The Newsletter

Faculty of Medical Psychotherapy Executive Committee

Chair: Susan Mizen, Devon
Vice Chair: Jan Birtle, Worcestershire
Financial Officer: Mark Morris, London
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Editors’ Welcome

Maria Eyres, Harriet Fletcher

Festive greetings and welcome to the autumn/winter edition of the Medical Psychotherapy Faculty newsletter. This is our second edition and we are quite excited by the way it has taken shape, with many interesting contributions from all around the UK and indeed the world. We were particularly pleased that some of you responded to our invitation to readers to send in photos and articles - several of these are included, notably a very heart warming piece by a trainee telling us why she feels that in Medical Psychotherapy she has found her place.

In her message, our Chair Sue Mizen outlines some of the important work the Faculty is involved in at a national level, extending an invitation to all Faculty members to participate, either by standing for election in the New Year or by joining one of the Faculty working groups.

In this edition we have introduced a research section, with the help of Jessica Yakeley in her role as Faculty Executive Committee research representative. We are very happy to have an article from David Taylor giving us his summary of the Tavistock Adult Depression Study and the work that went into it, finishing with a challenge to all of us about ‘where next?’, to build on this huge piece of work.

Importantly, when we took over as editors we wanted to make sure that the newsletter reflected contemporary practice in Medical Psychotherapy right across the UK. Some of our colleagues outside England contacted us to ask if we could write more about what is happening in their day to day lives as Medical Psychotherapists, and in this edition we have a brief report and request for support from a West Midlands peer group, and an article by Clare Cribb, Regional Rep for Wales, with some interesting information about how the specialty is underrepresented but also very active in her part of the world. We are also grateful to our International Editor, Angel Sanchez-
Bahillo, who has commissioned two very interesting descriptions of psychotherapy around the world, in Spain and in the USA.

The Executive Committee is saying goodbye in the New Year to Helen Gill and Celeste Ingrams, who have done some amazing work in their roles as the first Service User/Carer reps on the committee. As they describe, it has been a challenging but rewarding time for them and we introduce the new representatives who will be picking up the baton from January.

We would also like to mention James Johnston, who stood down this year as Chair of the Faculty Education and Curriculum Committee and has written an article describing his considerable achievements in putting our specialty on more solid ground and working to ensure that we can have a lasting influence in training for all psychiatrists and (more recently) medical students. The new FECC Chair, in his report, asks all of us to look out for the Second UK Psychotherapy Survey, which will be coming round in the next month, so that we can build on the success of James' work with first survey.

As well as the headlines and new developments, we want the newsletter to reflect some of the (perhaps less exciting, but very relevant practical issues) that we deal with every day, so we have included a new section which we have called ‘Contemporary Practice’. Jo O’Reilly has written about the Faculty's work around electronic case notes and emergency psychiatry, and we also have an article with an update about progress with plans to introduce credentialing in Medical Psychotherapy. As editors, we have included a call for reports of your experiences of the curriculum change regarding psychotherapy training for higher trainees in General Adult Psychiatry, in the hope that we can put together an article for the next edition outlining how this is being put into practice around the country.

As before, we will look forward to hearing from you. Please send us your thoughts about this edition, suggestions and articles for the next one and more of your photos for the front cover. But for now, happy reading and Happy Holidays!

**Editorial Team**

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

**Contributing editors:**
Tiago Gandra, Trainee Voices
Angel Sanchez-Bahillo, International Voices

Contact the editorial team c/o Stella Galea, Committee Manager stella.galea@rcpsych.ac.uk
Message from the Chair of the Faculty of Medical Psychotherapy

Susan Mizen

Since the general election the College Faculties have been actively involved in reviewing drafts of the mental health strategy for the next five years. Whilst the under-investment in mental health services is recognised, the priorities are likely to include improving access to services for children and young people, suicide prevention, clear commissioning pathways for early intervention in psychosis, Perinatal care and eating disorders and seven day access to emergency mental health care. There is unlikely to be an increased investment in psychological therapies outside IAPT services. There are references to the gaps in provision of services for people with personality disorder, but there is no coherent strategy for addressing this problem. It is clear that the impact of the lack of provision is not fully understood by policymakers, nor the health economic and quality of life implications.

So how will we find a solution to this poverty trap? At the beginning of October the Faculty hosted the first meeting of a psychotherapy collaboration. The UKCP, BACP, BPC, APP and the Society for Psychotherapy Research met with us and agreed to develop a national infrastructure to support and develop psychotherapies for those who have severe and complex mental health problems and are not eligible for IAPT services. Learning from the success of IAPT, we will be working on developing a national data collection system, free at the point of use for NHS psychotherapy services, as well as a national workforce development and training strategy. This group will be linked with the clinical working groups we have set up this year at the Faculty whose purpose is to promote the development of therapy services. The collaboration will be meeting monthly in the New Year to get the work started. A number of the clinical working groups have contributed to the newsletter, so it will be apparent to the reader how effective they have been in engaging with the national agenda.

Another major strand of work at the College has been collating the response to the draft consultation on mandatory reporting of child abuse. The College response has now been submitted to the Home Office consultation team. The Faculty, together with the Loudoun Trust, a charity established to promote understanding of childhood sexual abuse and paedophilia, have been fully involved in the consultation, and have underlined the unintended consequences which would follow the introduction of this legislation. A full public consultation will be launched within the coming weeks but it is now clear that two options are being considered: mandatory reporting, in which professionals could face a prison sentence for failing to disclose allegations of sexual abuse to the appropriate authorities, and the alternative of penalising a failure to act within the current framework. We have expressed the firm view that the latter, in which the obligations to disclose would remain largely as they are currently but the penalties for failing to act within this
framework would increase, would be least damaging to therapeutic work with both victims and offenders.

I would like to welcome our newly appointed service user representative, Angela Slater to the Exec. Service Users are a vital part of our work and we hope will continue the essential task of helping us to keep in mind what we are here for. She will be joining us for the January strategy day. Many thanks to Helen Gill, Celeste Ingrams and Alison Summers for the work they put in to the recruitment process.

So, what of the coming year? It seems to me that we need clear priorities, as there is much work to do and little time to do it in. Some of the clinical working groups are developing models of integrated care which lend themselves to becoming vanguard sites. Understanding the application process and using College structures to support these developments is a priority. Expanding and consolidating the work of the current clinical working groups (Medically Unexplained Symptoms, Historical Childhood Sexual Abuse, Personality Disorder, Tier 2 Psychotherapy Services and Reflective Practice, Psychosis, Eating Disorders and Perinatal Mental Health) to support these clinical developments will involve considerable ongoing work.

Our training priorities this coming year will be, to develop psychotherapy training for ST4-6 trainees in all psychiatric sub-specialties towards a mandatory endorsement, as is now the case for CT1-3 training. This, alongside developing a psychotherapy Credential for General Adult Psychiatrists who wish to retrain after completing their CCT, would do much to develop a more psychotherapeutic psychiatric practice. We need to develop our capacity to undertake research and to this end we will be working on developing Academic Research Fellowships in Medical Psychotherapy to train the future academic leaders of our profession.

I suppose it is clear this is an ambitious programme of work and there is much at stake regarding the future of the services we run, our specialism and the interests of the patients we serve. We have elections to new positions on the Executive in the New Year. Can I encourage anyone who is interested in supporting these developments to stand for election? There may be others who are interested in the areas we are working on, and feel they have a contribution to make, but are not in a position to commit themselves to working on the Exec. We would really welcome your input to the clinical working groups, subject to the working group Chair’s agreement. If you would be prepared to contribute your time and energy in this way, please contact Stella Galea, stella.galea@rcpsych.ac.uk letting us know which area you would like to be involved in. This is important work which is having an impact, and we need all hands on deck.

Finally, we have an excellent conference planned in April, so put the dates in your diary and encourage any interested Old Age Psychiatry colleagues to join you.

I will leave it to my colleagues on the Exec to tell you about the work they are engaged in which is impressive and productive on many fronts.

Sue Mizen
Faculty Chair
Contact Sue c/o stella.galea@rcpsych.ac.uk
Message from the Academic Secretary

Mark Evans

Medical Psychotherapy Faculty Conference 2016

The organising committee would like to welcome you to the annual Medical Psychotherapy Faculty Conference, which this year will be held in **Weetwood Hall in Leeds on 13th - 15th April 2016**. This is an open conference for medical psychotherapists, old age, general adult and perinatal psychiatrists and will also be of interest to non-medical psychotherapists. The conference title is ‘Attachment Theory Across the Life Cycle’ and is being run in conjunction with the Faculty of Old Age Psychiatry and sponsored by UKCP, BPC and APP. Invited speakers will address new research paradigms and new ways of working in psychiatry and psychotherapy, focusing on the application of attachment theory.

On the first day, internationally renowned speakers on attachment theory (Professor Peter Fonagy, UK; Dr Steve Suomi, USA; Dr Jeremy Holmes, UK) discuss the clinical challenges and opportunities thrown up by recent advances in this area. On day two, applications of attachment theory across the life cycle will be discussed. Presenters include Dr Andrew Balfour and Dr Sandra Evans (applications in older adults) and Dr Amanda Jones (applications in the perinatal period).

Once again we are planning to have pre-conference workshops on the Wednesday afternoon and a guest speaker who is yet to be finalized. We are looking forward to an exciting and interactive programme.

Mark Evans
Academic Secretary

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Message from the Chair of the Faculty Education & Curriculum Committee (FECC)

William Burbridge-James

It is a pleasure to contribute to the newsletter again. I want to pay tribute to my predecessor James Johnston, even if this repeats some of Sue Mizen's comments in the last newsletter, and link this to feedback about recent developments.
Over the four years that James occupied the Chair's role, building on the work of Chess Denman before him, he has been pivotal in placing medical psychotherapy at the heart of core psychiatry training. His article later in this edition outlines his core achievements, most notably the ratification by the GMC of the findings of the first UK Psychotherapy Survey, which he led together with Barbara Wood in 2012.

The survey showed that where leadership of core psychotherapy training was undertaken by a psychotherapy tutor who was a consultant medical psychotherapist, trainees were five times more likely to achieve their psychotherapy competencies compared to training schemes where there was no consultant medical psychotherapist leading the training.

Since the survey, evidence has emerged of new consultant medical psychotherapy posts being created as core psychotherapy training leaders. The FECC and faculty position has been that post holders in psychotherapy tutor roles need to be based within the context of a clinical service, to ensure that trainees have appropriate access to training patients in an appropriate setting for psychotherapy, and to ensure good clinical governance.

Before James left the Chair's role, planning was already in progress for the second UK Psychotherapy Survey. This is being undertaken with the support of the College and was instigated at the request of the GMC. The survey will not only re-evaluate findings from the previous 2012 survey into core training, but will also focus on psychotherapy experience for higher trainees across the spectrum of psychiatric sub-specialties, following the curriculum amendment in March 2015. The awareness of this change and its implications in terms of resources need to be evaluated.

Just as the first survey’s findings had significant impact, we anticipate that the second will have clear implications in ensuring that consultants in medical psychotherapy have a clear role in leading psychotherapy training for higher trainees.

The second UK Psychotherapy Survey will be sent out electronically within the next month and completed on Survey Monkey. I would like to ask those of you who receive the link to be active in ensuring that the survey is completed, and encourage other colleagues such as training programme directors and other colleagues in higher training, who should also receive the link, to complete the questionnaire.

In addition to the survey of the work of the FECC goes on, including developing further dual trainings, and I hope to report back in the next newsletter.

William Burbridge-James  
FECC chair  
Contact William c/o stella.galea@rcpsych.ac.uk
Executive Committee Task Groups

Introducing the Tier 2 Psychotherapy Services Task Group

Members: Ronald Doctor (Chair), Gordon Barclay, Sue Stuart Smith, Anne Patterson, Kate Pugh

In my correspondence with the editors of this newsletter, consciously or unconsciously, I started to call the Tier 2 Psychotherapy Services Group, the Tier 2 Personality Disorder (PD) Service. Perhaps my confusion brought up what I think is the crux of the current ambiguity in psychotherapy services, particularly in my Trust, but may also be part of other people’s experience, in the rest of the UK. I think the ambivalence in me is that my Trust is currently embedding the Tier 2 Psychotherapy Services, which have been generalist psychotherapy services, into the PD Pathway; in fact, in the Clinical Governance meetings, psychotherapy does not appear on the agenda, as we are now led and managed by the new Personality Disorder Clinical Lead. Psychotherapy is discussed, if it is discussed at all, under the item Personality Disorder, by the PD clinical lead. In my opinion this is an issue for debate and I would be interested in a discussion with other Psychotherapy Services Leads whether they are experiencing a similar process with regard to psychotherapy and whether this is the way forward in its future development.

