Faculty of Medical Psychotherapy Executive Committee

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

Maria Eyres, Harriet Fletcher

Dear Readers

Welcome to the Autumn/Winter edition of the Medical Psychotherapy Faculty Newsletter.

We are publishing it later this year to include an update from the Faculty Executive Strategy Day at the end of January, our annual meeting when we plan our objectives for the year ahead. One focus this year will be on working across interfaces, with Faculty members and other colleagues who work in other sub-specialties, in General Adult Psychiatry and in CAMHS. We will also think carefully about our trainees, to ensure that they are able to learn from other areas of psychiatry, and about other trainees, to make sure that fulfilling the core psychiatry psychotherapy training requirement is developmental and meaningful to their future careers.

We are embracing this outward looking focus in the Newsletter, and we are very grateful to Alison Jenaway who joins us as co-editor for members working outside Medical Psychotherapy. Please read her piece and respond to her call to get involved in shaping the Newsletter for yourselves!

This edition also introduces our new Suicide Working Group which aims to work across the specialties to think about how we can help all psychiatrists to manage these traumatic events.

We would encourage readers to look at two recently published College occasional papers from the Faculty, both the long awaited Learning from Cradle to Grave (OP102) by James Johnston describing psychotherapeutic psychiatry throughout the career cycle, and also the excellent overview, Using Formulation in General Psychiatric Care: Good Practice (OP103), prepared by Faculty members Alison Summers, Padakkara Saju, Celeste Ingrams and Helen Gill in collaboration with general psychiatry colleagues, which should be a useful resource in teaching and training. Both can be downloaded from the Faculty website. The third and most recent Faculty publication to celebrate, which has already been circulated to members, is the Joint Commissioning Panel for Mental Health Guidelines on Medically Unexplained Symptoms. These owe a considerable debt to the Co-Chairs of the Faculty MUS working group, as Simon Heyland explains below.
We are pleased to introduce a new Book Reviews section and we welcome Dan Beales and Andrew Shepherd as co-editors. They have started by writing a review of the Oxford Handbook of Medical Psychotherapy, a publication close to the Faculty's heart.

As we mentioned last time, we now have two new Service User Representatives/Experts by Experience on the Executive, Stephanie Guidera and Aakta Patel. Stephanie introduces herself in this edition with a fascinating piece about her own experience of psychotherapy, while Aakta will be introducing herself next time.

We welcome our two new Trainee Voices editors, Alex Chatzgoriakis and Anna Croxford, who have taken over from Tiago Gandra, with another lively and inspiring set of articles written by the next generation of Medical Psychotherapists. Tiago has offered to rejoin the team as International Editor and we will look forward to his contribution to the next edition.

Please look at our 'save the date' section for some interesting upcoming events, including the Faculty Conference in April (more about that in the Academic Secretary's round up) and another Faculty CPD event led by Dr Jo O'Reilly which should be of particular interest to non-Faculty members and to members working outside psychotherapy services.

On a different note, we also mark the passing of Anthony Ryle and highlight his huge contribution and commitment to psychotherapy in the NHS, with an obituary by Jason Hepple, Faculty member and Chair of the Association for Cognitive Analytic Therapy. Please save the date for the ACAT event to celebrate Tony's work, to be held in London on 10th March. And please also see the note from the Forensic Psychotherapy Special Interest Group who are planning a meeting at the College in tribute to their colleague Gill McGauley, who sadly died in 2016.

We hope that you enjoy reading this edition and look forward to your contributions to the next one.

Editorial Team

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

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

Contact the editorial team c/o Stella Galea, Committee Manager stella.galea@rcpsych.ac.uk
2016 was an extraordinary year. Whilst the political landscape underwent a seismic upheaval rendering the wider context scarcely recognisable, day to day we continue to struggle with the ordinary difficulties of providing therapy and training to reasonable standards. The March 2017 deadline for the GMC mandated leadership role for medical psychotherapists in core training has resulted in the development of a number of new posts. This growth in the training role of Medical Psychotherapists is likely to continue as psychotherapy training for higher trainees becomes more widely established. All of this is of course important in firmly embedding psychologically minded practice in psychiatry. We used our strategy day this year to think about the training and support we offer to psychiatric colleagues throughout their careers and across specialisms. We have summarised the work of the strategy day in the outline below.

The Faculty Executive, including the newly elected members, has continued to establish the case for development of clinical therapeutic services for people with severe and complex mental health problems. This is the main objective of the clinical working groups and the Talking Therapies Task Force. There are a number of events and developments arising from these groups over the coming year including the APP/NELFT MUS conference on the 27th of January at which the Joint Commissioning Panel MUS Commissioning Guide will be launched, a joint piece of work between the Medical Psychotherapy Faculty, Faculty of Liaison Psychiatry and the Royal College of GPs. Many thanks to Simon Heyland and Andy Soutter for the work they have put into that. The reflective practice working group is getting established alongside the Enabling Environments group at CCQI, and will be developing an e-learning module in reflective practice commissioned by Health Education England in the coming months. We are planning a Relational Economics Summit at the College on the 15th December 2017, highlighting the economic costs of factoring relationships out of the regulatory framework for health and social care.

