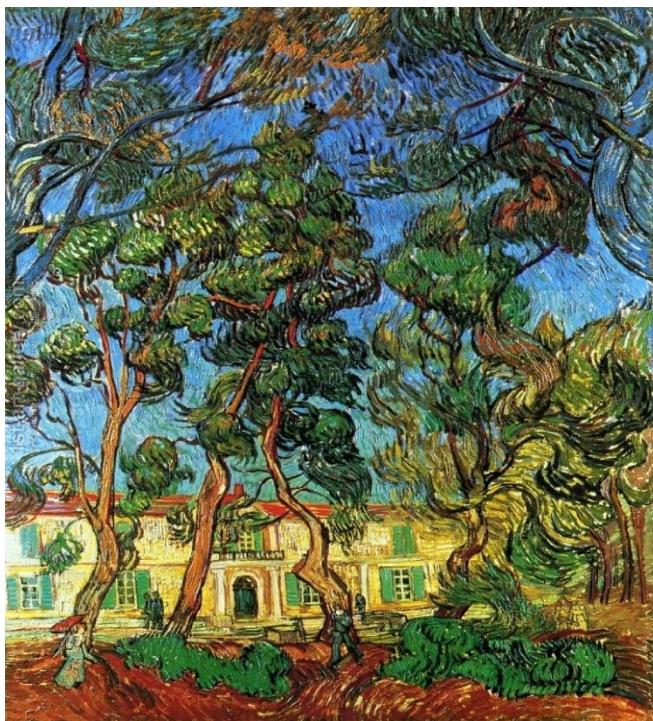
At the heart of the talk of our last speaker, Sheila Ritchie, was the video material from her perinatal team parent-infant therapy group. The video illustrated the impact of mothers’ projections onto their babies, repetition compulsion in action, and, the role of other babies in the group. It brought us all back to the importance of good enough mothering and the

containment of the primitive states of affect, a theme that developed through the whole conference.

The delegates made good use of the large group on both days, both in addressing and also in processing the themes that emerged during the conference including the issues of difference, gender and intergenerational dynamics. It also provided an opportunity to think together about our experiences in our working lives across the career span, from medical student to retirement. The feedback from the large groups was overall positive and my sense is that they contributed to the feeling of cohesiveness and collaboration amongst the delegates. We are already working on organising the large groups for the next year.

Last but not least, congratulations to our poster presentation winner, Anna Robinson for

winning the poster prize for the poster  
*Assessing Staff Response to the Introduction of an Intervention to Improve Patient Formulation on a Child and Adolescent Inpatient Unit.*



A week after the conference I went to see Van Gogh's exhibition at the Tate Britain and saw his painting of Saint-Paul Asylum in St Remy where he stayed for a year. It made me think about the conference we had just had, and the importance of creating spaces in our everyday lives where disturbance can be contained and understood. I thought I would share it with you here as my last comment on the conference.

### Other events

Since our last Newsletter, Mary Murphy-Ford and Anne Ward co-organised a Joint Medical Psychotherapy and Perinatal Faculty Conference on the 11<sup>th</sup> of October. This was well attended and received. Perinatal colleagues were keen to make this an annual event which I very much encourage. Trudi Seneviratne also explicitly welcomed the idea of Medical Psychotherapists moving into Consultant Perinatal posts in the future.

On the 1<sup>st</sup> of November 2019 the College hosted the 4<sup>th</sup> Psychodynamic Psychiatry Day organised by Jo O'Reilly and Rachel Gibbons, which attracted over 190 delegates. This event has been growing steadily every year. It demonstrates a real need to bring our

understanding of disturbance and its impact on staff to our psychiatrist colleagues, and I am looking forward to hearing about it in some detail. Having recently looked at this through the lens of being a relative rather than purely a professional, I cannot urge you all enough to support the teams and services through continuing this work on your patch. I have asked Jo to write something about the event for the next edition of the Newsletter.

### **Annual Conference 2020**

The working title for our next conference to be held in Oxford on the 22-24 of April is *Survival and Development; Exploring our Internal and External Landscapes*.

Our work can still be heavily influenced by the Cartesian duality of body and mind. 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.

This conference will explore the links between those aspects of our patients and ourselves, and how they impact on each other.

The opening talk on Wednesday will return to the topic of social dreaming which gathered much interest at our 2019 conference. This will be followed by two early morning events on Thursday and Friday for those who would like to explore this further in the experiential sessions.

Thursday will, again, be a more conceptual day, with talks on climate change, the presence of the body and the relationship between therapy and spirituality and three parallel workshops linked to the conference title.

Friday will focus on clinical work, looking at those themes in more detail and thinking about what we need ourselves to feel supported enough to develop and even thrive in our work.

There will be an experiential aspect of group work through a large group on Thursday and Friday, with the focus on ourselves, followed by the end of the conference plenary.

Please note that we have a new conference committee this year, with Parveen Bains, Andrew Williams and P J Saju; thank you very much for offering to support me in my role.

**Maria Eyes**  
**Academic Secretary**  
Contact Maria c/o [stella.galea@rcpsych.ac.uk](mailto:stella.galea@rcpsych.ac.uk)

## **Message from the Chair of the Specialty Advisory Committee**

**William Burbridge-James**



As autumn merges into winter and leaves of many colours carpet the ground, the slow process of working through and updating our curriculum to ensure compliance with GPC (Generic Professional Capabilities) framework continues.

I wrote about the process in my last contribution to the newsletter back in March. We are currently at the stage, along with all the other specialities where we have submitted our Medical Psychotherapy ‘purpose statement’ and higher learning outcomes (HLOs) to the GMC Curriculum oversight group (COG) in September for their approval. The college is expecting feedback on these in the coming weeks.

The Core psychiatric curriculum and General Adult higher curriculum purpose statements and HLOs have already been approved by the COG, and these have helped guide our drafting. These are available for viewing on the [college website](#). The HLOs are overarching and broad, corresponding to each of the nine domains of the GPC framework.

The next step which we have started on in our last SAC meeting in October is to map our current curriculum’s ILOs (intended learning outcomes) to each of the HLOs that we have drafted, and rewrite aspects as needed, remove duplication and streamline the curriculum. Once this is done the College will be submitting all the speciality curricula to the GMC curriculum assessment group (CAG) for approval in August of next year. There will not be major changes to the current higher curriculum at this stage, but a broader scope that is inherent in the GPC framework. Once this work is complete I will be passing on the baton of SAC chair.

I am also pleased that our previous trainee rep Ben Robinson has been developing a UK map of medical psychotherapy higher trainings which the college have been providing technical support for. This will help trainees to know more about the training schemes when applying for higher training and give a UK overview. This accessible national oversight is long overdue, as higher training remains an area where there is room for future development in terms of strategy and delivery. Regionally there remains a difficulty in recruitment at consultant medical psychotherapist level and we need to be able to address this through

accessible high quality regional higher trainings- as evidence shows that trainees will tend to settle where they undertake their higher training. However, it's difficult to adequately resource regional trainings where there maybe just one or two higher trainees and this is something that I would like to continue to address in my remaining time as SAC chair and pass on to my successor.

Please get in touch if you would like to discuss any curricula and training issues.

William Burbridge-James.

**William Burbridge-James**

SAC Chair

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## **COLLEGE REPORT CR224: THE ROLE OF THE CONSULTANT PSYCHIATRIST IN MEDICAL PSYCHOTHERAPY**

**Sue Mizen**

I am pleased to announce that the new version of CR139 *The Role of the Consultant Psychiatrist in Medical Psychotherapy* has now been published as CR224 and can be found on the College website through the following link [CR224 Role of the Consultant Psychiatrist in Medical Psychotherapy](#)

You might find it helpful during job planning as it specifies the number of PAs recommended for training Core and Higher Trainees. It may also be useful in making the case for new posts in discussion with managers. Many thanks to all those members of the Exec who contributed to it.