I know that Sue and Gill are the leaders of the new PD group, but as I understand, they are dealing with Tier 3 and 4 Personality Disorders Services, whereas in my puzzled mind I am in a Tier 2 PD/Psychotherapy group; Psychotherapy and PD Services have become indistinguishable.

To cut to the chase, the point at which specialist dedicated PD services should kick in is a big question. Currently, this line is effectively drawn at Tier 4 – nationally commissioned services. Whilst there is plenty of evidence for specific PD interventions, there is a growing debate about the differences between service and intervention. This becomes especially pertinent when one considers the hard to engage and those with severe conditions or co-morbidities, as they either never enter into interventions or have high dropout rates when they do. Just like all areas of mental health, the evidence base for dedicated services with a range of integrated interventions is limited. Linked with this, is where the demarcation of dedicated services in the spectrum of PD severity lies.

With the advent of psychotherapy moving towards a Tier 2 PD service, so is the training of future trainees in Medical Psychotherapy moving towards a dual training with General Adult Psychiatry. Coupled with this development is another exciting advancement taking place in the training of General Adult Psychiatry higher trainees, in that they now have a mandatory competency in psychotherapy as well. Following the paper on “Personality Disorder: no longer a diagnosis of exclusion;” patients with personality disorder were brought in from the cold, so it is that Medical Psychotherapy might be in the process of being brought in from the cold. Ironically it might also be that Medical Psychotherapy is asked to save the profession of General Adult Psychiatry (GAP) as GAP is struggling to recruit trainees into core and higher training.

We propose that a UK expansion of the dual training with Medical Psychotherapy, introduced in 2008, could be the way forward in terms of producing doctors, trained in both GAP and Medical Psychotherapy, for the new Tier 2 Psychotherapy/PD services. We suggest the setting up of a UK Dual Training Network to support, evaluate and promote dual training and Medical Psychotherapy.
across the UK with twin aims: to develop psychotherapeutic psychiatry and to enhance the appeal of General Adult Psychiatry by pairing it with Medical Psychotherapy.

Dr Ronald Doctor  
Consultant Psychiatrist in Psychotherapy  
West London Mental Health NHS Trust

Contact Ron c/o stella.galea@rcpsych.ac.uk

**Update from Psychosis Task Group**

Chair: Alison Summers

The Psychosis Task Group is concerned with improvements in all psychological aspects of care offered to people who experience psychosis, that is, not just with increasing access to an appropriate range of therapies, but also with improving the extent to which the overall approach of mental health services is psychologically informed. If this is work to which you might want to contribute, please contact Alison Summers c/o Stella Galea

The Psychosis Task Group is still at the stage of being ready to invite potential collaborating groups and organisations to an initial meeting. Unfortunately we were unable to go ahead as planned with invitations to a meeting in the autumn, as we have been resolving some issues regarding service user and carer participation which we regard as crucial to the task. However we now hope to hold a meeting in the New Year.

Dr Alison Summers  
Faculty Executive Committee member  
Contact Alison c/o stella.galea@rcpsych.ac.uk

**Update from the Historical Childhood Sexual Abuse Task Group**

Co-chairs: Maria Eyres and Jo Stubley

**Definition of task and terms of reference**

Focus is on the impact / effects of Childhood Sexual Abuse (CSA) on adults. This will then be used to inform:

1. Clinical Services – best practice from identification through the management, appropriate services from primary to tier 4 specialist care. Recognition that multiple psychiatric and medical diagnoses may include CSA histories including – Complex Trauma, Dissociative disorders, Depression, anxiety, Personality Disorder, Medically Unexplained Symptoms, forensic presentations etc;

2. Medical / Psychiatric Training;

3. Research;

4. Political Implications.
Membership of Task Group
1. We are pleased to report that Sue Stuart Smith has agreed to join the task group from January 2016;
2. Anne Ward has also agreed to contribute to the revision of the patient leaflet on CSA;
3. Need to carefully consider who is best placed to attend to all of the above and has influence and expertise in this area;
4. Involvement of “Experts by Experience” or Survivors group representation essential;
5. Forensic involvement would be useful;
6. Researcher in this area;
7. Cross Modality helpful.

Next Steps
1. We will present a workshop on HCSA at the Psychotherapy Faculty Conference 2016;
2. Maria has attended a meeting at DOH in relation to HCSA and has made some useful contacts including advising on a tender that was being developed and advising on the importance of reflective spaces;
3. We have written a letter to the British Medical Journal calling for cross College involvement on HCSA. Prior to sending it out, we are in talks with College departments of communication and policies as to how to proceed. We were advised that the next step would be to meet with Simon Wessely and then take it to the Academy of Royal Colleges;
4. We have asked William Burbridge-James to come to the Faculty Education Committee in 2016 to address training issues;
5. We are planning a strategy day in 2016 and will consider further issues around membership;
6. We have coordinated submission of vignettes to the DH regarding mandatory reporting.
7. Jo and Maria will be representing the Faculty in talks with Professor Cornelius Katona regarding the mental health of refugees.

Maria Eyres, Joanne Stubley
Faculty Executive Committee members
Contact Maria and Jo c/o stella.galea@rcpsych.ac.uk
Contemporary Practice in Medical Psychotherapy

The Medical Psychotherapy Faculty and Electronic Patient Records

Jo O’Reilly

The Medical Psychotherapy Faculty has been working on the issues raised by the use of electronic patient record keeping systems and the move towards paperless systems in some Mental Health Trusts and some of the issues this can raise for some areas of our work. This has been in response to concerns raised by Medical Psychotherapists over recent years. A position statement has been written by the Faculty and received support from the Royal College of Psychiatrists Policy and Public Affairs Committee. This position statement will be available on the Psychotherapy Faculty Website currently being developed.

In brief, in this position statement the Medical Psychotherapy Faculty fully supports the use of electronic records for information which is important to share with all teams involved in a patient’s care in order to provide a coordinated approach to care planning, treatment provision and risk management.

At the same time there are certain categories of information which are not appropriate to fully share with other professionals involved in the patient’s care which includes personally intimate information arising within the boundaries of a therapeutic relationship. For such information the Faculty strongly encourages its members to engage with Trust negotiations and Caldicott Guardians to ensure that electronic record systems are configured with confidentiality areas within the record system which preserve the confidentiality of such material adequately. This is also in keeping with the ethical guidelines of most psychotherapy registration bodies. In the absence of such arrangements detail of the therapeutic work may need to be kept within paper record systems within psychotherapy services. This arrangement should be transparent and does not preclude the need to utilize Trust electronic record systems as the main medical record.

We will continue to keep you updated about the progress of this work as the College continues to update its Confidentiality Document (CR160).

Jo O’Reilly  
Consultant Psychiatrist in Medical Psychotherapy  
Camden and Islington Psychotherapy Service  
Contact Jo c/o stella.galea@rcpsych.ac.uk

A call for news of your experiences with the new developments in mandatory psychotherapy training

Maria Eyres and Harriet Fletcher

Both trainees and trainers are now familiar with the well established framework of psychotherapy requirements for core trainees, which start with case discussion/ Balint groups, followed by taking on short and long cases under supervision and being assessed using the PACE.
In March 2015 the curriculum for higher training in General Adult Psychiatry was amended to include further mandatory requirements in relation to psychotherapy competencies. While the psychotherapy training framework for the ST4-6 still needs to be devised in more detail, and the assessments formalised, we are aware that this new development is leading to a variety of responses across the country, with some Training Programme Directors already implementing the changes and expecting their trainees to demonstrate progress in psychotherapy at the ARCP.

This presents us with great opportunity for our specialty to promote the development of an even more psychotherapeutically aware new generation of General Adult Psychiatrists.

The changes are likely to increase our workloads and therefore might lead to either cutting down on other commitments, or they could serve as an argument for increasing numbers of PAs, which would have to be reflected in new job descriptions.

The second UK Psychotherapy Survey includes some questions about the impact and effect of the curriculum changes. On a more narrative level, we would like to hear from anyone willing to share their experiences of this new and exciting development, as we all need to move forward with this. We would hope to collate your responses into an article for the next newsletter describing how people have accommodated the changes into their workload and outlining best practice and innovative developments around the country.

Maria Eyres, Harriet Fletcher  
Faculty Executive Committee members  
Contact Maria and Harriet c/o stella.galea@rcpsych.ac.uk

Royal College of Psychiatrists Survey on Emergency Work in Psychiatry

Jo O’Reilly

The Royal College of Psychiatrists is conducting a survey about emergency psychiatry. Information is being sought to clarify what work is being carried out and by whom amongst the different psychiatric specialties. This project is being led by Drs Helen Matthews and Matt Tovey and is intended to cover both consultant and trainee experience. The information gathered will be used to look into the current and future training requirements for psychiatrists in emergency psychiatry. My role in this survey is to find out more about emergency on-call work carried out by psychiatrists who are working or training in medical psychotherapy posts. If other faculty members would like to contribute please answer the questions based on whether you are a consultant or a trainee and state your main specialty.

The Faculty of Psychotherapy wants to fully support this survey and I have agreed to collate responses and report back by Christmas.

I would be grateful if you could respond in an email to these questions, to Jo O’Reilly c/o stella.galea@rcpsych.ac.uk.

Questions for Consultant Medical Psychotherapists (Please state what your main role is/the nature of the service you work in.)
• Are you involved in emergency on-call work?

• If so what services do you cover?

• Does your organisation have different rotas for sub-specialisms e.g. CAMHS, Older Age Adults, LD, forensics, PD etc

• Are there opportunities for multi-disciplinary working within your on-call work?

• Do you anticipate any changes within your organisation which will change your on-call work?

• Do you feel adequately trained and have the relevant clinical experience to cover all services included within your on-call work?

• Are there clinical experiences you are better/ less well equipped to deal with on an emergency basis as a medical psychotherapist?

• Do you receive any peer support/ supervision/ CPD for this work?

• Do you think your training as a medical psychotherapist has equipped you adequately to work in a range of clinical settings on an on-call basis?

• Do you think there are any issues about your on-call work which need addressing?

Questions for Trainees / Dual trainees in Medical Psychotherapy / Other Medical Psychotherapy posts (please specify)

• Are you involved in emergency on-call work?

• If so what services do you cover?

• Does your organisation have different on-call rotas for sub-specialisms e.g. CAMHS, Older Age Adults, LD, Forensics, PD etc

• Are there opportunities for multi-disciplinary working within your emergency work?

• Do you anticipate any changes within your organisation which will change the on-call experience for trainee psychiatrists?

• Do you feel your training is adequately equipping you to cover all services within your on-call commitment?

• Are there skills your medical psychotherapy training is equipping you with which provide particular strengths or difficulties in your on-call work?

• Do you receive adequate supervision / training for your on-call work?

• Do you think there are any issues about your on-call work which need addressing?
Questions for Medical Psychotherapists working in the private/other third sector organisations -
Please answer covering the areas covered in the questions above and stating the type of organisation you work for.

General Questions

- Do you think your training is equipping you/ has equipped you to be a consultant psychiatrist with pluripotential to work in a variety of settings including emergency work?

- Are there any other comments you would like to make about your on-call work?

Thank you for your help with this survey. All information will be treated confidentially.

Jo O’Reilly
Consultant Psychiatrist in Medical Psychotherapy
Camden and Islington Psychotherapy Service
Contact Jo c/o stella.galea@rcpsych.ac.uk

**Credentialing in Medical Psychotherapy**

Padakkara Saju and Svetlin Vrabtchev

The GMC has closed the consultation process for credentialing. The GMC proposal was to introduce regulated credentials in areas where there is patient need, service need, feasibility and support from authoritative bodies. We are awaiting the report of the consultation and recommendations.

Credentialing is a process which provides formal accreditation of competences (which include knowledge, skills and performance) in a defined area of practice, at a level that provides confidence that the individual is fit to practice in that area.

The Faculty of Medical Psychotherapy is in agreement with the proposals to introduce credentialing to improve quality and safety for patients. We think we could make a case for credentialing in medical psychotherapy, given the experience and interest of psychiatrists in psychotherapy. Setting standards for competences and evaluating them would be important.