The Talking Therapies Task Force (a collaboration by The MP Faculty, the APP, the BACP, the BPC, the Society for Psychotherapy Research and the UKCP) continues to meet monthly and now has a fully worked out strategy to promote the commissioning of new psychotherapy services for patients with complex needs. The first priority will be to build a health economic case, which we are doing with the assistance of Michael Parsonage from the Centre for Mental Health. This is likely to be made on the basis of those people with relational disorders who over-engage with inpatient services in physical and mental health and those who dis-engage but tend to be high users of emergency and out of hours services. The outcomes framework group has been meeting.
for some months to discuss the development of a national outcome data collection system and in the course of this year work streams will be developed to identify workforce gaps and to promote the development of training nationally. The aim of the project is to make the health economic case to commissioners for commissioning services as part of their sustainability and transformation plans and to remove the obstacles to commissioning. Services which measure and benchmark outcomes, can demonstrate cost effectiveness or savings, whose quality can be assured and to which commissioners can be confident they can recruit a competent workforce, are more likely to be commissioned. This is especially the case if they are able to offer solutions to current commissioning priorities such as bed shortages and use of out of hour’s services.

Finally, we would like to offer our congratulations to Wendy Burn on her election as the new President of the College, as Simon Wessely’s term comes to an end. Simon has been a great supporter of the Faculty and its work, supporting in particular the development of medical student psychotherapy schemes, the work on Medically Unexplained Symptoms and the Talking Therapies Task Force, to mention just a few. Having a President who is sympathetic to our training and clinical role with complex patients is vital to our continued effectiveness, and we know from Wendy’s support for our education and training work during her time as Dean that she will be someone whom we look forward to working with as President.

Sue Mizen
Faculty Chair
Contact Sue c/o stella.galea@rcpsych.ac.uk

Contemporary Practice

Recent publications by the Faculty

Using formulation in general psychiatric care: good practice

Faculty of medical psychotherapy position on electronic patient records

Outcome measures for psychodynamic psychotherapy services

Learning from the cradle to the grave: the psychotherapeutic development of doctors from beginning to end of a career in medicine and psychiatry
The annual Medical Psychotherapy Faculty conference of 2017 will be hosted at the Royal College of Psychiatrists in London between Wednesday 5th and Friday 7th April.

The overall theme of the conference will be ‘Dissociation, Trauma and Psychosis’ and speakers will include Ira Brenner (USA), Jaakko Seikkula (Finland), Valerie Sinason (UK), Remy Aquarone (UK), Brian Martindale (UK), Richard Brown (UK), Tim Reid (UK).

We will be running pre-conference workshops on Wednesday 5th April in the afternoon, and there will be a guest speaker slot on the Wednesday evening. We are hoping that Norman Lamb MP will join us for this slot but this is to be confirmed. As in the last two years, there will be a separate Neuroscience Interest Day on the Saturday (8th April) at the Institute of Psychiatry, Psychology and Neuroscience, details to be confirmed.

We are looking forward to what promises to be a fascinating and educational conference and hope to see you there. Please get the date in your diary!

Mark Evans
Academic Secretary
Contact Mark c/o stella.galea@rcpsych.ac.uk
Message from the Chair of the Specialty Advisory Committee (SAC)

William Burbridge-James

I am now reporting in my capacity as chair of the “Specialty Advisory Committee”: this title has replaced the previous “Faculty Education and Curriculum Committees” within the College’s structure. This reframing was put in place by Wendy Burn, our newly elected President, when she was in the role of Dean, bringing RCPsych educational and training committee names in line with other medical Royal Colleges. Alongside this is a formal and transparent governance structure, for both the appointing of the chair and committee members, which seems timely and appropriate.

The committee is engaged in work that is fundamental to the longevity of the speciality and I am grateful for the work and support of the committee members, and the lasting influence of the work my predecessor James Johnston. It is on the back of this work that new Consultant Medical Psychotherapy posts are being created to meet the GMC requirement in the core curriculum, that psychotherapy tutors leading training for core trainees require a CCT in Medical Psychotherapy.

Ben Robinson, one of the Medical Psychotherapy higher trainee representatives, has been helpful in liaising with trainees to compile a list of trainees nearing the end of their training who may be interested in applying for posts that are in development. This helps colleagues in the process of developing posts who can gauge interest and talk to potential applicants. We need to be able to meet the employment opportunities that arise as a Faculty.

As a committee we met earlier in January and, with the executive, are looking at job plans for Consultant Medical Psychotherapists that balance training and clinical commitments, so that we can develop guides that can help prospective consultants and future employers.

Adrian Husbands, the College statistician, has been helping digest the results of the second UK Psychotherapy Training Survey. The report from this is being finalised, and the initial findings show that while Core trainees are generally meeting their psychotherapy competencies, over a quarter of trainers report that they struggle to do so by the end of year 3 ARCP.

Limiting factors to being able to complete training by the end of CT3 ARCP included; access to Patients and to Supervision; and ‘Other’ reasons which could be grouped into

1) Patient factors: particularly patient premature termination of therapy or drop out.
2) Trainee issues: shifts, rotation, and competency
3) Resource/service issues.

Responses from the survey indicate that this is being addressed by LETBs and ARCP panels with trainees gaining outcome 3 and additional training time, as appropriate. Actual numbers of core trainees failing to complete their psychotherapy training (2013-2015) were low, gaining an outcome 4 at ARCP, and where this was the case responses indicated that these were generally aspects of more global difficulties that trainees were facing.