**Sue Mizen**

Contact Sue c/o [stella.galea@rcpsych.ac.uk](mailto:stella.galea@rcpsych.ac.uk)

## CONTEMPORARY PRACTICE IN MEDICAL PSYCHOTHERAPY

### Schwartz Rounds and the Consultant Psychiatrist in Medical Psychotherapy

**Richard Duggins, Lauren Moody, Lucy Buckley**

I would encourage my medical psychotherapy colleagues to develop a curiosity in Schwartz Rounds, if they have not already done so. The Consultant Psychiatrist in Medical Psychotherapy, in my mind, has the perfect skill set for launching and leading these in Trusts, and they fit very well with the recent College defined role of “developing reflective and psychologically minded practice in physical and mental health teams” (College Report CR224).

Schwartz Rounds were developed following the death of Ken Schwartz, who described during his healthcare for terminal cancer, that it was the “small acts of human kindness” by staff that “made the unbearable bearable.” They are used routinely now in many hospitals the USA and are gaining significant popularity in the UK. The Francis report listed them as one of the few evidence-based interventions that can positively influence culture in organisations.

In my NHS Trust, I lead and facilitate Schwartz Rounds alongside six colleagues. We have been running them for 3 years and have now facilitated 26 Rounds. Schwartz Rounds have some similarities with Balint Groups, and a useful comparative table was drawn up below for the International Balint Conference with my Consultant Psychiatrist in Medical Psychotherapy colleague, Dr Lucy Buckley.

|           |  |
|-----------|--|
| Focus     | There are many similarities. Both Balint Groups and Schwartz Rounds focus on caregiver-patient relationships, the emotional impact of work, hearing different perspectives and exploring the patient experience. Both create space for unconscious processes to become clearer.  |
| Structure | There are remarkable similarities. Leaders of both Balint Group and Schwartz Rounds provide structure and containment. In both there is an initial presentation, then reflection by the other members (or attendees), and then, towards the end, a return to the presenter to rejoin the discussion and contribute if they wish. In both, members (or attendees) are encouraged to speculate, and questions and advice are |

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|   | discouraged. The duration of Balint Groups tends to be 60 to 90 minutes, and Schwartz Rounds are 1 hour long.   |
| Size and composition of Group               | This is a key difference. Balint Groups are closed ongoing groups of 6-12 clinical members, which meet weekly or monthly for several years. Schwartz Rounds are open to all staff in an organisation (clinical and non-clinical) and attract 30 to 150 attendees on a monthly basis. Schwartz Rounds have a core of regular attendance, but the composition of the group will tend to change from month to month as some people choose to attend and others do not.                         |
| Presentations                               | This is another significant difference. In Balint Groups there is a single presenter discussing a current case without notes or preparation. In Schwartz Rounds a panel of 2-4 presenters speak, one after the other for 3-5 minutes each, on their experiences of a “patient journey” or on a pre-selected theme (such as “a patient I will never forget” or “working at night.”). Presenters in Schwartz Rounds are encouraged to speak without extensive notes but there is preparation. |
| Relationship to the healthcare institutions | We would argue both Balint Groups and Schwartz Rounds hold a countercultural position to healthcare institutions. They encourage a primacy of relationships and exploration of feelings, and provide an important counterbalance to a more process-driven and industrial healthcare culture.  |
| Outcomes                                    | Outcomes valued by both Balint Groups and Schwartz Rounds include improved communication, better patient care, reduced burnout and reduced feelings of isolation. There is also evidence that Schwartz Rounds positively influence the culture in organisations by creating more focus on patient and staff experiences.  |

Some recent themes of our Rounds have been: “On life lost” - thinking about the emotional impact of suicide; “New Beginnings” - the emotional impact of starting new in our Trust; “Emotional Liaisons” - working across boundaries in the general hospital; “Fire! Fire!” - dealing with the emotional impact of rare but critical incidents; and “Feeling Insecure” - exploring the emotional impact of the aggressive patient.

We have conducted some research with an undergraduate Lauren Moody, and the outcomes over the three years are excellent, with 84% of attendees stating the rounds helped them with their work with patients, 89% reporting the rounds improved their

relationships with colleagues, and 92% rated the rounds overall as excellent or exceptional. A qualitative analysis of the feedback found the attendees felt the rounds made an emotional impact, improved a sense of teamwork and commonality, improved their sense of emotional support, and widened their understanding of others' roles.

My involvement in Schwartz is one of my highlights in my work as a Consultant Psychiatrist in Medical Psychotherapy. The Point of Care Foundation website is a wonderful resource for more information (see below), and I would be pleased to provide further information to any of my colleagues on my experience.

Comprehensive Resource on Schwartz Rounds: [The Point of Care Foundation](#)

**Richard Duggins, Lauren Moody, and Lucy Buckley**  
**Regional Department of Psychotherapy, Newcastle upon Tyne**  
**Contact the team c/o [stella.galea@rcpsych.ac.uk](mailto:stella.galea@rcpsych.ac.uk)**

### GP at Hand: Meeting in the Middle

**Matteo Pizzo**

As well as receiving correspondence from Islington GPs requesting advice, assessments and consultations for their patients, our team also receives referrals from *GP at Hand*. Commissioned by Hammersmith & Fulham CCG, with around 60'000 registered patients, and 40 full-time GP equivalents, *GP at Hand* is the UK's largest digital-first GP practice. The first contact with a patient is either by phone or via video link.

Their patient population spans the whole of London. Referrals for Islington residents who require specialist mental health input and are registered with *GP at Hand* find their way to us.

When this began to happen a few years ago I found myself feeling confused about what sort of service I was corresponding with. There was something shapeless and remote about it. We would often request patients to re-register with an Islington GP so that we could be more available to them and the clinicians they were working with.

However, over the past year we have had a couple of meetings with members of the *GP at Hand* core team in order to better understand one another's work and lay the foundations for a closer collaboration.

It seems that *GP at Hand* may particularly appeal to those ‘on the go’, who prefer a short wait for video consultation with a GP they may not see again. We had noticed that, as well as their young, urban and relatively healthy population, some patients who had chosen to register with *GP at Hand* had more complex needs. A deeper exploration of the notes of some of these patients revealed a lifetime of precarious relationships, chaotic lifestyles, as well as struggles with impulsivity and suicidality. Several within this cohort had experienced neglect and/or abuse in childhood.

We hypothesised that some patients’ state of fragmentation may unwittingly find a match with a service perceived to be accessible ‘as and when’, with no wait, no continuity or consistency. We worried that the video GPs may become objects to be evacuated into without the mutual responsibility of building a relationship.

However, in our conversations with the *GP at Hand* team, we have found that they are working very hard to develop a service that is mindful of the possibilities for fragmentation. They now have 7 clinics across London where they can see patients face-to-face. They have a core group of GPs dedicated to the follow-up of patients with complex needs, where continuity of care is essential. They have also established a Care Coordination Team, comprising a multi-disciplinary team including a mental health nurse, to proactively engage this patient population.

There have been significant developments since the early days of *GP at Hand*. In many ways it is closer to an ordinary general practice than what I had originally imagined. There are still some cultural differences. For example, a video consultation may offer the chance for the GP to have a look at the patient’s living room, but doesn’t allow for the clinician to smell alcohol on the patient’s breath, or experience a subjective anxiety that may emerge with the person in the room. Nevertheless, the opportunity for a face-to-face follow-up and for an offer of a healthier sort of attachment is there, and we have agreed to join them in the room when it’s likely to be beneficial to all involved.

**Dr Matteo Pizzo**  
**Consultant Psychiatrist and Specialist in Medical Psychotherapy**  
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## INTERNATIONAL VOICES

### Bringing Balint to Foreign Lands

Muhammad Shameel Khan, Aisha Sanober Chachar, Humera Saeed, Shireen Najam,  
Marium Mansoor, Nida Khan, Nargis Asad

#### Background

The Aga Khan University is a tertiary care hospital located in the city of Karachi, Pakistan. The university has both an undergraduate, as well as a postgraduate training program, covering a vast range of nursing, medical and surgical specialties. In September 2019, the postgraduate medical education (PGME) department organized an annual PGME conference for trainee doctors. These include interns (foundation doctors), residents (senior house officers), and fellows (registrars) belonging to various medical and surgical sub-specialties. This year the theme of the conference was *Tawazun*. *Tawazun* is an Urdu word which means *balance*. The theme of “Balance” addressed the issue of maintaining a good enough equilibrium between work and life as a postgraduate medical or surgical trainee. The need for achieving balance is not only applicable to polarities of work and life as a trainee. It indeed applies to other dimensions too such as maintaining a balance between knowledge versus care or healing versus treatment as a healthcare professional.