If you are interested in a workgroup for setting standards and evaluating standards for competence for credentialing in medical psychotherapy, please get in touch with Padakkara Saju or Svetlin Vrabtchev.

Padakkara Saju and Svetlin Vrabtchev
Faculty Executive Committee members
Contact Saju and Svetlin c/o stella.galea@rcpsych.ac.uk
Research Reports

The Publication of the Findings of the Tavistock Adult Depression Study (TADS)

David Taylor

As many readers of this Newsletter know, the findings of the Tavistock Adult Depression Study (TADS) were published in the October issue of the journal World Psychiatry. From conception to the current stage of its fruition, the study has taken more than 15 years and cost something like £1.75 million. To say that its findings have been long-awaited is to understate. Are they worth the wait?

TADS is the first randomized controlled trial testing whether longer term psychoanalytic psychotherapy is of benefit to NHS patients; in particular those suffering from chronic depressions not helped by the treatments currently provided: mostly antidepressants and courses of counselling or cognitive behavioural therapy. The decision to test a mainstream psychoanalytic therapy with a chronic, hard to treat, patient group was strategic: depressive disorders are in many ways the central health condition; there is little evidence that speaks for the effectiveness of other kinds of treatments of chronic ‘treatment-resistant’ forms of it; patients with depression are generally regarded as unsuitable for psychoanalytic treatments; the condition is responsible for a large portion of the burden of disease associated with depression.

The TADS trial was designed intentionally to be a severe test of a psychoanalytic approach to patients suffering with a significant mental disorder. The Study’s two-year follow-up make it exceptional.

Findings

In brief its main outcome findings were:

☐ 44% of the patients who received 18 months of weekly psychoanalytic psychotherapy no longer met the criteria for major depressive disorder when followed up two years after the 18 months of weekly psychoanalytic therapy ended; for those receiving the NHS treatments currently provided the figure was 10%.

☐ Using customarily employed bands of the Hamilton Depression Rating Scale (HRSD) - which was the Study’s pre-nominated primary outcome measure - just 14% of those receiving the psychoanalytic treatment ‘recovered’ completely; however, ‘recovery’ occurred in only 4% of those receiving the treatments currently employed.

☐ After the two years of follow-up, depressive symptoms were found to have partially remitted in 30% of those receiving the psychoanalytic therapy; in the control condition it was 4% (NNT=3.9).

For every 6-month interval of the trial’s 3 ½ years period of observation, the chances of going into partial ‘remission’ were 40% higher for those receiving the psychoanalytic therapy than for those receiving the usual treatments.

A consistent pattern of more benefits accruing to those receiving the psychoanalytic psychotherapy was observed across all measures: the quality of the participants’ lives, general wellbeing and in their social and personal functioning.

Those who responded to the psychoanalytic psychotherapy usually continued to experience symptoms of depression but at a significantly reduced level. Over the two years after the end of therapy, they had less likelihood of ‘relapse’. In contrast, the smaller gains seen in control group patients tended to be unstable and to disappear over time.

A substantial proportion of patients did not benefit

The way of presenting findings I use here is beloved by US trials of antidepressants. It presumes far too many things. For example, the definitions of ‘recovery’, ‘remission’ and ‘response’ according to the HDRS lay claim to exactitude but are merely a consensus of opinion amongst predominantly biological psychiatric researchers. They are not founded on observational evidence. It is unclear what such terms actually mean in a condition where the notions of recovery and relapse may not even apply. The disorder of personal functioning involved penetrates every fibre of life and relationships and lies beyond the sensitivity of a symptom measure.

There is no suitable proxy that captures the changes associated with psychoanalytic treatments and their particular level of therapeutic action. There is an urgent need to find one. Meanwhile, the psychoanalytic individual case-study method is still the best way of describing them. Using this method, the psychoanalytic clinicians delivering the TADS treatments will produce a book: Understanding Depression. It is impossible to do justice here to the descriptions it will give. However, it was found that even in individuals who had their disorder for many years and who initially seemed mentally dulled, resistant and/or very ill, it was often possible to make contact, and for this contact to become increasingly meaningful. Apparently paradoxically, mentally painful work with conflicts and losses was associated with an increased sense of mental connectedness and aliveness: these movements were deeply valued by both patient and therapist. Each treatment had its distinctive vicissitudes. Although most of us experience analytic contact as disturbing and invasive to a degree, there were patients in the Study where it was not possible to understand this reaction enough to enable the patient to stay. In others, contact with the underlying psychic reality gives rise to fears of irreversible and uncontrollable breakdown. Others were trapped and enmeshed in a masochistic psychic economy.

Necessary Next Steps

By those in sympathy with them, the TADS findings have been warmly received. Properly, the security of the TADS’ results will be critically scrutinised by others. The comparison control condition was naturalistic: chosen to reflect what these patients generally receive rather than what might be considered optimal in terms of research protocols of medication or possible cognitive behavioural treatments for this group of patients. Although corrected for statistically, the properly randomised groups nevertheless had imbalances. These matters aside, however, the TADS study was of pretty good quality. The clinical effect reported seems solid: at least to a degree durable and thank goodness not a miracle cure; no one with any knowledge of this sort of depression would believe in one.

If the TADS study findings themselves are to have a significant effect on the climate of opinion, the NICE guideline revision, and ultimately on the services commissioned and provided, some further
essential steps are needed. Some can only come from the TADS team: the study detailing the cost-benefit equation: the cost per QUALY of the TADS effect; this should be available in 2016. Next are qualitative findings - the patients’ opinions of this psychoanalytic kind of treatment compared with those receiving the usual treatment: these may be eloquent lobbies documenting impartially the preference of most and the aversion of some. The TADS study project coordinator, Felicitas Rost, has collected before and after interviews with TADS patients and therapists. This material is now about to be processed.

The other next steps – making sure that the NICE Depression Guidance Revision, GP’s and Primary Care, and Mental Health Commissioning Groups as well as User groups know of the Study and its findings depends upon people like YOU! the reader, the wider community of clinicians and researchers. How well these next phases are carried through will determine whether the publication of the TADS study is the beginning of sea change in the climate of opinion or not.

Assuming all of this is done well enough many subsequent questions follow. For example, “Should further such studies of the outcome of psychoanalytical treatments be undertaken?” My answer would be “Yes”. “With which mental health condition should they be concerned?” Aside from a next stage depression study, my answer would be “Psychosis”. Although the practical, logistical and funding challenges are major they can be solved. Hopefully, the interesting and broadly positive nature of the TADS findings about the beneficial effects of a longer term psychoanalytical psychotherapy have sharpened the appetite for these tasks.

Note: I want to acknowledge the generosity and altruism of the participants in the study, the therapists and team of researchers without whom it would not have been possible for this piece to be written. I particularly wish to acknowledge the central contributions of Felicitas Rost and Peter Fonagy.

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Antisocial personality disorder: the challenges of treating and researching the ‘untreatable’

Jessica Yakeley

Antisocial personality disorder (ASPD) is a common, complex and costly condition with high rates of comorbidity, especially substance misuse, anxiety and depression, (Compton 2005; Goodwin 2003; Lenzenweger 2007) and mortality, including death through reckless behaviour as well as suicide (Black, 1996). ASPD is a key contributor to violence and criminal behaviour, is significantly overrepresented among offenders, who pose a high risk of harm to the public and a heavy burden on public services. Although there has been a proliferation of services for personality disorder in the last decade, these have mostly been for individuals with a diagnosis of borderline personality disorder, and there remains a lack of service provision, particularly in the community, for individuals with other personality disorders, including ASPD. Many psychiatrists and other

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2 This article is a shortened version of an article by Yakeley and McGauley published in the BPC newsletter New Associations (Summer Issue, 2015).
clinicians are reluctant to offer treatment to individuals due to concerns regarding their risk, substance misuse and the difficulties in engaging them, and despite the publication of NICE guidelines for ASPD in 2009, many still believe the condition to be untreatable. The few treatment programmes that do exist are derived mostly from a CBT model, are delivered in the Criminal Justice System rather than in the NHS, and are focussed on the reduction of risk rather than improving mental health. Many of these treatment programmes for offenders have been poorly evaluated and there have been only a small number of high quality treatment trials of specific psychological therapies conducted among people with antisocial personality disorder. A number of meta-analyses have highlighted the limited evidence base for effective treatments for this patient group, including the NICE guidelines (NICE, 2009) and a Cochrane review (Gibbon, 2010) which reflect not only the difficulties in engaging patients with antisocial personality disorder in treatment studies, but also diagnostic inconsistencies, differences in defining and measuring outcome, and a focus on treating incarcerated patients rather than those in the community. The Cochrane review concluded with a recommendation for urgent research efforts to determine effective and cost-effective interventions for this condition.

With these considerations in mind, we started a pilot community-treatment programme adapting MBT for men with ASPD presenting for help with their aggression at the Portman Clinic (Tavistock and Portman NHS Foundation Trust) in conjunction with Professor Anthony Bateman and his personality disorder service at St Anne’s Hospital (Barnet, Enfield and Haringey Mental Health Trust) in North London. We chose MBT as it is a psychodynamic treatment based on attachment theory and there is increasing evidence that for at least a subgroup of individuals with a diagnosis of ASPD, the disorder has its aetiological roots in early disruptions of attachment (McGauley et al., 2011)

The ASPD-MBT treatment programme comprises an initial assessment, which is in part psychoeducational, followed by concurrent weekly group psychotherapy and monthly individual psychotherapy sessions for a duration of 18 months. The overall aims of treatment are to promote mentalising by facilitating the patient in his interpersonal functioning by stimulating attachment bonds whilst encouraging him to examine the mental states he experiences in relation to others. This process may be more effective in group treatment, as this offers more opportunities to understand other peoples’ minds and is less arousing than individual therapy.

Despite many challenges in our attempts to treat these individuals including problems with engagement, boundary violations, substance misuse and managing relationships between the patients, the results of our pilot showed that those that we could engage (about two thirds of patients referred) showed a significant decrease within a few months in aggression as measured by the Overt Aggression Scale (OAS) (Coccaro et al, 1991). The OAS rates the frequency of thoughts of and acts of violence towards others and self over the past two weeks, and is also useful for monitoring the risk of suicidality in these patients, a risk which is often overlooked compared to the more obvious risk of violence towards others. The patients also showed a decrease in psychiatric symptomatology as reported on the Brief Symptom Inventory (Derogatis & Lazarus, 1994).

Following the results of our pilot, in 2012 we approached Nick Benefield and Nick Joseph, the architects of the National Offender Personality Disorder (PD) Pathway, with a funding proposal to further develop and research the MBT-ASPD services. The Offender PD Pathway, co-commissioned by NHS England and the Ministry of Justice, is the sequel to the Dangerous and Severe Personality Disorder (DSPD) programme (Home Office & Department of Health, 2002) which was
decommissioned in 2011 in favour of a reconfigured national strategy for managing high-risk personality disordered offenders based on a ‘whole systems pathway’ across the Criminal Justice System and National Health Service (Joseph & Benefield, 2012). This new strategy is informed by a developmental model of personality disorder and the recognition of the centrality of attachment experiences in the historical and current lives of offenders. It promotes education of the workforce about personality disorder towards the goal of creating more therapeutic environments in prisons and forensic institutions, as well as prioritising the development of specialized services for the management and treatment of neglected groups of personality disordered offenders. The importance of meaningful service user involvement in the development and delivery of services is also emphasized.

Following a tendering process, the Tavistock and Portman NHS Foundation Trust were commissioned in 2013 by NHS England and granted funding for us to develop and implement 13 new MBT community treatment services nationally. These are for offenders with a diagnosis of ASPD who are currently under statutory supervision of the National Probation Service and part of the Offender PD Pathway. The services are equitably spread across England and Wales, with sites in Liverpool, Preston, Leeds, Lincoln, Nottingham, Staffordshire, Bristol, Exeter, Wales, and four sites in London. Treatment is delivered within probation premises and consists of weekly group therapy with monthly individual sessions for one year. The MBT team in each site includes three MBT therapists, an assistant psychologist, a psychiatrist, a probation officer and an ex-offender service user. All members of the team are trained in MBT and receive on-going supervision from the Anna Freud Centre, led by Anthony Bateman.