The respondents reinforce the perspective of psychotherapy services as the main source of psychodynamic long cases. IAPT services also feature as the sources of a CBT short case. The range of responses also illustrated that Psychotherapy tutors were clearly being pro-active in developing innovative patient pathways for psychotherapy training cases.

However, a significant concern identified by a number of the respondents was the closure of secondary care psychotherapy services, or their reduction in size, making the provision of training cases more problematic.

The survey also looked into higher specialist Medical Psychotherapy training where the respondents indicate that dual training in Medical Psychotherapy and General Adult or Forensic Psychiatry, now predominates as the mode of delivery for higher Medical Psychotherapy training. However, half of respondents thought the single CCT in Medical psychotherapy still had a future place in training, and that the single CCT was needed as a base from which dual training originates and develops, which allows for immersion, depth and focus in the speciality. This is alongside the training pathway it provides for trainees who are clear in their wish to work in Medical Psychotherapy or who may have already come with a CCT in another psychiatric speciality.

The other significant aspect of the survey was to capture the current psychotherapy training experiences that higher trainees in other psychiatric subspecialties were undertaking. The responses indicate that this is very limited in the main subspecialties such as General Adult Psychiatry, yet WBPAs are being achieved in psychotherapy. As I have commented upon in the last two Newsletters, this raises a number of questions and challenges. What psychotherapy experience do we expect of higher trainees in other specialities to undertake in order to achieve their SAPEs? The SAC is currently drawing up broad guidelines that seek to lay out an achievable psychotherapeutic developmental learning pathway for higher trainees, following up on the feedback from the survey.

The new Dean of the College, Kate Lovett is engaged with the Faculty, supportive of training aims, and the importance of training psychotherapeutic psychiatrists. This connects with the publication by the College of the Occasional Paper 102, published this January, “Learning from the cradle to the grave: the psychotherapeutic development of doctors from beginning to end of a career in medicine and psychiatry”, by James Johnston. The publication describes an education strategy for the development of psychotherapeutic medicine and psychotherapeutic psychiatry in the UK, and underpins our aims to enhance the therapeutic relationships of doctors with patients.
by placing the therapeutic attitude at the developmental centre of CPD in a spiral curriculum model.

Those Faculty members interested in participating in the work of the SAC please get in touch. Contact William via stella.galea@rcpsych.ac.uk

William Burbridge-James  
Specialty Advisory Committee chair  
Contact William c/o stella.galea@rcpsych.ac.uk

**Summary of Strategy Day discussion**

Summary of Strategy Day discussion held by the Executive Committee of the Faculty of Medical Psychotherapy on 31 January 2017

**Recruitment: The Dean’s priorities**
- Building links with the British Psychological Society.
- Bridging the gap between IAPT (Improving Access to Psychological Therapies) and severe and complex in psychological therapies.
- Making reflective practice part of the culture in psychiatry.
- Cognitive Behavioural Therapy placements for Core Trainees in IAPT.
- Supporting recruitment and retention in Psychiatric training via:
  - Developing social media and College website materials to support recruitment to psychiatry including neuroscience,
  - Supporting trainees through their training years to improve retention.

**Higher training for general psychiatric trainees**
- Role for Medical Psychotherapy Tutor: monitoring quality control in conjunction with Training Programme Directors; looking at opportunities for developing trainees’ psychotherapy expertise at School Board level.
- Job planning for Medical Psychotherapists; Specialty Advisory Committee to identify number of PAs depending on the size of the cohort of higher trainees.
- Higher trainees to lead in identifying their training needs and developing a portfolio of appropriate psychotherapy experience relevant to specialism with the support and assistance from medical psychotherapy.
- Identifying minimal requirements for higher trainees who are not interested in psychotherapy.
- Firm up the requirement for Balint groups or case based discussion, for higher trainees (may be an achievable quick win) e.g. three years is equivalent to a SAPE.
- We would want to retain the expectation that trainees will take on a psychotherapy patient at some point in higher training.
Making links with other Faculties for higher training

- Exchange of training placements in both directions between Faculties.
- Developing CPD events and joint conferences.
- A national register of Medical Psychotherapists in new areas of expertise e.g. eating disorders and somatisation, able to offer supervision and relevant clinical experience.
- Links with Intellectual Disability Faculty with regard to a dual Certificate of Completion of Training (CCT).

Psychologically minded practice for psychiatrists following CCT through promoting Medical Psychotherapy models for supporting consultant colleagues

- Allowing examples of good practice to emerge rather than imposing them.
- Encouraging supervision and reflective practice: easier access.
- Mandating reflective practice. Can we define good reflective practice?
- Describing good practice examples on the Faculty website.
- Seminars at the College. Finding out what people are doing around the country is difficult. How do we communicate this and link Faculty members up to good practice?
- To be included in Faculty conference workshops.