In our approach to diagnosing and managing patients, sometimes the focus is primarily on treatment. The component of humanistic care often becomes clouded by investigations, numbers, figures, or data. In this context, Balint groups help a clinician develop a holistic approach and remain mindful of the effectiveness of interpersonal care as medicine on its own. This interpersonal care is often a by-product of the interpersonal exchange that happens between a doctor and patient, something that Balint helps us in understanding.

#### Maintaining the balance with Balint

When we talk about addressing the relational dynamics between a doctor and patient, Michael Balint’s name comes to the forefront. At once a doctor, psychotherapist, teacher, writer and humanist, Michael Balint surely ranks among the most influential medical figures of the 20th century [2]. His astute grasp of what happens within the interpersonal matrix between the doctor and the patient has allowed us to think beyond numerical data, diseases, symptoms, and view patients as whole persons.

As a psychiatrist who undertook all of his postgraduate training in the UK, the decision to move back to Pakistan 4 years ago was a difficult one. The socio-political adversities, combined with sharp economic and cultural divisions in Pakistan, often place a greater burden on the relational component between the doctor and the patient. The need for introducing Balint in Pakistan was dire so that the doctors can get a safe, neutral, and confidential space where they can talk about the psycho-social aspects of these human interactions, especially in a society where freedom to speak or express one's feelings, is often frowned upon.

The Balint initiative at the Aga Khan University Hospital (AKUH) in Pakistan dates back to 2016 when we started our very first Balint group with members of nursing staff from the oncology service. This group ran for one year, and a qualitative paper was subsequently presented at the International Congress of Balint held at Oxford in 2017. We subsequently formed the Balint working group for Pakistan, which currently consists of 4 psychiatrists, one clinical psychologist, and three psychotherapists. The aims and objectives of the working group have been to facilitate the expansion of Balint work both within the hospital community as well as outside in partnership with other organisations.

Since 2017, we have run Balint group workshops within Aga Khan University Hospital, which had been primarily attended by psychologists and therapists from both within the hospital as well as outside. In 2018, we started our first Balint group for postgraduate psychiatric trainees and made this mandatory for trainees to attend as part of their ongoing professional development. This specific Balint group with psychiatric trainees has been running for approximately one year, and we aim to publish our qualitative findings in a separate article.

#### **Annual PGME conference 2019, Aga Khan University Hospital**

The annual PGME conference held in September 2019 was a completely different platform in the sense that it gathered trainees from a range of different sub-specialties on the same stage. Keeping the PGME conference in mind, which focused on the theme of Balance, we thought it was the ideal time to introduce Balint as a balancing tool for addressing burnout, professionalism, and understanding relational aspects of our day to day clinical work. The conference had both national and international guest speakers. Dr Jane Dammers, a retired GP and ex-president of Balint council, United Kingdom, was one of the keynote speaker for the event. Dr Dammers delivered an online talk on "Balint work in continuing professional development" in which she discussed the benefits of Balint groups and their role in maintaining a balance in our professional lives. She also participated in a plenary discussion following her main talk on Balint.

As part of the PGME conference, several workshops were arranged during the three days of the event. The workshops were diverse, covering a range of clinical, technical and soft skills

training. As part of the PGME conference, a Balint group workshop was held on the 19<sup>th</sup> September 2019. We had a threshold for 10 participants in the workshop, but we received a much higher number of registrations. We therefore had to put a cap on registrations once there were no more vacant spaces. The postgraduate trainees who attended this workshop came from the departments of family medicine, internal medicine, and psychiatry. One of the participants was an external candidate who came to know of the Balint workshop through the marketing campaign for the PGME conference.

Our trainee coordinator, Dr Shireen Najam played a vital role in the administrative organisation of this workshop. Participants were also provided with background reading material related to Balint groups. During the first half of the workshop, participants were inducted into the history, methodology, and framework of Balint groups through didactic teaching. In the second half of the workshop participants had the real-time experience of being in a Balint group. The group was led by Dr Shameel Khan (Consultant Psychiatrist and accredited Balint group leader) with facilitation by Dr Nargis Asad (Clinical Psychologist). The group was diverse in composition with a mix of trainees from three different specialties. Due to the heterogeneous nature of this group, personal reflections focusing on doctor-patient relationship across various specialties brought a richness to the discussion between group members. It was interesting to note how Balint became a platform for these trainees from different clinical backgrounds to engage in a process of group empathy. The Balint group, in a rather subtle and gentle way, enabled them to mentalize about the difficulties that each experienced within their respective specialty when dealing with challenging encounters of an emotional nature. Within the setup of a tertiary care university hospital, there are so many divisions between specialties and services that may often filter down to trainees. It was however interesting to note how Balint temporarily dissolved those hierarchies and differences between trainees and engaged them in a process of shared thinking about feelings, emotions and affect. Some of these were rather painful feelings and emotions stemming from either losing a patient or not knowing what happened to a given patient who they had once cared for. The space of Balint allowed the trainees to digest and metabolize such vulnerable feelings which are otherwise often neglected when working on busy medical or surgical floors.

During the tea break of the workshop, the participants also got a chance to network with each other. Participants expressed a massive interest in piloting Balint groups within the postgraduate training programs of our hospital. Some of the feedback from trainees suggested that they liked the honest and open framework of Balint as well as that sensitive issues were being handled with care and consideration. Participants also found the diversity within the group an important strength of this activity as it allowed them to hear about each other's patients and the experiences of being with these patients.

Teaching psychological mindedness to a group of surgical or medical trainees can be a difficult and challenging task, especially in the socio-cultural context of Pakistan, where freedom to speak can be potentially penalized rather than celebrated [3]. Through Balint, psychological mindedness can be modelled in a somewhat covert, progressive and nurturing way especially in a culture where there may be extreme individual as well as group defences against “opening up.” Balint allowed these trainees to see not just their patients as whole persons but also each other as fellow human beings. This shift in the gaze can be fundamental when we connect, attach, understand, or care for others, be it either our patients or each other as colleagues.

Following the positive feedback from the workshop, the Balint working group, Pakistan is now actively working to further expanding Balint groups within the hospital community both at the level of trainees and early career physicians. Balint in Pakistan is still in its infancy but slowly and steadily, it is beginning to find its own identity within the context that we operate in. Here we would especially like to thank Dr Gearoid Fitzgerald and Dr Jane Dammers from the Balint council UK, for their constant support and mentoring in helping us to continue to foster the Balint initiative in Pakistan.

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## CONFERENCE REFLECTIONS

**Reflections on the joint conference with the Eating Disorders Faculty:  
Dual Perspectives, what's new in psychotherapy for Eating Disorders – 8  
February 2019, Oxford**

Parveen Bains

### **Introduction and Reflections from Parveen Bains, Medical Psychotherapy Faculty Exec. Eating Disorders Lead and Conference organiser**

I organised this conference with some colleagues from the Eating Disorders Faculty. Our aim for the day was to look at novel psychological treatments in the field of eating disorders and also to think about eating disorders from a relational perspective. We wanted to attract a mixed audience from both the world of eating disorders and medical psychotherapy and beyond. In addition to my reflections on the day as conference organiser, I have asked two junior doctors at very different stages of their training journey to also give their thoughts on the conference.

The setting for the conference was idyllic; Pembroke College which is part of the University of Oxford and a rather interesting mixture of old and new architecture.

The morning sessions had a different feel to most of the other conferences that I have attended on Eating Disorders as they had a much more relational and intrapsychic focus. The keynote lecture was delivered by Professor Hans-Christoph Friederich who is Professor of Psychosomatic Medicine at Heidelberg University. Professor Friederich presented the ANTOP study which is a large, multi-centre RCT looking at the efficacy of a manualised focal psychodynamic therapy for Anorexia Nervosa (AN) with CBT and treatment as usual as the comparison arms. This study has been influential in shifting the minds of our colleagues in eating disorders in thinking about how to combine the relational with the more widely used behavioural therapy models in this group. The findings showed that although the rate of initial weight gain was better with CBT, the group having focal psychodynamic psychotherapy showed better signs of recovery at 12 month follow up.