These treatment services commenced in April 2014 and predictably have faced numerous challenges in their implementation. The most challenging is the government’s restructuring and partial privatization of the probation services as part of the ‘Transformation Rehabilitation’ (TR) programme for how offenders are managed in the community. TR has led to widespread demoralization amongst probation officers, with high staff turnover, high rates of sick leave and many probation officers leaving the profession; so it has not been a good time to introduce and promote a new service. The reorganisation has also adversely affected the system at a practical level with access to data systems and buildings being disrupted. This wider turbulence in the organisation has impacted on the rate of recruitment of offenders into MBT treatment groups, which has been slower than anticipated. Efforts to boost recruitment have included changing our entry criteria so that MBT treatment may not always be completely voluntary for the offender, as originally planned, but may be made part of the offender’s licence condition or sentence plan. This ‘assisted compliance’ marks a shift in our thinking which has challenged how we conceptualise the benefits or not of treatments that are, at least in part, mandatory. Other related difficulties encountered in the implementation of the project have been how to negotiate complex issues of information and clinical governance, such as confidentiality, information sharing and recording information between two organisations with very different cultures and ethos – the NHS and the Criminal Justice System – exposing tensions as to whether our primary aim are to reduce risk to others or to improve health outcomes for offenders.

From the start, our commissioners were keen to include robust evaluation of the services. The evaluation and research of the services is being led by Peter Fonagy at University College London, and an application for funding from the National Institute of Health Research (NIHR) to conduct a randomised controlled trial (RCT) across all the sites is in progress. The trial will assess whether MBT is more effective and cost-effective than the standard care pathway of ‘Probation as Usual’ (PAU) for reducing aggressive antisocial behaviour, improving health status and quality of life and
reducing impulsivity, violence and criminality. One of the strengths of the proposed RCT is the use of ‘peer researchers’ - ex-offenders who have been trained in research methodology - to undertake measures with trial participants. ‘Experts by Experience’, or service user consultants, are already valued members of the local MBT teams, assisting with the recruitment and retention of group members. Engaging offenders will be one of the main challenges for the research, and we also need to persuade offenders’ probation officers to refer to a trial in which some of their clients may be randomised to PAU which in reality means no other therapeutic intervention except meeting with their probation officer. However, we have been able to commence a pilot feasibility RCT in two of the sites (Merseyside and Lincoln) in which eight men have successfully been randomised, and two more sites (North London and South London) will join the pilot shortly.

All sites are now operational in service provision and treatment groups have commenced. We ensure that all the teams meet regularly to discuss clinical and service issues and to learn from each other. The excitement and enthusiasm of the members of the MBT teams in developing these much needed treatment services has been heartening. The services are becoming more established and welcomed within the probation service, as well as in prisons where we are recruiting many of our participants before their release. Although it is early days and the services have yet to be properly embedded and evaluated, preliminary reports suggest some positive outcomes, such as decreased rates of recalls locally. Most importantly we have been able – for the moment at least – to take advantage of an opportunity to offer therapeutic input, informed by psychodynamic and psychoanalytic principles, for a neglected population which historically has found it very difficult to access treatment of any kind.

References


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A Report from the Chair of the Faculty in Wales

Clare Cribb

Wales is a small country with a population of approximately 3 million people. The NHS in Wales is organised differently to other countries in the UK – it is divided into seven Local Health Boards (LHBs), each with responsibility for both primary and secondary care. Six of the seven Health Boards have psychiatric training schemes (Powys LHB is the exception).

An important recent development for mental health here has been the introduction of the Mental Health (Wales) Measure (2010) which has a number of aims. Most relevant to Medical Psychotherapy was the introduction of ‘Primary Care Mental Health Support Services’. Additional funding (£5 million across Wales) was made available to strengthen assessment and brief psychotherapy services in Primary Care by Welsh Government, with aims which were comparable to those of IAPT in England. Unfortunately in some parts of Wales, this resulted in a loss to secondary care psychotherapy services, and overall we are still waiting to see overall the effects of this reorganisation of services.

With regard to Medical Psychotherapy, three of the LHBs have a clinical Medical Psychotherapy post:

- Betsi Cadwaladr LHB (in North Wales) has 1.0 WTE;
- Hywel Dda LHB (in South West Wales) has 0.5WTE;
- Abertawe Bro Morgannwg University LHB (serving the Swansea/Bridgend area) has 0.6WTE;
- Aneurin Bevan LHB (for the Newport area) employs a 0.1 WTE Medical Psychotherapist purely for training purposes;
- In addition to these posts there are a number of Consultant Psychiatrists (myself included) with an interest or other training in psychotherapy who may act as Psychotherapy Tutor for their LHB, and who contribute to our group.
It is clear that there are a very small number of post holders in Wales, who are very geographically dispersed, making communication and joint working a challenge. Until recently our most important point of contact was the annual All Wales Psychotherapy Network (AWPN) conference. This is a vibrant conference set up in 2002 by Dr David Crossley in Betsi Cadwaladr LHB. It attracts therapists from all backgrounds and modalities, and is often held in inspiring and ancient Welsh settings.

However we are fortunate that since 2014, the Royal College of Psychiatrists in Wales has also made Medical Psychotherapy a strategic priority and supported us in meeting more regularly as a group and in communicating with Welsh Government, and the Wales Deanery.

Our areas of work currently are:

1. Monitoring of ARCPs to audit how many trainees are meeting their mandatory psychotherapy competencies by the end of CT3;
2. Ensuring that Medical psychotherapy has standing representation on both LHB and National Psychological therapy Management Committees (PTMCs);
3. Supporting the continuation of the annual All Wales Psychotherapy Network (AWPN) conference;
4. Provision of a forum for peer support and group supervision for Psychotherapy Tutors across Wales;
5. Developing links with the medical schools in Cardiff and Swansea with a view to introducing the Medical Students Psychotherapy Scheme;
6. Monitoring of what happens when Medical Psychotherapy posts are vacated and developing business plans for their replacement and/or expansion.

A barrier to the development of Medical Psychotherapy in Wales is that we do not have a higher training scheme (although efforts are being made in this direction) and so psychiatric trainees in Wales with an interest in developing their psychotherapeutic work must often turn to private training schemes. In South Wales these are now offered in CBT, CAT, Systemic Therapy, Integrative/Gestalt therapy, and Dramatherapy (Sesame).

However, for trainees wanting a psychodynamic or psychoanalytic training, they would have to look outside Wales. Even then, these trainings will not gain them a CCT in Medical Psychotherapy, nor will it be formally recognised as part of their psychiatric training in any way. This then limits the weight and influence they are able to have in the development of psychological services nationally.

The picture I have painted may appear a little bleak, in terms of our low numbers, and the limited training opportunities; however there are advantages to being a small group, in terms of cohesiveness and commitment to our cause, and also in the creative potential to develop our roles. We would be delighted to welcome Medical Psychotherapy colleagues from the outside Wales to our next year’s AWPN conference, to discuss how we as a group relate to the rest of the UK.

Clare Cribb
Chair of the Faculty in Wales
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Developments in the Psychotherapeutic world of the West Midlands.

Helen Lloyd

The West Midlands Institute of Psychotherapy is going through a period of major transition. Its website www.wmip.org has been modernised and describes some of the changes that are taking place. Others will shortly be established.

The home base situated in the cottage of the Birmingham Medical Institute is closing as the lease for the site expires. Our administrator of many years is retiring mid December. We are having "Virtual Administration" by Administrative Angels, room renting and home hospitality.

Training continues:
The Training in Contemporary Psychoanalytic Psychotherapy (TCPP)
The Training in Jungian Analytical Psychotherapy

The Medical Psychotherapy peer group, a mix of six Independent and NHS practitioners will continue to meet for CPD activities and information sharing. Two of our group are closely involved with the developments in the Trainings, one of whom has relinquished her licence to practice. Only two of us are currently GMC registered.

I would be grateful if through the newsletter your readers could suggest an Approved Suitable Person for those of us without a Designated Body. Perhaps the Faculty could also address the Independent Assessment of Medical knowledge that will be required in 2016 by the GMC for those without a Designated Body or a Suitable Person whose area of specialism is Psychoanalysis Mentalization Based Therapy and use a biopsychosocial model.

Thank you for the invitation to express a view as advocated by Professor Simon Wessely at the Annual Faculty Conference in April.

Dr Helen Lloyd
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Welcome to the 2015 winter edition of Trainee Voices, a platform for discussion within the Faculty newsletter dedicated to training in Medical Psychotherapy.

These are difficult times for trainees. They have been difficult for a while now. Years of relentless restructuring created a state of perpetual uncertainty and instability across the whole of the NHS. At the same time, dwindling resources have led to pressures which we could only manage by having to stretch wider and wider - inevitably at the expense of how deep we could get.

Now junior doctors are negotiating for changes to a proposed new working contract that is widely perceived as unsafe and unfair, after voting in favour of a strike for the first time in decades. As such we are left with more anxiety, more uncertainty, to a point where we can raise the question: has there been a time in recent history when the conditions for the reflective practice of psychotherapy have been more attacked? Or a time when this was more necessary?

So, it is no surprise to find echoes of all these challenges in the articles that follow. The authors featured in this edition of Trainee Voices come from different backgrounds and different stages in their training, yet a common thread comes through – a concern in capturing something real and meaningful in the encounter with the patient/other, the value of the emotional resonances of that experience in their clinical work and, crucially, the sense of a real struggle to protect the conditions for such an encounter to happen.

It is not a simple task, and the resistances are not only external, as illustrated by Katie Stevens in a candid description of her particular anxieties in the consulting room which I am sure will resonate with many of us.

Alex Chatziagorakis follows with an account of his experience at the 19th International Balint Congress, and a compelling assertion of the importance of a Balint group in contemporary health care. But group processes can mobilize individual resources in different ways - Georgina Fozard’s report of her experience at the Tavistock Group Relations conference is the starting point for a reflection on the constant tensions between the individual and the system, the clinical and the political, and how these always affect the work we do.

Parvinder Shergill’s article comes to life with the enthusiasm of a clinician who is finding her own voice within the family of psychotherapy, a voice that again needs to be rescued from the considerable background noise.

Finally, Giuliano Aiello’s experience of a psychotherapy group for inpatients highlights the value of psychotherapeutic thinking even (or particularly) in the most pressured environments.
Here we could also flag up the paper by our colleagues Anuradha Menon et al, recently published in Psychoanalytic Psychotherapy. This is ‘A Psychoanalytic View on Staff Burnout in a Crisis Service in Leeds’ – bringing together a number of the themes mentioned above, and a reminder that this is a struggle that involves the whole of the NHS.

Looking ahead to upcoming trainee events, the upcoming Trainee and Trainer’s Winter Conference will take place on the 15th January, at the Royal College of Psychiatrists in London. The programme will focus on the very topical issue of ‘Doctor’s Health’, and we hope to see many of you there.

Please continue making use of this space to express your views and interests. Contributions and suggestions are very welcome at any time of the year - do not hesitate to contact me c/o stella.galea@rcpsych.ac.uk.

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Becoming real – reflections from a trainee in the consulting room

Katie Stevens

Even now, in my last year of medical psychotherapy training, I still sit with patients in psychodynamic therapy, those I know well and those I am meeting for the first time, and think ‘oh, what should my face be doing now….?’

This may come from one of those moments where, from being ‘lost’ in the countertransference and the patient’s story, reality comes sharply back into focus – the room you’re in, your physical body, what you have to do later in the day – in other words, a heightened awareness of yourself. I think about how to re-attune and of course what may be the unconscious dynamic behind it. But also, importantly, did the patient notice the shift in me? The shift away from them?

This brings, in me at least, a reminder that yes, I’m a trainee, I’m still learning, and I’m not yet experienced enough for these occurrences to feel completely ‘natural’ and acceptable, grist for the analytic mill. The image (caricature, really) still persists in my mind of the all-knowing, beard-stroking Freudian, always one step ahead, always ready to deliver the killer interpretation. I should be like that! I think, in the moment. The patient might know I’m not! So... my face – how best to calmly reassure the patient that they are in the presence of a true psychotherapist – a slow, sage nod perhaps? A puff on an imaginary pipe?!

Then I remember, actually, there’s room for ‘realness’, letting the patient see something of your own, unique self with attendant flaws and strengths. So you trip over words sometimes? That’s ok. Let the patient see a smile? Fine, you’ll have thought about its potential genesis and impact, have created a space where it can be talked about. It’s not a mistake if it has arisen from a true feeling.
Be assured that the patient will know at some level when you’re trying to be something you’re not.