Faculty clinical working groups and Medical Psychotherapy Training

- Adapting training to emerging roles for Medical Psychotherapists, e.g. trauma, psychosis, MUS, eating disorders, Tier 4 PD, perinatal, adolescent Tier 4.
- Changes in the curriculum need to be agreed by the GMC, best to put changes in all together rather than piecemeal.
- General Medical Council, Intended Learning Outcomes (ILOs) allow some flexibility in Medical Psychotherapy training timetables to pursue special therapeutic interests.
- Encouraging trainees to think about future jobs at the outset with a register of placements where they can get relevant experience and interfaculty events at the College offering taught elements to make up a portfolio.

Links with CAMHS

- Dual CCT; preparing the ground before the curriculum is agreed by:
  - Identifying National Training Numbers (NTNs) in conversation with Heads of School;
  - Identifying the posts dual CCT will lead to in order to encourage applicants.

Credentialing

- We clarified that the purpose of credentialing is for Medical Psychotherapists to develop our expertise to work in different areas.
- We agreed on a watching brief for now.
Contemporary Practice

Recent publications by the Faculty

Using formulation in general psychiatric care: good practice

Faculty of medical psychotherapy position on electronic patient records

Outcome measures for psychodynamic psychotherapy services

Learning from the cradle to the grave: the psychotherapeutic development of doctors from beginning to end of a career in medicine and psychiatry

Executive Committee Task Groups

Post-suicide initiative

An introduction to the newly-formed Working Group on Suicide from Dr Rachel Gibbons

Suicide is a very important area for psychiatrists who work in adult psychiatry and in psychotherapy. It is an area where we are experts, in that we think about it and discuss it extensively with patients on a daily basis.

Together with Dr Rob Hale, I have been running a suicide group for consultants over the last 7 years. It is clear from the experience of the psychiatrists who come to the group, and from my own experience of patient suicide, that psychiatrists are generally deeply affected by these tragic events. Many of those presenting cases at the group have suffered high levels of depression and post-traumatic stress following these deaths.

This psychiatric morbidity appears to result, not only from the impact of the incidents themselves, but also from the SUI investigations that follow, the distress of families and friends that can be directed at us personally, the Coroner’s Court and sometimes even the press and wider societal response. The experience around a patient’s suicide is frequently cited as the reason psychiatrists retire or leave the profession. We are often under intense and unrealistic pressure both internally, and externally, from our organisations and from society when it comes to suicide. We often live in fear, we feel persecuted and are often persecuted in reality.
It can be very difficult to create an atmosphere where psychiatrists feel safe to talk about their response to suicide, perhaps in part because we feel tainted, ashamed and implicated in these deaths. The universal feedback following from those who have presented at the suicide group is that it has been helpful to talk. This is not news to those of us who work in psychotherapy.

The Medical Psychotherapy Executive Committee has recognised the importance of this difficult area and has a newly formed working group focussing on suicide. The aim is to raise awareness and thinking about suicide in the College and to start some broader work on mitigating the pain that patient suicide can cause for psychiatrists.

Dr Rachel Gibbons
Co-opted member of the Medical Psychotherapy Executive Committee
Contact Rachel c/o stella.galea@rcpsych.ac.uk

Neuroscience Interest Group
The Neuroscience interest group has started a reading group. We met twice over the autumn, discussing Mourning and Melancholia and a neuroscience paper by Robin Carhart-Harris and David Nutt amongst others which reviews Freud’s model in the light of current neuroscientific perspectives on depression. Robin Carhart Harris then joined us for our December meeting to discuss his research into the use of psychedelics in depression. We had a further meeting in February where we read about the neural correlates of dreaming in preparation for the neuroscience day at the conference, which will be on the subject of trauma and dreaming following on from the main conference theme. There will be a further meeting on 7 June. The references for the papers by Mark Solms which we read at the February meeting are given below, together with the reference for the Robin Carhart-Harris paper mentioned above. Those who have expressed an interest and others who are sceptical are all invited. We have some truly interesting and engaging conversations and are developing our understanding of the neuroscience perspective. I can confirm that I am now on the Gatsby and Wellcome Foundations neuroscience project implementation group. The work of writing the new neuroscience curriculum will soon start in earnest, so I will be contacting those generous and interested souls who offered to write curriculum content and training modules.

Mourning and melancholia revisited: correspondences between principles of Freudian metapsychology and empirical findings in neuropsychiatry
Carhart-Harris, Mayberg, Malizia and Nutt

New Findings On The Neurological Organization Of Dreaming: Implications For Psychoanalysis
Mark Solms
Psychoanalytic Quarterly 1995, 64:43-67
Summary and Discussion of the Paper: ‘The Neuropsychological Organization of Dreaming: Implications for Psychoanalysis’
Mark Solms
Bulletin of the Anna Freud Centre 1993, 16(2):149-165

Sue Mizen
Faculty Chair
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Tier 2 Psychotherapy Services Group

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 Service. Perhaps my confusion brought up what I think is the crux of the current ambiguity in Psychotherapy Services, particularly in my Trust, but which may also be part of other people’s experience across 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 Personality Disorder 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 Personality Disorder clinical lead. In my opinion this is an issue for debate and I would be interested in a discussion with other Psychotherapy Service Leads about whether they are experiencing a similar process with regard to psychotherapy services, and whether this is the way forward in their future development.

As I understand it, the Personality Disorder Working Group is focussed on Tier 3 and 4 Personality Disorders Services, whereas in my puzzled mind I am in a Tier 2 Personality Disorder/Psychotherapy group; Psychotherapy and Personality Disorder Services have become indistinguishable.