There was some consternation among the audience. that although these study results are impressive, brief focussed psychodynamic psychotherapy for Anorexia remains only a second line treatment in our NICE guidelines for AN, because the manual for the ANTOP study was not published in English at the time of the guidelines being updated.

The session then continued with a presentation by Dr Paul Robinson on his study on *Mentalisation Based Therapy in Eating Disorders* and this then linked well with a stimulating dialogue between Sue Mizen and Katerina Fotopolou from UCL about Sue's developing Relational Affective model and how this might apply to patients with AN. Dr Fotopolou gave some fascinating insights into the possible neuroanatomical deficits and mechanisms behind this by thinking about how some stroke patients lose a sense of their paralysed bodily parts being their own. We were invited to think how something similar may be happening in patients with eating disorders in relation to their own bodies. The summing up of these sessions seemed to begin a dialogue between the faculties on how some of this type of thinking, and perhaps even how the MBT and the focal psychodynamic therapy models, might be implemented more widely in the UK.

The afternoon workshop sessions were mainly focused on other therapeutic models which are more widely used within eating disorders services in the UK, namely looking at developments in DBT, CBT and MANTRA in eating disorder. Alongside these, there was a stimulating workshop run by Dr Richard Taylor on running reflective groups in multidisciplinary teams working with eating disorders. Richard spoke about how he had introduced the teaching of MBT concepts to the team and gave a very clinically focussed real world account of the challenges of introducing relational thinking in inpatient eating disorder services as well as the absolute need for this.

A debate finished off the day with the audience invited to reflect with a panel of speakers on how to improve the functioning between the two faculties. There was a realisation that perhaps we were often dealing with similar clients and a number of points were raised for more joint working such as further CPD events, joint guidelines on how to work with patients with personality disorder and eating disorder, and thinking how to further develop joint higher training in eating disorders and psychotherapy.

I hope we fulfilled our aims of providing a lively and stimulating day for a wide range of delegates from differing backgrounds. This was certainly reflected in the winners of the poster prizes who came from the field of dramatherapy, group analysis and Psychology as well as psychiatry. Overall, the day provided a much-needed feeling of unity and connection between the two faculties to think about and consider how to help a complex group of clients and also manage the anxieties of staff working in these settings.

**Reflections from Numaya Siriwardena, CT1 LAS Hertfordshire Partnership University Foundation Trust**

Up until a few months ago, anorexia nervosa meant nothing more than an unhealthy obsession about body image, to me. But then I started my first post in Psychiatry. Placed in CAMHS, I came across many young people with eating disorders. Their stories and presentations were complex and completely different to what I had in mind. They had very little insight, if any, in to why they did what they did. The psychologists seemed to be unravelling many interesting aspects buried within these individuals, such as dysfunctional family dynamics and the way these adolescents saw themselves. All of a sudden, what seemed to be a child-like obsession, has proven itself to be a symptom of deep-rooted underlying problems. It became apparent that there was only so much one could do by treating the brain (by medicating it), without helping these individuals to come to terms with, and actively change, their malformed thought processes.

This is when I received an email about the joint conference of the Faculty of Medical Psychotherapy and Faculty of Eating Disorders psychiatry, to discuss what was new in psychotherapy for eating disorders. Needless to say, I was delighted. The venue not being too far and the ticket price affordable, I was all set to attend this conference.

Learning how little I understood about eating disorders during my CAMHS placement, my main objective in attending the conference was to broaden my understanding about eating disorders. After all, how can one possibly mend something they did not fully comprehend? And secondly, to gain some insight in to the role of psychotherapy in exploring the root causes of eating disorders and in their management.

The conference was beyond my expectations. It was not only very well organised and informative, but had a number of short workshops, in which we actively participated. It was a great honour to get a chance to listen to a number of prominent researchers in the field. Some of the aspects I enjoyed the most would be the comparison of different approaches (e.g. focal psychodynamic vs. CBT vs. treatment as usual), probing in to negative predictors, identifying pro-anorexic beliefs, and their roots in developmental psychiatry. I was fascinated to learn that a large percentage of people developed eating disorders as the result of seeking emotional security and the need for control. Also, on a par with my own experience during my CAMHS placement, only a very small number were keen on attractiveness.

The workshops were an eye-opening experience. We got a chance to experience some of the DBT techniques used on these service users. It was fascinating how certain personality traits, parenting styles and coping mechanisms of an individual could be associated with

different types of eating disorders. Thus, eating disorders inevitably had strong links with certain personality disorders, such as EUPD.

It became evident that different types of psychotherapies employed different approaches in treating eating disorders. Psychodynamic psychotherapy explored the intrapsychic and interpersonal dynamics. The role of mentalisation based therapy in correcting the malformed attachment styles, to develop theory of mind, empathy and mindfulness was just as remarkable as the role of DBT in equipping these individuals with immediate life skills.

If there was anything more beguiling than the cascade of information brought forth, it would have been the contagious level of enthusiasm with which each of these lectures were delivered. This conference helped me expand my understanding of eating disorders and has most certainly fuelled my ardour in psychotherapy.

#### **Reflections from Dr Marchelle Farrell, ST in Medical Psychotherapy, Oxford Health NHS Foundation Trust**

I attended the joint conference between the Faculties of Medical Psychotherapy and Eating Disorders with a great deal of curiosity. In my time in training my dealings with patients with eating disorders have been relatively limited, apart from a spell in CAMHS where it was my supervising consultant's special interest. I still remember a bruising attempt at psychotherapy with a young woman with anorectic symptoms, probable emerging personality difficulties, blistering wit, and deep contempt for 'grown-ups' like the young doctor attempting to help her. I also had a current clinical question motivating my attendance at the conference in the form of a distressed patient allocated to me for therapy for anxiety but presenting with a vast complexity that seemed to centre around issues with food and the body but meeting no clear diagnosis or sense of what the most effective treatment would be. I hoped to find some inspiration for resolving my clinical predicament in the interesting programme for the day.

The opening presentation, which was well received by the packed lecture theatre, quickly led me to realise that I was not alone in either my predicament or my hopes for the day. Professor Hans-Christoph Friederich of the University of Heidelberg presented compelling evidence for the efficacy of a manualised form of Focal Psychodynamic Psychotherapy for Eating Disorders. It showed significant improvements in BMI, on par with enhanced CBT and treatment-as-usual with experienced therapists at the end of treatment, but seeming to surpass both at 12 months post-therapy. The questioning at the end revealed huge interest in this promising treatment with a real sense of buoyant hope. One could almost hear the deflation when it was revealed that many co-morbidities had been excluded from the study population. I found this strangely comforting, as it confirmed that my sense of not-knowing

what was best for my own complex patient was not purely down to my own ignorance but shared more widely for a cohort much-discussed in the panels between talks displaying a complex overlap of symptoms of Eating Disorders, Autistic Spectrum Disorder and Personality Disorder. There was further disappointment when the response to the question of whether anyone could be trained in this new manualised therapy was a clear no, with the recommendation being that a grounding in a psychotherapy training was first required to successfully apply such a manualised treatment. I was left wondering about the potential for expansion of a psychotherapy presence throughout psychiatry, backed by evidence such as this to uphold its value and importance in treating some of our most intractable and lethal conditions.

Of the workshops on offer, I particularly enjoyed Reflective Groups in Eating Disorders by Dr Richard Taylor. He gave a wholly realistic, very inspiring and thoroughly engaging account of using reflective practice to change culture on a struggling inpatient unit. He also gave a very practical and achievable outline of how he translated complex psychodynamic ideas using the basis of MBT in a way that was simple and digestible enough for all ward staff, including the often-neglected administrators. This enabled the team to begin to speak the same language and start to understand and articulate the difficult dynamics they found themselves caught up in with this complex patient group. I left this workshop feeling both inspired and endowed with the necessary tools for implementing the ideas.

This conference left me with more burning questions than answers, which always strikes me as the mark of a good, stimulating event. The shared sense in the vibrant panel discussion at the end of the day was that this joint conference had been a tremendous success, and there were immediate calls for its repetition next year. I hope this does happen and feel strongly that more joint conferences between the Faculty of Medical Psychotherapy and others would be a rich soil for facilitating new ways of thinking about complex patients who invariably cross diagnostic and specialty boundaries.