Now, as a medical psychotherapy trainee with a leaning towards critical introspection, I have wondered if this is, in fact ‘just me’. But no! This piece isn’t merely a personal therapy session on paper. Having had the opportunity in my later years of training to teach and supervise trainees earlier in their career, and in their first experience of delivering therapy, it seems a common worry. Psychotherapists aren’t allowed to laugh, are they? What if my patient asks me a question? The patient could see I didn’t know what to say! So all too easily, the patient can become, to the novice psychotherapist, the all-knowing, scary object (minus the pipe, usually).

My experience working in this speciality in the NHS is that thankfully, the ‘blank screen’ therapist is fading into memory. Or at least, the caricature of one, cold, opaque and frustrating or frightening. As medical psychotherapists, interfacing with other teams, consultants or agencies, we have the opportunity to bring a unique set of skills and knowledge in a collaborative way, not set apart from other psychiatric specialties, ready and willing to bring ourselves wholeheartedly into the fray, ultimately for the sake of the patients.

I try to share my experience, supported as it has been through excellent supervision, to my trainees worrying about how they should be in therapy with their patients (aka ‘what shall I do with my face?’) - If your intentions are good, you have some drive to understand the patient, and you, as a real person in their world, can help them to know what they cannot or will not, you’re doing ok. Well, good enough, at least.

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On the importance of the patient-doctor relationship in the contemporary health care and the relevance of Balint work

Alex Chatziagorakis

Located at the confluence of the Moselle and the Seille rivers, Metz, the capital city of Lorraine, is only 26 miles away from the Schengen tripoint, where the borders of France, Germany, and Luxembourg meet. As an important city in the heart of Europe and the crossroad of different cultures, Metz was the ideal place to host the 19th International Balint Congress, where delegates from 21 different countries met in September 2015 to discuss the importance of the patient-doctor relationship in the contemporary health care and the relevance of Balint work, which was the theme of the congress.

Over the course of 5 days, the delegates, psychiatrists and GPs, had the opportunity to participate in 10 Balint group sessions discussing their concerns about their patients and reflecting on the different perspectives on the narratives. Despite the language barriers, the socio-cultural differences, the geographical distance and the differences both in the healthcare work conditions and the service delivery and organisation, I was surprised to discover how much we, doctors, have in common no matter whether we work in the NHS in the United Kingdom, or in war-stricken...
countries such as Israel or Kosovo. We share the same anxieties and frustrations, as well as the same passion to learn about and from our patients so we can help them in their journey to recovery. We also face the same challenges to continue caring for our patients in a world of budgetary constraints and new managerial politics and policies. I was equally astounded to realise that our patients’ problems are also universal. Their stories were remarkably similar, whether they lived in the affluent and “civilised” West, or on the isolated Mauritius in the Indian Ocean.

Alongside the traditional Balint groups, the delegates also had the opportunity to experience the psychodrama Balint groups, where the members enact and react to the emotional nuances of the case.

There were also scientific communications addressing a variety of important issues, such as the role of Balint groups in an era where continuity of care both in general practice and in medicine in general seems to be in danger of disappearing, or their role in undergraduate and postgraduate medical education.

However, the highlight of the Congress was the presentation of the three Ascona prize winning papers, which captured medical students’ reflections on the doctor (student)-patient relationship in the most powerful way. Even though none of the students had prior experience or even knowledge of Balint work, their essays could not have been any more relevant not only to this Congress but also to what Balint groups are all about. They reminded me of my own career trajectory which appeared to find a new meaning (rather than direction) when I stumbled across a Balint group at the beginning of my Core Psychiatry training. It was then when I began to realise the importance of talking about one’s feelings and emotions and allowing oneself to stir away from the facts in order to gain a new perspective into a patient’s life and a better understanding of their inner world. Four years later, I continue to be a Balint group enthusiast but also an advocate of their significant role in medical education.

Last but not least, the social programme, which included two guided tours in Metz, with its beautiful gothic cathedral of St Etienne, and a visit to the neighbouring city of Nancy and the Musee de l’Ecole, allowed for a holistic experience, where the delegates not only learned about the local history and culture, but they also got to know each other on a more personal level.

In conclusion, in the words of Francis Peabody, “the secret of the care of the patient is in caring for the patient”. I think this captures the essence not only of the 19th International Balint Congress but also of our everyday work and ethos.

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Tavistock Group Relations Conference – a trainee perspective

Georgina Fozard

Not a day goes by when I don’t draw on experiences I had at the Tavistock Group Relations Conference - a year on, and I am so glad I did it at a relatively early stage in my training. The conference has shaped my thinking hugely and provided me with insights into groups, systems and myself, that no amount of reading psychoanalytic papers could have achieved.

It lasted for 5 days and every day was long and intense. Everything had to happen organically, meaning that even the process of making a group became a complex and stressful process. Once a day we had a session with a group we kept constant, and with the same consultant, a welcome interlude of cohesion and reassurance within the surrounding chaos.

As the week unfolded I experienced what it is to be ‘me’ more intensely than ever before. Think you can curb your personality? Try being put in a room where 100 people who do not know one another are asked to come up with a ‘plan’ for creating groups without any guidelines as to how to do this. After an hour of disparate debate, there was no consensus. Ideas were thrown out and seemingly wafted into thin air, some grumbled and dissented, and some just left the room. I realised I was finding the whole experience deeply frustrating.

I had never before realised how anxiety provoking it is when expected rituals fall away, when it is not possible to just ‘be’. Every act or sentence uttered had a ripple effect on others in the group, and with open reflection encouraged, we were put in touch with the way other people might experience us. It seemed to me that as the conference progressed people’s identities were dismantled and disturbed, then defensively build it back up again. Character traits or ways of relating which might be endorsed in a certain role or job were suddenly questioned. At times it was hard to know who one was, and hold onto anything solid within oneself. This process of learning happened repeatedly throughout the week, it was an emotional rollercoaster.

The conference also made very clear the group processes that surround us every day, at work, at home and in society at large. At times, people were scapegoated - those perceived to be withholding personal contributions viewed with suspicion. There were constant tensions between the need to maintain group cohesion on the one hand and individuals’ impulses on the other. Cohesion and unity within groups was often gained by excluding or criticizing other groups or a perceived outsider.

The conference has allowed me to be more in touch with how others might experience me within groups, how I experience others in positions of leadership. It has also allowed me to note processes such as scapegoating and the exclusion of the ‘other’ in the day to day at work. This has never been so relevant as now in helping understanding of processes that operate in larger systems, such as the NHS, the government and society.

At a time when the NHS and junior doctors in particular are under attack, it is vital we remain mindful of these processes at work in order that we are not drawn unthinkingly into dynamics that might be unhelpful, but also so that we might call out the government and the press as they spin, split and distort. As a junior doctors’ strike becomes more likely, we know we see no other option but to rebel. Jeremy Hunt uses social media to attempt to create splits within the profession, for example last week pitting ‘moderate’ vs ‘militant’ doctors on twitter. However, ironically in
uniting against a common ‘enemy’ the medical profession has never felt so full of understanding for the value of one another’s roles. As the debate becomes ever more polarised, it feels as though trench warfare might have been exactly what was intended by the government, in that a stalemate shuts out dialogue. Attempts to have meaningful conversations about the future of the NHS become drowned out beneath the din of media mud-slinging and unless we can communicate these dynamics to the public, we will be scapegoated for the demise of the NHS. I hope that by calling the DH out on bullying dynamics as they occur, and gathering strength in unity, and maintaining the space to think, we might be able to move on from the current stalemate. Either that or let’s invite the health secretary to the next group relations conference and see how he gets along...

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**Stresses and struggles in 21\textsuperscript{st} century healthcare**

Parvinder Shergill

When I was young, I remember being asked by anxious parents what I dreamt to be when I was grown up. I would pipe up, ‘A doctor! A doctor!’ I would bounce on my toes with avid excitement. I am now, well, not a little girl, but most definitely a doctor. However, when I reflect back I wonder, if I had known the harsh realities of the job...would I have still chosen this?

The constant moving of rotations across London simply adds to this wheel of madness that is our lives. Never being permanently based on one site makes it incredibly difficult to actually do ‘grown up things’...of owning my own home. Nope, I still live with my parents. The realities of any speciality trainee of squeezing their revision in any place anywhere with absolutely no shame...whether it be leaning over a fellow passenger’s shoulder on the hustle and bustle of the morning tube ride, or reading your notes on your sister’s birthday. Anytime...is precious time.

Being a 21\textsuperscript{st} century psychiatrist has certainly changed from the pleasure of being able to pore over patients notes and books, as we have all imagined possible in the 1900s, to a world of computers, email zaps, the screaming blast of the bleep to the constant alerts of appointments. I certainly have felt the medical profession has become a place for IT geeks and without such skills you would become extinct.

It appears that the world has a false impression of the doctor’s role, and feels we do not do enough. The looming ‘strike’ that looms over us makes me want to yell that ‘we are only
human…and not martyrs!’ Why does being a doctor have to come with a price of sacrificing our own autonomy, missing our birthdays, our few friends’ special events, working over the Christmas holidays to help others? Why must the little we have in finance be ripped away?

I must be sounding resentful. However, if I was to speak to the 6 year old little me I would still tell her to be a doctor. Regardless of the grey hairs, and wrinkled face you indeed wake up to being a doctor, I have found the greatest pleasure in psychotherapy.

I feel as though I have found a second home in the readings of Freud, found my letter z with Bion, and my inner child with Winnicott. I think it is an incredibly humbling privilege, as well as an enriching experience to be allowed into someone’s internal world. This everlasting chest of memories and thoughts that is so enticing to dwell into. Having my own short and long psychotherapy cases has given me hope that, through the constant exams and ladders to climb, there is such beauty in the psychotherapy room that only you can experience with your patient. This private space where the room is filled with theories and interpretations feels as though I have quite literally stepped inside the patient’s mind and am swimming through it as though to a mysterious ocean. I feel alive and thoughtful. I suppose this is how surgeons feel when they do surgery, or medics in diagnosing rare exotic diseases. I have only heard when others say ‘this is my speciality, I love it’. I feel I finally understand this feeling within this thought provoking niche in psychiatry. Going to related conferences and doing ‘The Foundation Course’ at the Institute of Psychoanalysis does not feel like work. I do not feel the dull drone of ‘having to go’ to such events for the sake of my CV, but in fact ‘I want to go’…what a pleasure. Finally!

When I speak to adolescents about career opportunities, I am honest about the involvement and the ever changing face of the NHS and constant worries of staff cuts. However, I cannot shout from the rooftops enough, that the stress, the constant coffee runs, endless night shifts become a distant memory when you’re faced with the passion you find within this magical profession: and for me that’s psychotherapy.

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Picture by Parvinder Shergill

Notes on an inpatient psychodynamically informed psychotherapy group “The Talking Group”

Giuliano Aiello

These notes pertain to a psychodynamically informed psychotherapy group for inpatients on an acute psychiatric ward at the City & Hackney Centre for Mental Health. The group has run regularly with few breaks since November 2014, with an average of 2-6 attendees per session. The diagnoses reflect the variety of patients on the ward with mainly Schizophrenia, First Episode Psychosis, Bipolar Affective Disorder, Personality Disorder, Panic attack and Depression. The aim of the group is to provide a space for psychotherapeutic work dedicated to people who are going through a mental health crisis where emotions arising in this complex situation can be safely expressed, shared and contained. We have set simple goals for the group: engaging patients in a therapeutic process, reducing isolation, reducing anxiety connected with hospitalization, providing experience of universality and of being helpful to others.
The group takes place once weekly on the ward for one hour at the same time and on the same day. Initially we used the ward round room but after a while we moved to the activity room, a space that is not so closely associated with power structures or medicalisation, and this led to an increase in number of attendees. It is co-facilitated by a middle grade psychiatrist, the clinical psychologist and a psychology trainee, at times other staff members have also joined the group for a limited number of sessions. Few demands are made of attendees: to attend, turning up on time, suggesting topics, showing that they are listening and taking turns. Facilitators are expected to be more proactive than in classic psychodynamic groups in offering connections, ideas and containment to the group. Supervision takes place every three weeks, with the consultant psychiatrist in psychotherapy for the local service. Attendance and notes of the sessions are recorded at the end of the session by the facilitators. This is a rapid open group with a single session format: we begin each session as if the group is meeting for the first time and we end as if the group may not meet again. Each session is planned to be a self-contained experience.