To cut to the chase, the point at which specialist dedicated Personality Disorder 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 Personality Disorder 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 comorbidities, 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 the question of where the demarcation of dedicated services in the spectrum of PD severity lies.

As Psychotherapy Services appear to be moving towards becoming Tier 2 Personality Disorder services, so is the training of junior doctors in Medical Psychotherapy moving towards a Dual
Training in Medical Psychotherapy and General Adult Psychiatry (GAP). Coupled with this development is another exciting advancement taking place in the training of GAP 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, and so it is that Psychotherapy might be in the process of being brought in from the cold. Ironically it might also be that Psychotherapy might be asked to save the profession of GAP as it is struggling to recruit trainees into core and higher training.

We propose that a UK expansion of dual training with Medical Psychotherapy, introduced in 2008, could be the way forward in terms of producing doctors, trained in both GAP and Psychotherapy, for the new Tier 2 Psychotherapy/ Personality Disorder 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 Psychiatry by pairing it with Medical Psychotherapy.

Dr Ronald Doctor  
Consultant Psychiatrist in Psychotherapy  
West London Mental Health NHS Trust  
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**Medically Unexplained Symptoms working group**

You may have noticed that medically unexplained symptoms (MUS) have emerged in recent years as a topic of growing interest in the NHS. Doctors have been observing the phenomenon and commenting on it for centuries, for example Henry Maudsley’s famous quote: ‘Sorrow which finds no vent in tears makes other organs weep’. Current political interest in MUS is more about the potential for cost-savings than anything else, but the focus on this group of patients is long overdue. They are estimated to account for around 10% of the annual NHS budget, yet rarely get access to specialist care.

So MUS is a markedly undeveloped area of healthcare, as well as being one where medical psychotherapists can have a significant role, since we are the only group of professionals trained in medicine, psychiatry, and psychotherapy. The clinical work is challenging but also satisfying, helping bring together mind and body. The organisational work can reconnect us with other kinds of doctors and demonstrate the value of our specialism.

In 2014 our Faculty set up a working group to think strategically about MUS. Below is an overview of our current areas of work:

**Commissioning**

We are very pleased to announce that the **Joint Commissioning Panel for Mental Health (JCPMH) MUS commissioning guide** was published in January 2017. Simon Heyland is co-chair, and he and Sue Mizen are Expert Reference Group members and lead authors.
Education & CPD
We are in the process of setting up a Faculty MUS interest group which is broader than the working group, offering support and CPD to members. The launch is provisionally planned for the Faculty Conference in April 2017.

We were part of a successful conference on the theme of MUS organised together with Dr Andy Soutter from NELFT and the APP on 27th January 2017 in London.

We are planning a Faculty education strategy on MUS, to consider both the needs of higher specialist trainees and of their trainers, aiming to cover academic programmes as well as opportunities for supervised clinical experience. We are currently undertaking a review of the core and higher curricula as a basis for this.

We are also offering to deliver one of the national Trainer-Trainee days in 2017.

Peer support
As mentioned above we are setting up a Faculty interest group. We would also like to find a way to track service developments nationally and use the interest group as a forum to discuss these.

Link to the Talking Therapies Taskforce
1. We are compiling a draft of current activities and future plans linked to the TTTF workforce development strategy
2. We are putting together a draft of staffing requirements, pathway algorithms, quality standards and service targets from PCPCS/Camden TAP documents.

If you are interested in learning more about MUS as a medical psychotherapist, please look out for the launch of the faculty peer group this year.

Simon Heyland and Sue Mizen (co-chairs)
Contact Simon Heyland c/o stella.galea@rcpsych.ac.uk

An introduction to the non - Medical Psychotherapist Members Section

Dr Alison Jenaway, Co-Editor

Hello to all you ‘non-MP’ members. Hopefully some of you responded to the survey which the Faculty sent out last year to all our members. This was to try and find out how we as a Faculty can be more responsive, and relevant, to those of you who are primarily psychiatrists, but are interested in psychotherapy, and wanting to keep it up as a special interest. Two of the key areas
of focus for the people who responded to the survey were the Faculty conferences and the newsletter. They wanted these to be more open and welcoming to non-MP members, with contributions which were more relevant to general psychiatric work. I have volunteered to be responsible for driving some of these changes within the Faculty and to act as a co-editor for this non-MP section of the newsletter. I do, in fact, now work as a medical psychotherapist, but was previously a general adult psychiatrist with a special interest so I have been in the position that I suspect many of you find yourselves in — the lone voice of psychotherapy within a system that has no space or time to reflect. So do let us know what you would like to see in this section. Perhaps you could write something about “How I keep psychotherapeutic ideas alive in my work” or I could perhaps do some BMJ style interviews of those who are struggling to combine both roles and how they have managed that?

I think that where the conferences are concerned, things have already started to happen. The Faculty have already made some changes to the way they organise their annual conferences so now the conference on every other year is a large one in London, often held jointly with another Faculty. These will hopefully be more “outward-facing” and will encourage presentations from a wider variety of psychotherapeutic perspectives. Do put the dates in your diary for the next conference on 5th to 7th April 2017 in London which has a focus on “Dissociation, trauma and psychosis”. There will also be occasional “Medical Psychotherapy Seminars” running, like the recent one on “Psychiatric illness – a psychodynamic approach”, organised by Dr Jo O’Reilly in November 2016. These are designed to appeal to all interested clinicians.