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## **Review of Large Groups at the Medical Psychotherapy Faculty Conference: Creative and Destructive Forces in Groups, London April 2019**

**John Hook**

Large Groups were part of the Faculty Conference programme in the residential conferences held biennially in the late 1980's and early 1990's at Queens' College, Cambridge. In those first three conferences the programme consisted of lectures, small groups and large groups. The small groups were all conducted by Group Analysts and the large groups by Colin James, Consultant Psychotherapist in Cambridge and Meg Sharpe, Jungian Analyst and Group Analyst. The Large groups were held in the beautiful 15<sup>th</sup> century Old Hall, which definitely added to the atmosphere of the event.

One of my abiding memories over the three conferences is how one could observe a maturational development in the Large Groups over time. I recall being impressed how this could happen with three groups every two years. Testament to the dynamic processes inherent in large groups and the competence of the two conductors.

In the following conferences small and large experiential groups played no part in the programme as the conferences became increasingly academically focused with more lectures and workshops until the Leeds conference in 2016. There were complicated political and other dynamic influences within a changing Faculty which underlay these changes. In Leeds and again in Cardiff 2018 small groups were re-introduced. There was a significant change in theoretical approach: a shift from a traditional open, experiential model to a themed model specifically to explore the themes of the conference including emotionally.

There is an important practical consideration in terms of what is possible in different venues. The College building has small rooms that are all set up as meeting rooms and therefore not available to be converted to rooms where small groups could be held as this would involve moving tables with attached media equipment. So when Maria Eyres asked me to organise small groups for this conference it was not possible. Instead I suggested we could include large groups. The organising committee welcomed this.

It was necessary then to decide how best to convene this large group in keeping with the current Faculty organisation and the aims of the conference e.g. to continue with the aim of the group being specifically to explore the conference themes or a traditional open, experiential event, how many groups to hold and the duration of the group.

After discussion between myself and Earl Hopper (a Group Analyst and Psychoanalyst who had been a small group conductor at one of the early Cambridge conferences and who brings a wealth of experience in conducting large groups around the world) we decided to invite a second convenor who would if possible be a member of the Faculty and a woman. Thus, the invitation to Jale Cilasun, a Consultant Medical Psychotherapist and Group Analyst with experience of convening large groups. After discussion between Maria and myself we decided against a group on the Wednesday evening given the expected lower turn out, and to convene groups after lunch on Thursday and Friday. It is inevitable that some attendees would take the opportunity to leave the conference early if the groups were at the end of the day which would introduce an unnecessary disruptive element into the dynamics. The organising committee allotted an hour and a quarter, less than the usual hour and a half. This is an issue to be returned to for future conferences not only from a practical perspective but also to consider how repeated difficulties in organising groups are likely to represent ambivalence towards the experience of being in groups.

It is difficult to judge how much knowledge and experience the current Faculty membership has of experiential groups, particularly large groups. Therefore, we provided a brief information sheet, as we had done for the small groups at Leeds and Swansea, outlining the model and aims of the groups and linking the groups to some of the themes that had emerged in the small groups previously (Appendix 1). The aim was to use the groups to explore the conference theme of “Creative and Destructive Forces in Groups”.

Formal and informal feedback at the conference and in the feedback questionnaire, and the atmosphere generated in each group, suggested that the experience was well-received and appreciated. There was a sense of continuity across the two days in spite of the conference membership being about 50% different on each day. There were about 80 participants in the large groups on both days. There was a general sense of goodwill within which some tensions were able to be voiced.

Dominant themes in previous conferences had included aspects of identity of the Medical Psychotherapist and tensions between the generations. These re-emerged through a fascinating and rich exploration of the College crest, one of those things we are all familiar with but barely notice the detail.

The symbols of snakes and butterflies on the College crest are of course rich in mythological significance. The group explored ideas around snakes as poisonous and a symbol of healing, butterflies as carrying the idea of dying yet the soul surviving. Snakes and butterflies together picked up directly on the conference theme with the implicit interconnectedness of the two processes of creativity and destruction, life and death. This seemed to lead to the idea of transformation – the snake laying eggs only after it has changed its skin and butterflies emerging from their cocoons. The snake is coiled around the staff of

Aesculapius, the first doctor. The word in Greek for medicine is the same as poison. Thus the group began to explore the quality of the experience in the group.

This sense of accomplishment was countered by expression of envy e.g. of those in London posts, of retiring consultants and of the group convenors in the moment. It seemed difficult to explore this, perhaps because Medical Psychotherapists feel themselves to be under such pressure and do not feel valued within the psychiatric hierarchy that the idea that as a professional group we might be envied doesn't seem thinkable. This idea had its counterpoint in how much other professionals need and want our particular expertise.

Another dominant theme was the question of legacy left by the older generation. There was grief for colleagues who have passed away and expression of loss of experienced colleagues who have retired early alongside complaints that the older generation have in some ways failed the younger. This was linked to a question of whether our Faculty has been clear about its tasks over the years, perhaps too internally focused having to fight for recognition with the College (the College crest) and for psychotherapy services under threat within the NHS. Disappointment and anger as expressions of failed dependency at many levels were briefly expressed but were left largely unexplored.

Much has changed within psychiatry and NHS psychotherapy since the 1980s to which the Faculty has had to adapt. This was not explicitly discussed but the focus on legacy implicitly raised the question in what ways have the changes been manifested and have they been helpful or not? Then the Faculty was male-dominated and led largely by psychoanalysts. Many more of the following generation qualified as Group Analysts in parallel with the increase in training schemes outside London. The old question of the relevance of Psychoanalysis to NHS practice seems no longer to be debated as other and increasingly shorter forms of therapy have become more dominant. Consultant posts in CBT were developed and holders became Faculty colleagues. These changes have not been without their tensions and we might postulate that some of these tensions have been played out in how the conferences have been organised.

We could think about the dynamics of the groups in terms of various kinds of social/collective trauma in the field of psychiatry and the College leading to a sense of failed dependency on the leadership who of course is caught up in the same processes; problems of envy and jealousy associated with guilt and shame; difficulty in mourning people; the 'purity' of the psychoanalytical model versus multiple and adapted psychoanalytic models; difficulty in working together and holding a productive consensus with agreed tasks.

There was, as is usually the case, limited written feedback. In one sense the feedback represented a continuation of the Large Group itself. Comments were mainly positive, reflecting the overall mood in the groups. They might be summed up in one comment,

“Let’s have more experiential learning please.” The negative comments concerned the pre-conference handout as unnecessary and responses to some of the conductors’ interventions. Some complaints are likely and must be heard as an element of good dynamic administration, which is essential to the success of such groups at the Conference. A Large Group can provide a healthy setting for exploring discontent with authority. Whoever organises the group component of future conferences and the conference organising committee will need to give due consideration to these points. On the other hand the theme of failed dependency expressed in a range of sub-themes was so prominent that criticism of the conductors can also be viewed within that context.

Following the general acceptance of including small and large groups in our conference we are now in a better position to decide what are the most effective formats. One option is to proceed as we have done: small groups at regional conferences and large groups at the College. This would provide different but complementary experiences. Alternatively, we could have small and large groups in the regional conferences although this would reduce time for other parts of the programme. This question relates directly to that of legacy. **How is it that we as psychotherapists have developed our conferences without space for reflection? Have we lost sight of an essential component of learning through experience?**

It might therefore be timely to reconsider what we want the aims of the conference to be and to prioritise those aims. We have moved from the early conferences of having a discrete number of quality presentations with spaces for active participation and digestion in groups. This fostered shared emotional experiences between participants which led to long-lasting, mutually supportive, collegial relationships. Conferences attracted a significant number of trainee psychiatrists who were influenced in their career choices towards psychotherapy. We moved towards a model where conferences were packed with presentations and workshops where there was little space for reflection. We are a profession that is based around reflection as a central tenet. A paradox of recent years has been the complaint on the one hand that our working lives have little or no space for reflection and yet when offered space in conferences there has been a significant resistance to using it.