Commonly the group discussion involves psychotic experiences, direct questions to the facilitators, and the condition of being an inpatient on a mental health unit. When psychotic material emerged in the room, denial/avoidance was often the first reaction from fellow members. Facilitators aimed to explore psychosis as a human experience (expressing curiosity rather than pinning symptoms down) help contain the psychotic anxiety and reflecting freely on the psychotic experience. Direct questions to the clinicians were discussed encouraging the group to tolerate uncertainty if direct, unambiguous answers were not given back and to accept different views. Conflicting feelings for the ward, experienced at the same time as caring and also as intrusive were safely shared and contained; being in the group was also an opportunity to express anger and fear.

Our experience of running this group tells us that a psychodynamic group on the ward is possible and meaningful; patients came, talked and reflected on their experiences! It enriches the current psychological intervention on the ward offering containment, openness and reflection. Benefits are difficult to measure but our group has shown that emotions can surface in this type of group and be processed using the group as a container.

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Trainees wishing to join our Googlegroup email:
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By the late 1990s American psychiatry had drifted away from psychotherapy and toward a biological focus. The biopsychosocial model gave way to a “bio-bio-bio” model, as APA President Steven Sharfstein named it in his inaugural address. Concerned about the potential loss of psychotherapy as one of the skills of psychiatrists, the Residency Review Committee (RRC) of the American College of Graduate Medical Education (ACGME) identified psychotherapy as an endangered skill for psychiatrists, and made teaching it to a measurable level of competence an essential part of residency training. Currently residents are required to learn three schools of therapy; psychodynamic, cognitive behavioural and supportive therapies.

Sharing the ACGME’s concern, in the late 1990s the American Psychiatric Association (APA) established a Committee on Psychotherapy by Psychiatrists (COPP). Over the roughly ten years of its existence, COPP promulgated evidence about the efficacy of psychotherapy, evidence that psychotherapy is a biological treatment, reported on the decline in psychotherapy practiced by psychiatrists, and developed an approach to psychotherapy teaching called the “Y model.” This evidence based teaching model locates shared factors across schools of psychotherapy on the stem of the Y, with the forks of the Y representing differentiating features of cognitive behavioural and psychodynamic therapy. The Y model provides a teaching framework used by a number of residency programs that reduces competition between schools of therapy and orients trainees to the core theoretical assumptions of these therapies and their technical implications.

Following the recession of 2008 the APA faced major financial shortfalls and terminated over 90 components and committees it had previously supported, including COPP. Although the current financial recovery and revenue from the publication of DSM-5 have helped the APA’s financial situation, its leadership has not reconstituted a Committee on Psychotherapy by Psychiatrists despite requests from concerned psychiatrists.

In the absence of “top down” APA reinstatement of a group representing the role of psychotherapy within psychiatry, a “bottom up” grass roots effort began. Two years ago, using procedures allowed in the APA operations manual, a dozen psychiatrists concerned about the future of psychotherapy within US psychiatry petitioned the APA to create a Psychotherapy Caucus. The effort led to establishment of a Psychotherapy Caucus, with the author first appointed and then elected as its leader. The Caucus has grown from its founding dozen members to between 250 and 300 members by late 2015. Although resources provided by the APA are limited to a meeting room at the annual APA meeting, the Psychotherapy Caucus has been successful in seeking a small amount of additional support from concerned financial institutions like the Austen Riggs Center, the Sheppard and Enoch Pratt Hospital and the Menninger Clinic. An application for grant funding from a Foundation is currently in review. The Caucus has established a Steering Committee, defined its identity as a “big tent” organisation that welcomes
psychotherapists from all schools who share concern about the place of psychotherapy and psychosocial treatment in psychiatry and who hope to bring this concerned perspective to the larger field of psychiatry. The Caucus has received notable publicity, with two articles about it appearing in psychiatric newspapers. The APA leadership has come to recognise the importance of the Psychotherapy Caucus as a representative voice of psychiatrists interested in psychotherapy within the United States.

Establishment of the Psychotherapy Caucus has galvanized enthusiasm and optimism among its members, but there is no doubt that the practice of psychiatry in the US has shifted toward a model in which the psychiatrist’s role is to diagnose and prescribe. The shift to a “15-minute med check” model of practice has helped increase psychiatrist income, but it limits the utility of the profession to patients, especially as evidence of significant overestimation of the effectiveness of medications comes to light. Meanwhile, emerging molecular genetic research suggests gene-by-environment interactions or epigenetics is far more important than genes alone, with environmental factors like early adversity powerful predictors of subsequent psychopathology. Further, most patients present with comorbid clinical pictures that leave them more likely to fail evidence based treatments tested and developed in samples composed of the minority of patients who have non-comorbid disorders. How well the field recognises and responds to these issues will be important for the future of psychotherapy in psychiatry.

US insurance companies tend to pay psychiatrists more for diagnosis and prescribing than for conducting therapy. US mental health benefits generally have had higher utilization review barriers and lower funding than medical and surgical treatment. In 2008 the Mental Health and Parity and Addictions Equity Act (MHPAEA or Parity Law) became law. This landmark piece of legislation, championed by former Congressman Patrick Kennedy, requires that mental health and addiction benefits be comparable to those offered for medical and surgical care. The legislation explicitly requires that there be no quantitative (limits in dollars or numbers of sessions) or non-quantitative (higher utilization review barriers) limits to the provision of mental health and addiction care than for medical and surgical care. The Parity Law, though, was largely ignored by insurance companies. President Obama’s Affordable Care Act helped the cause of parity by requiring that insurance policies made available to American citizens must include coverage for treatment of mental health and substance use disorders as part of the essential benefits package.

However, the most hopeful element in the strengthening of the Parity Law has been the initiation of a series of class action lawsuits against the largest US insurance companies for flouting the Parity Law, such as by excluding coverage for diagnoses like personality disorders, when these disorders have a practice guideline, significant morbidity and mortality, respond to multiple evidence based treatments, and complicate the treatment of comorbid disorders. Although it will take time for resolution of the court cases, initial rulings have suggested that the judges involved support the plaintiff’s position that there are Parity Law violations by the insurance companies.

Anticipating full implementation of the Parity Law, the Institute of Medicine (IOM) of the National Academies of Science prepared a report in 2015 to establish a framework for Psychosocial Interventions in Mental Health and Substance Use Disorders. This report was written from a high altitude perspective, looking for ways to design quality measures across populations receiving psychosocial treatment under parity. The IOM report calls for increased research into psychosocial treatments, and avoids choosing one school of therapy over another. Instead, the IOM report calls for research on “specific and non-specific elements” across types of psychotherapy that may be associated with beneficial outcomes.
Despite this call for increased research into outcomes associated with elements of psychosocial treatment, the National Institute of Mental Health has essentially stopped funding clinical trials research for medications or psychosocial treatments, requiring, instead, that investigators target study of biological brain mechanisms linked to the NIMH Research Domain Criteria (RDoC) in their grant applications. Clinical trials research is replaced by a focus on translational research into animal models. Concerned about this shift away from clinical trials research, in late 2015 the APA Assembly passed an action paper calling upon the APA to prepare a white paper exposing changes in NIMH funding practices and then to respond accordingly. The hope is that the APA will use its influence to shift the NIMH away from an exclusive focus on translational research and back toward inclusion of the kind of clinical trials research that can help patients in the near term. Although there is much to be gained in the future from bench science and translational research of animal models, real patients need treatments now that have been found to be effective, including, especially, study of elements of psychosocial treatments, as the IOM report suggests.

Psychotherapy within psychiatry in the US is in the midst of a high risk, high reward environment. The irony is that, even as evidence emerges that psychosocial factors are far more important than many realized in the causation and treatment of disorders, that varieties of psychotherapy are highly effective and associated with brain change, with imaging studies able to distinguish therapy responders from non-responders, getting the field to attend to this has been difficult. It remains to be seen whether we will move away from a reductionistic “bio-bio-bio” model and back toward a biopsychosocial–genuinely epigenetic—model that re-emphasizes the value of psychosocial treatments like psychotherapy.

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Psychotherapy in Spain

Miguel Angel Gonzalez-Torres

The situation of Psychotherapy in Spain is encouraging yet complex. To date, training and practice in psychotherapy are hardly regulated, entailing much inequality, depending on the region and facilities, whilst favouring the practitioners’ creativity. The possibility of a patient in Spain receiving psychotherapeutic treatment depends almost entirely on the place of residence and the clinic attended by the patient. There, some very specific professionals will determine, according to their training and experience, the type of psychotherapy to be received and the application conditions. As is the case in the rest of the world, Spanish therapists tend to adopt an eclectic approach to patient treatment, with a combination of interventions drawn from different schools and which are difficult to evaluate and are adapted to the specific setting and to the characteristics of the patient and clinic. Although cognitive behavioural therapies are widespread, psychoanalysis, which is extremely disorganised and heterogeneous, continues to exert an important influence on the care provided and on the cultural milieu of Spain. Access to training is not easy, given the fact that it primarily depends on private centres that are created by professional associations that are distanced from higher education institutions.
We will now move on to briefly analyse a few aspects relating to the organisation of psychotherapy in Spain, the models applied, which professionals work as therapists and some brief comments with regard to the future.

**Organisation**

It is possible to distinguish two psychotherapy (PT) application frameworks in Spain: public and private.

When looking at PT in the public sphere, account should be taken of the fact that there is no single public sphere in Spain, instead there are 17 autonomous communities. Each one has its own way of organising public health care, although all communities comply with a series of minimum requirements established by the Spanish Government Ministry of Health. However, all communities agree on some problems that concern psychotherapy and its application. There are two principle difficulties: the lack of a formal qualification as a psychotherapist; and the impossibility of recruiting psychotherapists as such in the public system.

To date, there is no official government institution that awards psychotherapist certification. Those who identify themselves as psychotherapists in their CVs are professionals who are able to demonstrate training and experience in this field, yet neither the Ministry of Education nor the Ministry of Health grant psychotherapist status. This status is solely granted by professional associations that offer training programs and give a certificate that is only valid at a private and personal level. A number of factors have favoured this situation, some of which also exist in other countries around us. Here we could highlight the peculiar way of organising and managing training in these techniques, often in private institutions connected to professional associations. Over the last few years, PT post-graduate training programs have been created in a number of universities. In general, these programs are university-accredited degrees and, therefore, are not official and are not endorsed by the Ministry of Education or the Ministry of Health. In many cases, neither do these post-graduate programs involve complete training in the psychotherapeutic technique in question, given the fact that clinical experience is generally lacking, which is rarely provided by the University, or else the number of hours of supervision is inadequate. Frequently, those professional associations that do organise complete training programmes consider these post-graduate programs organised by the Universities to be insufficient.

There have been a number of attempts to unofficially structure training in psychotherapy in Spain and to certify professionals. The most successful scheme was developed by the Spanish Federation of Psychotherapy Associations (FEAP), an institution which, over time, has gradually grouped together a large number of professional associations dedicated to PT in Spain and which has made a great effort to agree on some minimum training requirements in the different types of PT, to be met by any professional wishing to be certified by the FEAP. This institution has the added merit of having grouped together all types of associations, of highly different orientations and origins. Psychoanalytic groups have joined forces with groups dedicated to behavioural or cognitive therapies, or systemic or existential therapies, etc. etc. This achievement, consolidated after years of operation, has tremendous merit, and this is possibly insufficiently recognised by the health authorities and by the professionals themselves. The FEAP is the closest thing we have in Spain to an official certifying institution for psychotherapists. However, it should not be forgotten that this is a private association and its requirements and certificates are little more than the agreement of a group of private individuals - even though an important one at that.
The Spanish public system, in its different regional variants, is characterised by a very strong participation of the trade unions and by a certain inflexibility in recruitment. Generally, in any public system, two types of professionals can be found: with or without an indefinite contract. In practice, an indefinite contract with the public health authorities in Spain is equivalent to a contract for life and is logically sought after by most healthcare professionals. Access to this status is through some highly regulated public competitive examinations, which include professional knowledge exams and the assessment of those merits indicated in the CV. The process facilitates a more equal access and gives opportunities to professionals who have had no prior contact with the administration. The result is that the heads of clinical teams often have little influence on the selection of personnel. And, as there is no official PT qualification, then this cannot be demanded as part of the access criteria. Consequently, the psychologist or psychiatrist entering a clinical institution, after successfully passing some competitive examinations, may or may not have training and experience in PT. Once the professional has joined the centre, the person in charge is responsible for assigning PT work, if he/she has adequate training, or for providing training in PT if this is not the case. Obviously, the degree of voluntariness and collaboration must be very high. It could be said that psychotherapy is carried out in the Spanish Public System despite the system itself and not thanks to the system.