The Faculty is also keen to get involved in the issues facing non-MP psychiatrists in the areas where psychotherapy skills are perhaps most useful. One of these areas is the effects of suicide and you will see that there is a report from Rachel Gibbons, elsewhere in this newsletter, about her work in running a “suicide clinic” where teams who have experienced a suicide can book themselves in for a reflective practice session. Rachel is hoping to raise the profile of this kind of support and, I think, to increase the number of such clinics around the country.

Another issue which may be relevant is the idea of credentialing. The GMC have introduced this as a possibility for small specialities which have no other way of gaining a specific CCST and the liaison faculty has taken the lead in organising a pilot credential course this year. It is not yet clear whether this kind of process is suitable for the much slower, experiential learning required for psychotherapy, so we may have to look for other ways for people who want to be able to demonstrate their psychotherapy expertise.

We are also conscious that many of you are acting as psychotherapy tutors, where Trusts do not yet have a medical psychotherapist post. One way of supporting this work could be to have a “psychotherapy tutors’ day” to give people a chance to get together and share best practice and creative ways of helping trainees meet the curriculum requirements. Would you be interested in attending such a day?
These are just some of our ideas, but we are eager to hear yours, so please do get in touch. You can contact me via Stella

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Conference Reflections  

Faculty Conference 2016: A Review of the Small Groups

This was a new venture for the Faculty, to include small groups in the programme in a more formal way since the earliest days of the residential format in the mid 1980’s. The first three conferences, held in Queens’ College Cambridge, were structured around formal lectures followed by large and small experiential groups. These were memorable conferences which generated strong emotional experiences and created lasting bonds between participants. They were well attended particularly attracting a cohort of psychiatric trainees, who were influenced to pursue careers in psychotherapy, and general psychiatrists. There was also strong opposition, in some quarters, to the experiential format which led to a change in format towards a more cognitive learning style.

Conferences have increasingly had full programmes with little space for a reflective process. There have been various attempts at reintroducing this space with elements of group experience, small and large, over the years. These have had variable results perhaps because they were not sufficiently well thought through in terms of what the aims were.

This year we aimed to provide a small group experience across both days of the conference with specific aims which were communicated to the delegates in advance (included in Appendix 1 for reference).

There were a number of administrative problems in planning the groups. The most problematic was the number of delegates attending only one or other day with significantly different numbers on each of the days making it difficult to know how many group conductors and group rooms we would need. Both of these have cost implications. Secondly two group conductors had to pull out close to the date meaning that the size of the groups as planned was larger than we would have liked. Thirdly a significant number of delegates booked in the days leading up to the conference again made it difficult to plan the groups in terms of numbers and gender balance in each group.
In the end we had 4 groups for those attending both days, 3 groups for the Thursday only and 2 for the Friday only. All the groups had a planned number of around 14 – 17 people. The groups running across both days were well-attended although with not everybody attending both days. There was a problem with the allotted time being eroded with late starting because no time was allowed in the programme for moving between sessions. There was a large non-attendance for the 1-day groups. This was perhaps understandable from a practical standpoint on the Thursday because the groups were booked at the end of the day end of day and perhaps people took the opportunity to catch an earlier train. It is less clear on the Friday as the groups were in the middle of the programme. There was a further administrative problem in that the 1-day groups were all booked for the main lecture room as other rooms weren’t available and we did not know this could be partitioned into 3. It is obviously helpful to know this sort of detail for planning. So we made last minute changes which were disruptive although didn’t appear to impact on the attendance level. There were comments in one group that we mirrored the general chaos of working in the NHS! Highly likely! Additionally, few of the speakers attended the groups. We will need to be clear with them that they are invited and ask whether they wish to attend.

It seems paradoxical that people didn’t take the opportunity for reflection and discussion as an integral part of the learning experience when a commonly voiced complaint is how little time there is in every day working lives for this. Perhaps it will come with perseverance of the model.

Each group was evidently different in its themes and interweaving of personal communications with material from the presentations. There were some common themes. Most notable were differences between consultant and trainee sub-groups. Generally trainees felt more anxious and took longer to find their voice in the groups but did so as the groups progressed. Perhaps unsurprisingly trainees were more interested in the now and the future of working in the NHS whilst older consultants were preparing for retirement and loss of role. Common to both was a sense of loss of the NHS as it was and having to accept how it is now with particular reference to the pressure on long-term therapy. The junior doctors’ strike was mentioned with some juniors appreciating consultants’ support whilst others experiencing them as unsupportive. Clearly trainees feel under considerable strain. In 2 groups there was a regret that it didn’t seem possible to address more difficult and potentially more conflictual subjects. I wonder specifically that there was no talk about boundary violations especially given two of the group conductors were presenters of the masterclass on Wednesday. Do we need the conference to be a ‘good’ experience to counter the strains of our working lives?

There were a number of appreciative comments about the quality of the lectures alongside there being too much to take in. Steve Suomi’s presentation seems to have attracted most attention. There were mixed feelings about the ethics of the experiments. There was some identification with the monkeys – the austerity of the NHS compared to their wire cages; security and insecurity; aggression and violence. This linked to the theme of identity and threats to it – particularly from external forces.