Large and small groups, expertly conducted, separately and/or together can be of invaluable use, even when held once a year, in helping us to understand more about ourselves, our work and the Faculty. They provide a place where we can explore the current dynamics within the Faculty and profession as well as personally. This can create a better dialogue between the membership and the Faculty executive committee and guide the committee in its work.

Whatever we decide practical arrangements need to be built into the choice of venue e.g. small groups need to have a sufficient number of appropriate rooms so that the organiser is not having to arrange rooms in unsuitable spaces on the day of the conference; we need to

check that room space in the College for small groups really isn't available. The absence of such arrangements represents one aspect of the unconscious resistance to these experiences.

I have organised the groups now over three conferences. My impression is that we have done enough to re-establish groups as a valuable component of our conferences. I am one of the older generation and it is time to pass on this task. I am sure Maria and the organising committee will appreciate expressions of interest. I will be happy to consult with whoever takes over regarding the lessons I have learnt.

I and the convenors enjoyed being part of this experience. Earl Hopper is editing a book on Large Groups for the New International Library of Group Analysis. We will submit a chapter on the theme of how a Large Group experience can be understood as a commentary on the current dynamics of the organisation. If you have any thoughts from your participation we would be pleased to hear them.

I thank Earl and Jale for their participation in the groups and their comments on this review.

**John Hook - Organiser**  
**Earl Hopper – Group convenor**  
**Jale Cilasun - Group convenor**  
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#### Appendix 1

#### **Psychotherapy Faculty Conference April 2019: Introduction to Large Groups**

Some may not be familiar with the use of large groups as a tool for experiential exploration of the theme of the conference. The following is intended to be a guide to the process and underlying theoretical frame.

Learning in groups gained through an experiential group process is a well-recognised although underused form of learning which adds an affective dimension to more traditional academic forms of learning. It involves learning with and from each other. It can be an exciting and at times disturbing experience. To be most effective it requires an attitude of openness and trust in the process and colleagues, and a commitment to trying to understand any obstacles to this. It can be a deeply satisfying experience that additionally promotes closer bonds between colleagues.

The task of the group is to explore, through the development of dialogue, the relevance of the overall conference theme of "Creative and Destructive Forces in Groups, Clinical Settings, Organisations and Society" to our own professional organisations and settings i.e. medicine, psychiatry and psychotherapy, Faculty, College and NHS and the impact on our professional lives. The task of the group conductors is to help the participants to understand conscious and unconscious processes that might militate against their fulfilment of the task. In other words, the conductors model a reflective function. This responsibility can be taken up by the group members as the group progresses.

Beyond this there are no other instructions or agenda for the group, whose open dialogue is analogous to free-floating communication and free association. Each group will last 1½ hours.

The theme this year lends itself to continued exploration of themes that have emerged from the small groups in Leeds and Cardiff around identity i.e. what it means to be a Medical Psychotherapist in today's NHS where there are limited resources, competition between models of treatment and pressure to provide short-term treatments. There has been a pessimism about the role of Medical Psychotherapist. The large group could be a space in which to understand the stresses in our systems that affect the profession and to begin to re-establish the professional identity and role with confidence and creativity.

What learning is facilitated by such a group process? It is social, organisational and personal. It is partly based around how individuals experience themselves within the virtual society that the group becomes and on each person's observations of the how the group functions and how this represents states present within the profession, Faculty, College etc. The individuals themselves are not the focus of attention but more the group and the individual-within-the-group. To be clear: this is not intended to be a form of personal therapy.

The group convenors are qualified Group Analysts and have considerable experience of conducting large groups across a range of settings.

As is normal for experiential processes confidentiality is a key principle. In this setting confidentiality refers to personal information that may be revealed in the group. However, themes explored in the group and learning from the group is part of the conference and can be shared with other attendees. The team of convenors will meet together to process their experience of the group as a whole as part of the overall learning process for themselves and the conference organisers. Although there will not be a session of formal feedback to the whole conference a summary of this will be published in the Psychotherapy Newsletter.

You will be invited to comment on how you found the group experience along with any suggestions you may have for improving it as part of the conference feedback.

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**What are the experiences of psychotherapy, psychoanalysis and counselling for clients with a label of schizophrenia?**

**Dieneke Hubbeling**

**This was a conference organised by the Critical Psychotherapy Network on 14<sup>th</sup> September 2019.**

The conference took place in the building from the Philadelphia Association. There was a big photograph of Ronald Laing in the room, hence one could expect a very different conference from the ones organised by the Royal College of Psychiatrists.

After a brief introduction by the conference chair, Del Loewenthal – Elizabeth Nicholl spoke about psychotherapy experiences of people who have been given the label

schizophrenia. Many people who have been diagnosed with schizophrenia will not get psychotherapy, almost certainly not on the NHS. People looking for private therapy often get rejected at an initial assessment and, if they get therapy, clients often perceive a reluctance on the part of the therapist to really engage with them. However, for some clients it can be useful to discuss their (past) symptoms and their experiences of having been given that diagnosis.

Then we were shown an impressive film made by Tom Cotton about the lives of some patients with schizophrenia, called *There is a Fault in Reality*, a film about three people with 'psychotic' experiences. However, in all of them the hallucinations related to past traumatic experiences and they turned out to be quite meaningful. The film also made clear that quality of life was quite poor, at least for some people. I do not always realise this, if I only see clients in an outpatient clinic.

The last presentation was by Jo Watson, one of the founders of the *Drop the Disorder* movement. She was challenging the medicalization of emotional distress in counselling and psychotherapy. She pointed out that diagnoses are often unreliable. Furthermore, they can sometimes prevent people getting the treatment they preferred, and should it not be a choice whether patients want to receive a formal diagnosis or not?

There was a lively discussion in the room. The original aim was to focus on psychotherapy, but there were quite a number of psychiatrists and service users/carers in the room and there was more a focus on risk assessment. If you do something outside recommended guidelines and something happens, you are going to be blamed. However, sometimes patients do miss out on something that could be useful.

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## TRAINEE VOICES: MEDICAL PSYCHOTHERAPY TRAINEES SECTION

Alasdair Forrest, Michael Millmore



*....and so our journey goes on....*

It's been a year, would you believe it, since Dr Forrest and myself picked up from the great work done by our predecessors in co-editing Trainee voices? Well, with winter definitely upon us, we can choose to slow things down, conserve energy and perhaps have the proverbial soup in front of the fire, or maybe we can find some energy to keep us going on our journey.

This issue begins with the story of Dr Chris Field who's changing of direction from medicine to psychiatry was driven by time with, and feeling for, his patients. Congratulations go to him to for getting a higher training post in Child & Adolescent Psychiatry where his therapeutic skills will be welcome for sure. How special our time with our patients is will then be taken up by Dr Ademola Alalade who reflects, with some theory too, on the subject of the therapeutic alliance. He realises how we grow as our patients do, on our journey together. Finally, we turn back to clinical practice with a piece by Dr Akif Khan who has recently returned to NHS higher training and shares his learned experiences here.

Thanks as always to all of our contributors, to the editor and to the team at the Royal College for their support on the way. A special thanks is also owed to Dr Khan who gives us the opening image of this Winter/Spring issue as well as the closing photo. Perhaps it helps us all remember that our journeys aren't always the easiest but that there's hope on the horizon as we spring on with the next issue. Feel free to join this newsletter journey too, and until then best wishes.

Alasdair Forrest, Michael Millmore  
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## My journey in to Psychiatry and beyond

**Chris Field**

It has been nearly 10 years since I qualified and during that time I have tried medicine, GP and now psychiatry. I initially thought medicine was the way forward for me but being a medical registrar did not appeal to me. I then chose GP thinking getting to know my patients long term would suit me, but I found trying to assess problems in 10 minutes was too difficult. This said, I did find that the patients I had the most empathy with were those with anxiety and depression. This gave me the realisation that psychiatry could be for me.

I love psychiatry and have enjoyed my three years in core training. As a child I experienced significant amounts of bullying which I now realise affected me psychologically. Whilst I enjoyed all my placements, I found my CAMHS one the most enjoyable. It allowed me to reflect on how vulnerable children are and how when the correct support is given a children's situation and outlooks can really be changed for the better. I am not going to say that my journey to and through psychiatry has been easy, as it has involved lots of stress and heartache for me and my family. Thankfully though I have just completed core training and will begin higher training in child & adolescent psychiatry in February.