It is appropriate to make a final consideration with regard to PT and the Spanish public system, which this time concerns the professionals themselves. All of us psychotherapists know by experience that PT practice demands a certain level of commitment with the patient and his/her process. When dealing with critically ill patients or intensive approaches, particularly group ones, then the commitment can be very demanding. In a context in which, in practice, it is not mandatory for professionals to practice PT, there is a great temptation to abandon complex and demanding PT approaches and to deal with tasks with a lower commitment. An easy-to-understand example would be that of a psychiatrist with training in group therapies. Should an attractive possibility arise to attend a conference or course then, as a group therapist, this presents tremendous limitations. Any change or cancellation of a meeting would seriously affect the group. On the other hand, if the basic work of this clinician is the psychopharmacological monitoring of patients, then any change in appointment is not a problem given the fact that if the appointment of a patient who is seen every one or two months is changed to a nearby date, then this is no major concern. Something similar can be said of a clinical psychologist who has the possibility of choosing between different tasks with a major or minor commitment. The consequence is that, in the Spanish public system, there are many clinicians with PT training yet who do not use it, sometimes because the organisation of tasks in the system does not favour it or else because they prefer to dedicate themselves to less demanding tasks.

Psychotherapy in the private sphere in Spain is historically limited by the extremely low coverage given by private insurance companies to their customers in this area. Very few policies allow holders access to psychotherapeutic treatment at market prices. Insurance companies often offer PT approaches in which the clinician is paid around 50% or even 80% lower than the amount that would be demanded by a professional not working for the insurance company. This "low cost" PT (for the professional, not for the patient, who pays high insurance premiums ...) often means that the least experienced therapists work for the Insurance Companies, withdrawing once they have gained sufficient experience and patients. The other alternative is direct payment in full by the patient to the clinician, a normal system in Spain throughout history. As far as this matter is concerned, two circumstances should be considered carefully. On the one hand, private health care expenses are not tax deductible in Spain. The current thinking is that the Spanish public
health system covers all the care required and, therefore, the private option is not eligible for a tax rebate. On the other hand, the current economic crisis has created an extremely high level of unemployment (on average 19% in Spain, 40% if only young people are considered), producing a fall in the purchasing power of employees, with substantial salary reductions. As a result, the possibility of paying for psychotherapy "out of pocket" is considerably lower. Patients seek shorter, less intensive treatments which are more affordable for them.

Psychotherapeutic model

Like other places in the world, all types of psychotherapeutic approaches can be found in Spain, with an unquestionable predominance of the cognitive-behavioural approach. Psychoanalysis, in its different forms, occupies a position of importance and has its own particular history. Freud’s work was very quickly translated into Spanish and exerted a certain influence in prestigious intellectual circles in Spain. After the Spanish Civil War (1936-1939), the psychoanalytical movement was reduced to a minimum, following the flight into exile of a good number of its practitioners. The situation changed as a result of the coups d’état in Argentina and Chile in 1973, which drove many analysts in these countries to settle in Spain. Together with this, the death of the dictator and the transition towards a democracy resulted in a great expansion of the psychoanalytic theory, which has had a different course of development compared to that of other countries in Europe and America. Thus, psychoanalysis in Spain is still young and possibly has more energy than in other countries. However, it is also affected by two problems that are frequently encountered in other countries, namely a distancing from the University and also a distancing from traditional research. There are practically no chairs in Psychiatry or Clinical Psychology held by psychoanalysts and the number of hours dedicated to teaching psychoanalytic theory in the Psychology degree studies in many Faculties in Spain are practically non-existent. Psychoanalysis in Spain, as in other countries, is not included in major research programs and, for most analysts, what is known as psychoanalytic research is reduced to theoretical reflection based on a very limited number of reference authors taken from some highly selected clinical vignettes.

All the models practised in Spain suffer the same training problems indicated above: the forms of training are extremely varied and are usually unofficially conducted by professional associations.

Therapists

Therapeutic treatment in Spain is basically performed by Psychologists and Doctors, normally Psychiatrists. Exceptionally, Nurses or Social Workers can be found, but not yet as frequently as is the case in other countries. This is possibly due to the lack of tradition and also to the fact that it is more difficult for these professionals to access training programs in psychotherapy, with are often restricted to psychologists and doctors. It is very rare to find professionals dedicated to psychotherapy and whose university education is different from that described.

In many countries, strong pressure has been exerted by the authorities and insurance companies for PT techniques to be applied by professionals that are unrelated to the traditional medical groups (psychologists and doctors). Even within these groups, there has been a certain amount of pressure to move Psychiatrists away from PT. The great difference in the salaries of the various professionals in most countries is a fundamental cause for this trend. The general principle is that a clinical task should be performed by a professional who is able to do so, yet earning the lowest possible salary. In Spain this pressure is not so powerful, due to the fact that the difference in the salaries of the different professionals is not so great. Doctors and Psychologists in the public
system are paid salaries that are very similar, and even nurses and social workers are not very far from the former.

**Future**

Psychotherapeutic techniques are part of the clinical picture in Spain, at a private and public level alike, although this varies considerably, according to region. The future will depend on the evolution of the factors indicated above and two of these factors in particular. On the one hand, the creation of official certification as a psychotherapist, granted by the Administration and in some way regulating the training and practice of psychotherapy. On the other hand, the development of university training programs that provide students with complete training in the corresponding technique. Finally, economic recovery is required, in order to allow Spain to continue to develop its Mental Health public services and to ensure that its citizens will be in a position to potentially finance private treatment. The participation of Spanish therapists in major research projects will primarily depend on the creation of psychotherapy research groups in Spanish universities.

*About the author:*

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**Welcomes and Farewells**

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**A message from the experts by experience**

We are very happy to report that the recruitment process has been successful and that a new patient representative was appointed this autumn. In the articles below, Helen Gill and Celeste Ingrams reflect on the experience of shaping and developing the role as the first people to take up these positions on the Executive, and Angela Slater introduces herself as she prepares to pick up the baton in January.
Helen Gill

I almost can’t believe I am coming to the end of my term as a Service User Representative on the Faculty Executive Committee. It’s been a long and interesting journey, and I will be sad to go. I suppose I have a particular affection for this role, given how it came about.

Just over 5 years ago, Celeste and I were, so to speak, snuck in through the back door and thrust into meetings of an Executive who weren’t quite prepared for or comfortable with that. I can still remember palpable tensions, raised eyebrows and caged responses in those first few meetings. Change is always difficult. But, when I reflected on this, I was surprised at this initial reaction of a group of people whose very bread and butter is change. We were all thrown in at the deep end. But we swam. Eventually. I now look back on those early days and remember those frosty stares with a smile on my face. It is actually quite a cherished experience of mine. On further reflection it reminded me that no matter who we are, or which chair we sit in the consulting room, we share the bond of humanity. And for my work in the Faculty, that sense of sharing a common ground has been invaluable over the last few years.

At first it was incredibly challenging as we carved out this Service User Role for ourselves. With no blueprint to follow, we occupied a new point of view in the executive and tried to negotiate a minefield of acronyms in search of how to most effectively contribute to and engage with the work. We spent many hours discussing meaningful engagement, and puzzling out what that would look like and how to foster that within the faculty. We had (sometimes difficult) discussions around boundaries and expectations, and at times it felt like I was beating my head against a brick wall. But, actually, by joining the Executive, I realised what we were initiating was a culture change, and I would have to be patient. Since those early years, things have dramatically shifted – now it’s as if we’ve always been a part of the Faculty.

Looking back over the work we have done, makes me realise how much we have done and how far we have come, individually and as a whole Faculty. From conference planning to policy reviewing and writing, from workshop creating to role defining – it’s been a hugely varied workload. I feel honoured to have been part of this. Through the Faculty I have had some amazing opportunities and experiences and have met so many fantastic people. I have learnt so much more about both the world of Psychotherapy and Psychiatry and in turn, about myself. This work is vital to the provision of appropriate treatment and care for the people who need it; and I believe working in partnership with Service Users, collaborating and working as a cohesive whole truly brings about the most helpful, supportive and effective solutions to problems faced in Psychiatry and Psychotherapy. Remembering our shared common ground, we can continue to tap into our different experiences to strive to create an improved healthcare system (and world). I hope that my involvement has enriched and informed the work of the Faculty, and I know we have created the right culture for meaningful Service User engagement to continue.

I want to thank Celeste for negotiating this journey with me. Supporting each other within this role has been an experience I have learnt so much from and has enabled me to engage fully and feel comfortable in this role. Also, thank you to the particular individuals of the committee (you know who you are) over the last 5 years, who have worked closely alongside us to help define our roles and bring Service User engagement to the forefront of the Executive. Finally, thank you to the Executive as a whole. It has been a challenging but enriching experience and I truly will miss being a part of the Faculty.
Celeste Ingrams
Reaching the end of the term in the position on the Medical Psychotherapy Faculty it feels somewhat sad, but mostly positive in the change that is ahead.

In coming to write this reflection and starting out with saying how I feel, I notice the bit of internal dialogue saying 'I wonder how that’s going to be analysed or interpreted'. This is not an unfamiliar thought in working in the setting with Medical Psychotherapists – I guess it comes with the territory! But sometimes in communications straddling between this place of someone who has needed the input of therapeutic and mental health services and therefore been in these “patient - professional” dynamics, and a place of relating as a colleague meeting on a more equal footing, has been tough to negotiate. Five years down the line though and I can more often see the funny side of it!

It has been a period of lots of learning through the involvement, and sharing this with Helen Gill as co-worker here has been an essential, substantial, and nourishing part of this. Negotiating the challenges of what was initially quite undefined roles and how we could best contribute to the evolving work and vision of the exec, and to bring about more emphasis on collaborative working with people who use services has been something we were asking ongoing questions about and grappling with.

Recalling how daunting I found the first meetings – the struggle to even comprehend some of the language, let alone understand how it was I could contribute to the dialogue, and know how to focus what I could offer from my perspective in these areas of work. Being the first non-medical members of the Exec was a challenging process at times all round, but it feels positive that through our presence and involvement there has been an adjustment and development in seeing and understanding how service user involvement can enrich the Faculty work. There is such potential for this to continue, and I am optimistic about what is ahead for the faculty in what Angela and Rosemary (our successors) will bring with their fresh perspectives, wealth of experiences, skills and knowledge. I feel very confident about how things will proceed here.

It has been really fantastic to have the opportunity to be part of the Faculty – I’ve learnt so much, been inspired, met some great people, and grown a lot through the experience. I see it as so important in the current context with health services to promote and support more thoughtful, reflective, and therapeutic approaches, attitudes, and systems to offer individuals and communities the care they need to cope and grow, and I know that bettering communication channels and understanding between people who need and use these services, and those in the professional roles is crucial for this to happen. I wish all the best in how this continues to happen in the Medical Psychotherapy Faculty, and want to say thank you for working with me as part of this process, and for the support in this.

Angela Slater
My name is Angela Slater and I recently became a new Service User member of Royal College of Psychiatrists Forum and the Medical Psychotherapy Faculty. I was delighted when I heard that I had been accepted after putting in an application and having a telephone interview. It was my first experience of having a telephone interview and it was something that I felt very passionate about being involved with so I was very nervous. Despite my nerves I hoped that my enthusiasm and experience would come through.
There were many reasons why I applied for this role. I have experienced mental health problems since I was fourteen (I’m now thirty nine) and in that time I have used a range of services including inpatient care for three years when I was eighteen. Over the years I had a range of talking therapies including counselling, CBT and EMDR and I am currently undergoing psychotherapy. I feel that talking therapies are extremely important for many peoples recovery from mental health problems (as it has been for me) and I want to see the best possible therapies available for people who need it. I would not be able to do the things I do today (work, travel, etc.) without the therapies that I received and continue to have. I think that if people are consulted from the beginning you will get something that is useful and relevant to the people who use the service and this is a great opportunity to do that.

I am very fortunate to work in the field of mental health (with Mind and Time to Change as well as other freelance work) as well as still doing involvement work on a personal level. Before I worked in the field of mental health I worked mainly with children and young people with multiple and profound disabilities in social care, the youth work sector and in education. I loved this work but I felt that it was so important to use my personal experience around mental health which I am now able to do. I am now very eager to getting started, meeting everyone, and being involved in this process.