One group consciously tackled the prescribed theme of their own attachments, although all the groups can be said to have addressed different aspects of the theme less explicitly. Dependency and fears of dependency, external and internal, surfaced – fears of our own endings with
reference to Chris Mace and Jane Knowles. Professional identity was explored in terms of holding the tensions between talking about feelings and prescribing; defences against feelings using dissociation and intellectualisation; the interplay between psychotherapy, pharmacotherapy, genetics and neuroscience; inter-professional tensions with psychology.

Themes of loss, death and memory – what would be lost as older colleagues retired and died versus what could be passed on – and mourning linked to the lecture on dementia. Most groups touched on personal losses and family bereavements.

The conductors of the 2-day groups commented on the development across the 2 days with greater sharing of personal material as the groups progressed, allied to an increase in cohesion as the two initial sub-groups of trainees and older consultants were able to come together. The 1-day groups were more problematic without that sense of development and perhaps therefore more difficult to assess. Nonetheless they appeared to be a useful experience for people to voice something of their experiences of what it is like to be working in the current NHS. We need to give more thought to these groups.

Formal feedback from the post-conference questionnaires was limited in numbers (10 on Thursday and 9 on Friday). 8/10 and 6/9 rated them good or excellent whilst 4/19 rated them as not relevant to their needs. I wonder what that means.

The group conductors enjoyed the experience themselves, thought their groups did so too and would welcome the opportunity to continue with this model.

There are valuable lessons to be learnt in terms of planning from the difficulties described above - nothing that should not be soluble. I think specifically linking the groups to the overall theme of the conference is helpful as opposed to them being open, experiential groups. What needs more discussion is how far we might go and indeed need to go to make best use of this form of learning and to embed it successfully in the conference format. A clear learning point is the requirement for sufficient time to allow the groups to develop. There is an argument therefore for more groups to balance and leaven the lecture presentations: - 2 groups each day – e.g. before lunch and towards/at the end of each day of 1 to 1¼ hours duration. This might particularly improve the 1-day experience and encourage attendance at the end of the day if the earlier group provides a sense of attachment. There is a cost implication in terms of how many rooms need to be booked and reducing fees for the group conductors.

Is there a place for a large group? There will be polarised views about that but we ought to at least think about it.
A separate issue now is the plan to have every other conference at the college aimed at a wider audience. I don’t know what the room situation is to accommodate the groups. It may also encourage more 1-day attendees. A solution may be to offer groups as part of the conference programme in the same way as we offer workshops.

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Appendix: Introduction to Small Groups

This is the introductory material distributed to all group participants at the conference.

Some may not be familiar with the use of small groups as a tool for personal learning in workshops and conferences. The following is intended to be a guide to the process and underlying theoretical frame.

Learning in groups gained through an experiential group process is a well-recognised although underused form of learning which adds an affective dimension which can bring alive academic and cognitive knowledge. It is learning with and from each other. It can be an exciting and at times disturbing experience. To be most effective it requires an attitude of openness and trust in the process and colleagues. It can be a deeply satisfying experience that additionally promotes closer bonds between colleagues.

The groups will be themed to fit the overall conference theme of attachment through the life cycle. Specifically the theme of the groups is “Our attachments: - to our professions (medicine, psychiatry, psychotherapy), colleagues and patients, and how these may impact our practice for good or ill”.

The task of the groups is to explore the theme in whatever way each group chooses. The task of the group conductor is to enable the group to keep to task partly through understanding unconscious processes which militate against this. In other words the conductor models a reflective function for how well the group is managing its task. This responsibility can be taken up by the group members as the group progresses. This model has been embodied in what is known as the Double-Task model designed by Harold Bridger based partly on his work with Bion at Northfield during the war. Task one is ‘the task’, and task two is reflection upon how well the group is achieving task one. This is the model for the Tavistock Institute of Human Relations annual group relations conference.

In order to do this beyond setting the theme there are no other instructions or agenda for the groups. It is an open discussion analogous to free association. It is a setting within which to explore the theme of our attachments through here-and-now experience of attachments formed in the groups.

Jill Savege Scharff & David E Scharff in their book “Tuning the Therapeutic Instrument: Affective Learning of Psychotherapy” describe the process as follows: -

“The individual’s task is to discuss the theoretical and clinical material that has been read or presented and at the same time to examine intellectual and emotional responses to it. As each member attempts to do this, discussion follows, and a group process develops. The group’s task is to facilitate its members’ learning from all levels of experience. While studying the theoretical and clinical material provided, the group
examines its own process to discover how the individual’s inner world combines with the personalities of others to illustrate the concepts and to foster or impede the learning.”

What learning is facilitated by such a group process? It is personal learning based around how each individual aligns themselves to the group process both in relation to the task and anti-task processes. In Bion’s terms ‘valency’. It allows the individual to understand the basis of their membership of the group, the roles they adopt. This of course relates to family dynamics but these are not the focus of attention, rather it is the group and social processes that derive from them which are the focus of attention. To be clear this is not intended to be a form of therapy and is not therefore Group Analysis.

All of the group conductors are qualified Group Analysts and have considerable experience of conducting groups across a range of settings.