Psychiatry has given me the opportunity to assess people and their situation as a whole and to get to know them in a way that I believe no other speciality is able to. It is a privilege to come to work each day and do a job that I love. I feel that at a time when young people and their families are struggling to deal with some very difficult situations that my team and I can make a small but significant difference.

**Chris Field**  
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## On Therapeutic Alliance

Ademola Alalade

### Background

The therapeutic alliance was first described by Freud in 1912, in which he outlined the concepts of transference and countertransference, which are the unconscious feelings or emotions that a patient feels towards their therapist, and vice-versa.

This is a well-known phenomenon often described, by some, as an invisible bond that develops in the therapy room. In fact, it is one of the main drivers of achieving a positive outcome in the lives of clients irrespective of the modality of therapy used.

Another way of thinking about it is to observe the relationships formed between people in our everyday lives; parents, siblings, friends, work colleagues. If you trust others, you can truly be yourself and tend to learn and develop to become a better version of yourself.

In fact, some clinical studies have repeatedly proven that more than the modality of the therapy provided, or the experience of the therapist, the single most positive indicator of the likelihood of success or failure in therapy is the nature and strength of the therapeutic alliance.

### A personal Experience

I chose to write about this topic as part of a reflective learning process. My first full clinical exposure to psychotherapy during my training was a supervised short case work in Cognitive Behavioural Therapy (CBT) and Exposure Response Prevention (ERP) for a client suffering Obsessive Compulsive Disorder of moderate severity. The patient in question, as is often the case in tertiary care, had already been through various treatment courses, both pharmacological and nonpharmacological. During various phases of the illness, the patient had already been tried on two different SSRIs, and this was going to be the third attempt at CBT.

Given that this was the third attempt, with the additional natural anxiety of a trainee, I found this task slightly daunting, wondering if there was any hope for an improvement in the client's recovery process. I did manage to contain both my anxiety and the fears of my patient from the beginning of therapy perhaps applying some CBT techniques on myself. Together we explored the onset, duration, course of the illness and what has worked in previous therapy, and what could be improved upon. We settled on utilising some more assisted exposure techniques in ERP work, because unassisted exposure techniques had

already been tried with very little evidence of success. After about two months we started to see some progress. The speed of progress reported, and evidenced during sessions, by my patient surprised and pleased me, because I had underestimated the value of using simple techniques in assisted exposure work in ERP. On discussing with my supervisor, he enabled me to see that, more than the actual ERP, the patient had been able to make remarkable progress because she felt more of a rapport, and “an alliance” with myself than some of the previous courses of therapy she had been on. She felt that from the first meeting she had felt listened to, and therefore trusted a little bit more in the process of therapy, despite some doubts.

I learnt a lot from this experience because it reinforced the value of making sure your client feels listened to. It appears the therapeutic relationship that would become critical in improving her growth, had started from the very first session of assessment and grown over the course of therapy. In addition, I learnt that the therapeutic alliance is a useful, oft understated tool in treating patients on the longer term, not only in psychotherapy or counselling, but every clinical encounter in psychiatry and even medical treatment in general. I will end with this quote by Carl Rogers; *“In my early professional years I was asking the question: how can I treat, or cure, or change this person? Now I would phrase the question in this way: How can I provide a relationship which this person may use for his own personal growth?”*

Dr Ademola Alalade  
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### Back in the Game

**Akif Khan**

I am an international medical graduate from Pakistan. I came to the UK in Oct 2004 after finishing House jobs in surgery/medicine and allied subjects including psychiatry. I had always wanted to work in Psychiatry and had planned to pursue a career in mental health in the United Kingdom via formal training.

It is a long story about what happened after arriving in the UK and how I got into mental health but in short, I eventually joined a psychiatry training scheme in Charing Cross and started work in different specialities, gaining experience and sitting for exams. I managed to do the written papers and took some time in between papers to start a family.

Whilst enjoying the marital bliss and working full time as a psychiatric trainee, I found out that I only had certain number of days left to sit for the CASC. I sat for it, failed and then sat for it again, and again failed by a small margin. I was out.

At least that is how I felt at the time. I took up locum SHO and Staff grade jobs after that with the intention in mind that the exams are not for me and that I would just continue to work in SHO roles etc as I was earning good money. I had the ease in my life, no pressures of any kind to study etc and started enjoying marital life once again. I made friends along the way and saw people sitting for exams and passing and then becoming SPRs and then eventually consultants, but I was able to justify my own actions as I thought that I had had my try and I wasn't going to be a consultant at all and that I had spent the money and time on exams without anything to show for it. I was not ready to do that again.

My other half, who is a doctor, was by this time, going through the foundation program and then decided to do GPVTS. I admired her for that and supported her through her full-time career in training whilst having two children in between. When she got through her CSA exam, I had a feeling that I was missing something in my life, a fulfilment in terms of career. Money was not much in the forefront by this time. I had accepted a job in private mental healthcare, Priory Group, in a small inpatient unit in Nottingham, where they had been having difficulty in recruiting and retaining doctors. I got on the right foot with the hospital director and we hit it off. I stayed in that hospital for 4 ½ years working as a staff grade. There was just one ward in the hospital with 14 beds. These were sourced from all over the country initially and in the later part of the job, mainly by the Nottinghamshire and Lincolnshire patients, outsourced by the NHS trusts.

I was earning good money and eventually had good support from consultant staff, who initially had been changing as frequently as I change my underwear. I believe that this is the best 4 ½ years of my career so far, I learnt a lot, I got motivated once again. I became positive and started to think more positively about the future and what I wanted to do. This links in with my wife, who passed her CSA around this time.

I started doing some research on going back to sitting for the MRCPsych exam and started preparing for Paper B. I gave it two months of solid prep and was able to get through it with ease. As I had found this paper more difficult the first time around, I was thrilled. I went for paper A and after a couple of tries, I was able to get through that as well. I started preparing for CASC and had some excellent support from my supervising consultant who not only did prep with me but also gave me pointers on how to get through the exam.

I was on the other side finally. I had passed my MRCPsych exam and I was over the moon. I had decided that the financial incentive was not what would keep me away from opting for higher specialty training but my own reservations and fears. I had to get over these before I

could get on the training. Most of my colleagues from the time I was in CT training had been consultants for years. I, to some degree felt that I was behind and getting older by this time. Grey hairs had started showing on my head and it seemed rather like a good idea not to think about going into training but to try and get through CESR. This at least got me thinking and as by this time, I had section 12 approval. I managed to get approved clinician status to give myself some motivation and a fighting chance towards CESR.

Though this thing niggled in the background that I was not a consultant yet and that eventually I did not hold the last word. I guess some of these insecurities come from being of South Indian origin as well. My parents would ask whenever they visited whether I had become a consultant or not, as for them, this is what I had left my country for. I was also under pressure from other relatives who would be very much interested in my rise and fall.