Helen Gill
Celeste Ingrams
Angela Slater
Faculty Experts by Experience
Contact Helen, Celeste and Angela c/o stella.galea@rcpsych.ac.uk

From the outgoing FECC Chair: Thinking Cradle to Grave: Developing Psychotherapeutic Medicine and Psychotherapeutic Psychiatry

James Johnston

I was invited to write a valedictory article for the Medical Psychotherapy Newsletter as Chair of the Medical Psychotherapy Faculty Education and Curriculum Committee between summer 2011 and summer 2015 – after four years’ work, a FECC farewell.

The Trojan horse for my therapeutic activism in leading the FECC was the education strategy Thinking Cradle to Grave which I innovated to extend the educational brief from a sole focus on the therapeutic education of core and higher trainees in psychiatry, widening the scope to include medical students, foundation doctors, senior psychiatrists and other doctors. I used the title Thinking Cradle to Grave to embody a developmental overview from the beginning to the end of a medical career and also to echo the developmental leitmotif from the beginning to the end of life, the early mind of the cradle of thought to the grave risks and risks of the grave which evoke disturbance.
The idea behind *Thinking Cradle to Grave* is that psychotherapeutic education for psychiatrists does not aim to train most of them to be psychotherapists but aims to train them to develop and retain a therapeutic attitude to their patients. The same idea applies to medical students and to doctors throughout their career, except that at the beginning developing a therapeutic attitude and towards the end retaining a therapeutic attitude to patients are quite different developmental challenges.

The key elements of *Thinking Cradle to Grave* leading to substantial change are:

**The first UK Psychotherapy Survey 2012**

The recommendations arising from the first UK Psychotherapy Survey were:

1. Consultant Psychiatrists in Psychotherapy should lead the coordination and educational governance of all core psychotherapy training in psychiatry as Psychotherapy Tutors.
2. The aims of core and advanced psychotherapy training need to be linked developmentally focusing on training which is a better fit for trainee capacity and is fit for the purpose of the work of psychiatry.
3. Multidisciplinary participation in core and advanced medical psychotherapy training should be formally developed, organised and led by Consultant Psychiatrists with a CCT in Medical Psychotherapy.

**GMC Medical Psychotherapy Report and Action Plan 2013**

The General Medical Council Medical Psychotherapy QA review in 2012 incorporated the findings of the first UK Psychotherapy Survey. Training as a Medical Psychotherapist in the leadership, governance and delivery of psychotherapy training in core psychiatry was included in the GMC action plan as a requirement and incorporated in the core curriculum in March 2015.

**Medical student Balint Groups and psychotherapy schemes 2017 & beyond**

I chair a Medical School Psychotherapy Scheme Working Group established in June 2014 aiming to establish medical student Balint groups and student psychotherapy schemes in all 34 UK medical schools by 2017.

**Medical student psychotherapy schemes symposium 2016**

A UK Medical Student Psychotherapy Scheme Symposium will be held in the Royal College of Psychiatrists in 2016 (date TBA) to showcase existing and new student psychotherapy schemes and student Balint groups – with medical students presenting their experience alongside workshops on how to build the schemes and preliminary evaluation data.
Foundation year psychotherapy
UK Foundation doctor Balint groups are being developed in psychiatry placements (e.g: Yorkshire) 2011-2015.

Core psychiatry psychotherapy
Short therapy case and longer therapy case durations specified in the core curriculum requested by the GMC and ratified by the GMC 2013: short – 12-20 sessions, longer over 20, any model. Precise duration agreed with supervisor on basis of patient need.

I introduced a new intended learning outcome: ILO19 self reflective practice ratified by the GMC and included in the core psychiatry curriculum in 2013.

Advanced or higher medical psychotherapy
The place and funding of personal therapy in specialist psychotherapy training has been clarified with the UK deaneries (LETBs), the College and the GMC - to be included in the curriculum from 2016.

Advanced or higher psychiatry psychotherapy
The requirement and clarification of ongoing psychotherapy experience in advanced training across all psychiatric sub-specialties has led to questions on advanced psychotherapy being included in the second UK Psychotherapy Survey in 2016.

Advanced or higher medical psychotherapy dual and single CCT training
A single CCT in medical psychotherapy (three years duration) remains an advanced training option and is analogous to a therapeutic ‘stem cell’ from which the dual trainings in medical psychotherapy are derived. The dual training in medical psychotherapy with general adult psychiatry (GAP/MP) I introduced in Yorkshire in 2008 was ratified as a national model of training by the GMC in 2012. Dual child and adolescent psychiatry (CAP/MP) will be established in 2016.

Credentialing and CPD
For post membership psychiatrists, Balint groups, therapy courses, trainings and CPD modules some of which will lead to psychotherapy credentialing (Shape of Training) are being introduced by the FECC and Exec as the ‘grave side’ of Thinking Cradle to Grave.

Communication strategy of the Medical Psychotherapy Faculty
A Communications Working Group on behalf of the Executive Committee is developing improved communication between the Medical Psychotherapy Faculty internally and externally – within and beyond the College with other professionals and members of the public for all the activities of the Faculty.

The new theme of the Medical Psychotherapy Faculty website will be listening with medicine in mind and will reflect an approach to describing medical psychotherapy which aims to inspire active engagement from medical students and doctors interested in psychotherapy including people in psychotherapy or curious about psychotherapy.
Oxford Specialist Handbook of Medical Psychotherapy
I had the idea of an Oxford Specialist Handbook (OSH) of Medical Psychotherapy in 2008, on being reminded of the crucial OSH of Medicine in my white coat pocket as a house officer - a companion with whom to consult in times of anxious need and doubt.

The book is a compendium of contemporary evidence based therapies offered in the NHS and will be published by the Oxford University Press in early 2016. I’ve illustrated each chapter in the book which is an outline of human development and its vicissitudes and of contemporary psychotherapy in theory and practice – a psychotherapeutic vade mecum.

Thinking Cradle to Grave RCPsych publication 2016
Thinking Cradle to Grave will be published by the Royal College of Psychiatrists as a College Position Paper in 2016. The development of psychotherapeutic medicine and psychiatry will be placed in the context of working towards meaningful parity of esteem between mental health and physical health through the education of future doctors.

Gratitude, good wishes and goodbye
I want to thank all my colleagues in the Medical Psychotherapy FECC who inspired, supported and helped me – I will miss working with you, though I won’t miss the work.

I wish my able successor, colleague and friend Dr William Burbridge-James all the very best. I’m grateful that William is completing some of the work I’d begun arising from Thinking Cradle to Grave and embarking on his own journey, in his own Trojan horse.

Dr James Johnston
Past chair of FECC
Contact James c/o stella.galea@rcpsych.ac.uk
Illustration by James Johnston

Special notices

Zoonia Nazir

We would like to acknowledge the loss of a much loved and respected colleague, Zoonia Nazir, who died unexpectedly and very tragically in October. We have included a few lines from a tribute written by Jan Birtle, one of her colleagues from the West Midlands.

Zoonia made a tremendous contribution both as a trainee in Medical Psychotherapy and later as a Consultant. It was a delight to see her commitment to her work, her determination to help others, her wisdom and at times her mischievous humour express itself, in her more relaxed moments. She made a very positive impact in raising the compassion and understanding of her colleagues towards their patients, right across all branches of psychiatry in Birmingham and Solihull. Zoonia was a very special person. She will be sorely missed.

Jan Birtle
Faculty vice chair
Deborah Hutchinson

It is with great sadness I have to report Deborah’s death on 2nd December. Deborah trained in Psychotherapy at St George’s Hospital, Tooting in the unique dual training post combined with Learning Disability. Her first consultant post was a Learning Disability post in Croydon before moving to the Psychotherapy Service in Southampton, where she remained until her retirement. She was greatly respected by her psychiatric colleagues. She was also Clinical Tutor for several years and did much to support the trainees as well as consolidate their psychotherapeutic experience.

I met Deborah whilst training at St George’s. Our close relationship as colleagues and friends was cemented during our work with victims of the Clapham train crash in 1988. It was typical of Deborah that she identified the need for these patients to receive psychiatric and psychological support and was influential in delivering it. She was clear-thinking and decisive. Deborah was the kind of person as colleague and friend who, if you were in a tight corner, you would want standing next to you.

It is sad that in the last years she struggled with serious ill-health but did so with courage and fortitude.

Dr John Hook  
Consultant Medical Psychotherapist and Psychiatrist

Events, notices and dates for your diary

Faculty of Medical Psychotherapy Notice of Election

Vacancies will arise in 2016 for the positions of Vice Chair, Financial Officer and Executive Committee Member (7 vacancies) on the Medical Psychotherapy Faculty Executive. This is a call for nominations. Notice of Election and Nomination form and job descriptions can be found by following the links below. Nominations should be received at the College by 11 January 2016.

Notice of election and nomination form

Job descriptions

Faculty of Medical Psychotherapy annual conference

The 2016 annual conference will be held between 13 and 15 April 2016 at Weetwood Hall, Leeds. Visit the conference page of the website for updates.
Invitation from AcOMP

Svetlin Vrabtchev

The Accrediting Organisation for Medical Psychotherapy (AcOMP) is the link between the Faculty of Medical Psychotherapy and the United Kingdom Council for Psychotherapy (UKCP). Its main function is to process applications for registration with UKCP. We began processing applications in 2014 and have already accredited 26 applicants for UKCP registration. AcOMP is represented by the College of Medical Psychotherapy (CMP) at UKCP operational forums.

We would like to invite medical psychotherapists to apply for UKCP accreditation through AcOMP. You are eligible for membership of AcOMP if:

- You are in good standing for CPD;
- You are currently registered with the General Medical Council and have a licence to practice;
- You hold Medical Psychotherapy specialist registration (including dual specialist registration) with the General Medical Council, either by the CCT or CESR route;

There are number of opportunities to become involved in the work of AcOMP and UKCP. We are keen to establish medical psychotherapy training and medical psychotherapy practice on the map of those recognised by UKCP psychotherapy practitioners.

We need help and support from new and existing members to increase the presence of medical psychotherapists in the life of UKCP. We would like to hear from colleagues who are willing to become involved.

For any enquiries and expressions of interest please contact Stella Galea.

Svetlin Vrabtchev
Faculty Executive Committee member
Contact ACOMP c/o Stella stella.galea@rcpsych.ac.uk

Open Dialogue conference 25th April 2016

Russell Razzaque

Open Dialogue is a holistic, person-centred model of mental health care pioneered in Finland that has since been taken up in a number of countries around the world, including much of the rest of Scandinavia, Germany and some US states. It involves social network approach to care, where all staff receive training in family therapy and related psychological skills, and treatment is focused around whole system/network meetings. It is a quite different approach to much of UK service provision, yet it is being discussed with interest by several Trusts around the country. Part of the reason is the striking data from nonrandomised trials so far e.g. 72% of those with first episode psychosis treated via an Open Dialogue approach returned to work or study within 2 yrs, despite significantly lower rates of medication and hospitalisation compared to Treatment As Usual.
Several NHS Trusts in the UK - including North East London (NELFT), North Essex, Nottinghamshire and Kent & Medway - are setting up pilot peer-supported Open Dialogue services over the next couple of years, and the first group of clinicians have completed the training in 2015. We now also have a couple of dozen service users and families who have experienced the approach in the NHS from for the first time and, along with the staff, they will also be featured in our forthcoming conference.

The conference will be from 10am to 6pm and the address is:
20 Bedford Way, London, WC1H 0AL

Tickets & further information can be found here: https://www.eventbrite.com/e/2nd-annual-conference-on-peer-supported-open-dialogue-tickets-19312655673

Dr Russell Razzaque
Consultant Psychiatrist and Associate Medical Director
North East London NHS Foundation Trust

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Your contributions to this Newsletter are welcome!

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We encourage you to contribute to the dialogue. Please send contributions for the next newsletter, which will be published in Spring/Summer 2015 to Stella by 30 April 2015. You can also contact our sub-editors for international, trainee and academic matters.

We would also be very happy to receive photos for the front cover, with a summer theme for the next edition.
Contacts...

Contact the Faculty and any of the contributors c/o Stella Galea: Faculty Committee Manager
stella.galea@rcpsych.ac.uk

Happy Holidays!