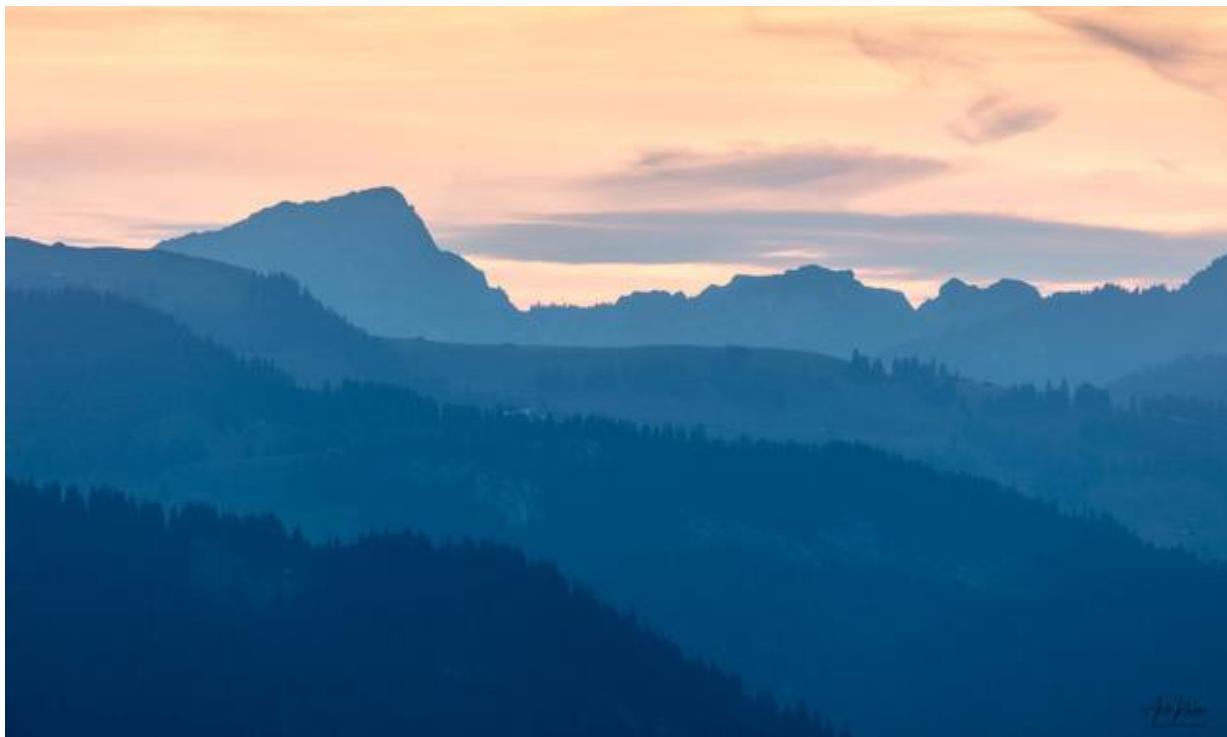
I got through my insecurities by going through these in my mind one by one. Tackling the prejudices that I had and telling myself that it was never too late to go back into training. Even though I had gained a lot of clinical experience, I needed leadership and management as well as research and to explore other faculties of mental health besides general adult acute, which I had been doing for the past 4 ½ years. I learnt along the way that it is never too late and started my specialty training in general adult psychiatry.

I feel that during the years that I was out of training, I gained valuable experience which I would not have otherwise. I got to see patients for mental health act assessments and got good at it, even devising my own system of assessments which I would print off with my portable printer and computer, making sure that data is not stored on my devices and there was no breach in confidentiality. I got to work with certain types of patients, who would never end up in the NHS wards in general e.g. mental health nurses, medical consultants, psychiatric consultants and junior doctors etc. I learnt how to put boundaries in place, especially when dealing with colleagues as patients.

I feel that I have chosen the HST not to just become a consultant but to gain the necessary experience to take on more responsibility eventually. I might have achieved similar results by going through CESR but I felt that the working environment in the private sector was not ideal or suited or geared towards providing that necessary experience.

All in all, I am enjoying being BACK IN THE GAME.

Akif Khan  
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## NEWS OF FRIENDS AND COLLEAGUES

Dr Pamela Ashurst

Consultant Psychiatrist in Psychotherapy

Southampton from 1976 to 1995

Pamela died on August 18<sup>th</sup> 2019, at the age of 79 after a prolonged battle with malignant illness. I first met Pamela at trainer-trainee events when I was a Senior Registrar in Psychotherapy at St George's in the 80's. Much to my surprise she encouraged me to apply for the forthcoming Consultant post in Southampton on the retirement of Dr Zaida Hall. I was appointed there in 1990. I later learnt that her work in support of trainees was one of her strengths and satisfactions. She was greatly appreciated locally and nationally, working for the College and the GMC. She strongly supported trainee women doctors.

Unfortunately, Pamela was already having a long struggle with a failed hip replacement, the initial problem having started many years earlier in life and which led to a prolonged period of absence from work and her retirement. I learnt a great deal from her in the few years we worked together. It was with sadness when she retired and curtailed the possibility of gaining further from her extensive experience and expertise.

Together with Zaida Hall she pioneered group work with women who had suffered sexual abuse as children. This was one of the first departments to offer such a service. We went on to offer a similar group for men who had been abused. She was a great supporter of groups more generally and encouraged many of the psychiatric trainees to participate in conducting groups in the psychotherapy department. She was also a great believer in short-term psychotherapy and hosted several successful annual conferences with such leaders in the field as Malan and Davanloo. These are just a few of her many achievements.

Pamela could come across as a formidable woman and indeed she was so. She was determined and forceful in getting things done, not always by the book. She did what she considered to be in the best interests of the patient. She was generous and respectful of others and interested in their opinions. She was much admired and rightly so.

Outside work she was devoted to her family and enjoyed many interests which she kept up to the last. On learning of her diagnosis she set out to enjoy life as fully as possible and to help lay down happy memories for those around her. It was so typical of her attitude to life and her capacity to care for others in the face of her own ill-health.

**Dr John Hook**

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## BOOK REVIEWS

**Editors: Dan Beales and Andrew Shepherd**

**Why We Sleep – The New Science of Sleep and Dreams, by Matthew Walker,  
published by Scribner 2018**

**Hannah Rowlatt**

A truly eye-opening look at the world of shut eye. Why We Sleep is a feast of fascinating research woven into a wholly readable narrative. Matthew Walker knows so much about slumber one gets the sense he could talk about it in his sleep. The compelling account of sleep's vast benefits and reflections on the way we live make me want to convert to a life lit only by candlelight (I'm still working on persuading those I live with...) and the author dissolves the stigma of laziness around sleeping (cue my new-found smugness after a weekend siesta).

I would recommend the entirety of the book to anyone, but of particular interest to the readers of this newsletter might be Chapters Nine and Ten: *Routinely Psychotic – REM Sleep Dreaming and Dreaming as Overnight Therapy*.

Chapter Nine includes an interesting account of how MRI scans have demonstrated that the emotional and autobiographical regions of the brain are activated during REM sleep, whilst the opposite is true of the regions typically associated with rational thought (including parts of the prefrontal cortex). The author credits Freud with the ‘paradigmatic shift’ of placing the origins of dreams in the brain, although somewhat labours his argument regarding Freud’s dream interpretations being impossible to prove/disprove using scientific methods. The chapter also describes an interesting study suggesting there is a much stronger link between participants’ dreams and their emotional concerns, than between their dreams and their day to day activities. The author concludes the content of dreams is not disguised, and there is no need for an interpreter.

I am less certain. Given the findings of all the studies outlined in this chapter I would ask: is it not possible to have a dream with an underlying emotional quality relevant to the dreamer’s life yet with a seemingly illogical irrelevant plotline? This would require some pondering. Perhaps we should be cautious drawing firm conclusions using regions of our prefrontal cortex whilst awake regarding the dreams produced apparently largely outside the prefrontal cortex whilst asleep. But it seems clear there is value in exploring the emotional meaning of dreams, and Chapter Ten further underlines the merits of dreaming for our emotional health.

There is an interesting account of research showing REM sleep is the only time of day or night when the brain is lacking noradrenaline. The author hypothesises dreams are a ‘safe space’ to review memories whilst starting to dissipate difficult attached emotions, as he puts it ‘through its therapeutic work at night, REM sleep performs the elegant trick of divorcing the bitter emotional rind from the information rich fruit’. The use of the phrase ‘safe space’ is interesting; it is a phrase I associate with therapy and group contexts – the idea of creating a safe space, perhaps a space lacking in adrenaline, to think and review.

Chapter Ten also has something to say relevant to the work we do: evidence has shown that people are better able to accurately interpret the subtleties of others’ facial expressions after sufficient REM sleep – clearly an advantage to any job that heavily relies on human communication and the creation of a therapeutic relationship.

Now, for so many reasons, I’m off to bed.

Hannah Rowlatt

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## Call for 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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## COLLEGE EVENTS, NOTICES AND DATES FOR YOUR DIARY

### FACULTY OF MEDICAL PSYCHOTHERAPY ANNUAL CONFERENCE

22 – 24 April 2020

Venue: Oxford Thames Hotel, Sandford-on-Thames, Oxford

[Further information](#)

## 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 27 February 2020 c/o [stella.galea@rcpsych.ac.uk](mailto:stella.galea@rcpsych.ac.uk)

## **CONTACTS**

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