As is normal for experiential processes confidentiality is a key principal. In this setting confidentiality refers to personal information that may be revealed in the group. Themes explored in the group and learning from the group is part of the conference and can be shared with other attendees. There will not be a session of formal feedback to the whole conference.

Group conductors will meet together to process the experience of the groups as a whole as part of the overall learning process for themselves and the group organisers. If possible and helpful we may write a summary of this to be sent to all delegates.

You will be invited to comment on how you found the group experience along with any suggestions you may have for improving it as part of the conference feedback.
Faculty Executive Service User Representatives: welcome to Stephanie Guidera

Stephanie Guidera looks thoroughly at home in Liverpool’s Philharmonic Hall. The bubbly 25 year-old mezzo soprano is preparing for forthcoming performances St Mark’s Passion at Liverpool Metropolitan Cathedral in spring and back to the Phil later this year to sing Mahler’s 2nd Symphony, “The Resurrection”.

But for many years Stephanie’s stage persona only concealed the pain inside her mind. Severe bulimia led her to Mersey Care’s eating disorder service at 17. Later the promising young singer dropped out of music and Drama College and was abusing substances.

“I began singing at age five. By 13 I was studying under a Senior Professor at the Royal Northern College of Music in Manchester. I got into the Guildhall School of Music and Drama in London and toured Europe with the famous Monteverdi Choir. I had a televised solo at the BBC Proms and sang at the Palace of Versailles in Paris.

“It was amazing, but all the time I was struggling to read the music. I was diagnosed with dyspraxia, which means I was unable to process and organise information. When I tried reading music my brain shut down.

“Having a diagnosis felt clearer, but there’s no cure and I became so depressed. I thought I was ‘stupid’. I had always felt different, this just seemed to confirm it. I used substances to take away my pain. I self-harmed. It felt like I’d lost my entire personality. I wore black because it felt to me like life was dark – I had no confidence to dress boldly. My voice and my personality slowly disappeared. It’s scary looking back.”

The specialist therapy Stephanie receives from Mersey Care’s Psychotherapy Service has changed her life ‘beyond recognition’. Mentalisation based therapy helps people with borderline personality disorder to differentiate and separate out their own thoughts and feelings from those around them.

“I get incredible support, the staff are wonderful. They’ve taught me to slow down and think about why I have such strong feelings; I reflect a lot; that’s crucial to maintaining relationships and keeping friendships strong. I keep track of my progress in journals, it’s astonishing to see it on paper. I’m determined to reach my potential and I work hard... and these days I rarely wear black.”

Article reprinted with kind permission of Mersey Care NHS Foundation Trust
Photography by Joel Goodman
Welcome to the 2016/2017 winter edition of Trainee Voices, a platform for discussion within the Faculty newsletter dedicated to trainees with an interest in Medical Psychotherapy.

We would like to thank Dr Tiago Gandra for introducing us in the last edition as following in his footsteps as co-editors of the Trainee Voices section of the newsletter, to continue his work in providing an opportunity for trainees with an interest in Medical Psychotherapy to develop and share their interests, views and ideas related to psychotherapy with the wider community via the medium of written word. We would also like to thank Tiago for his hard work as editor of Trainee Voices over the last couple of years.

As a brief introduction we are pleased to be a part of a wider group interested in Medical Psychotherapy, Anna as a dual trainee in General Adult Psychiatry and Medical Psychotherapy in London, and Alex as a senior General Adult Psychiatry trainee in Yorkshire, with a strong interest in Psychotherapy, and plans to continue into Medical Psychotherapy in the future. We were both struck by the importance of the themes of group identity, belonging, and coming together to support each other on many levels, in the following interesting articles contributed by trainees for this edition.

This reminded us of the value, importance, and enjoyment of having spaces to come together and think as a unique group who often occupy geographically isolated positions and also as part of other diverse groups. So please do continue to join other trainees at upcoming Faculty meetings mentioned at the end of this newsletter and to continue to actively converse with the trainee representatives and other trainees via the online ‘Google group’ which can be a valuable way to keep in contact in between other events and has been rather active of late.

We begin trainee articles with another welcome introduction, of Dr Kate Highton, Dr Victoria Barker, and Dr Ben Robinson, the current Medical Psychotherapy Faculty trainee representatives. They share the beginnings of their important work including developing a map of Medical Psychotherapy trainees across the country, via the Google group, to make us more accessible as a group, and also thinking about the challenges and exciting new developments within our field such as Medical Psychotherapy tutor roles and other projects.

Dr Jamie Richardson gives a rather fond account of his varied experience of Balint groups throughout his Psychiatric training, as both a group participant and facilitator, whilst thinking about the emotional impact our patients can have on us and how Balint can help us work through
this. He also thinks about varying experiences and views of Balint, how these might occur and what these may mean for different people.

Dr Caroline Reed-O’Conner, the recent winner of the Trainee Speaker competition at the Annual Psychiatry Trainee Conference on 23rd November 2016 with her emotionally touching and passionate discussion of the ‘Tea and Empathy’ support network for healthcare professionals, shares with us the development of the group amid the Junior Doctors’ Contract dispute. She describes how this has developed, and in particular notes the importance of coming together to support each other.

Last but not least, we look forward to seeing you at upcoming events (mentioned at the end of the newsletter). In the meantime, please continue to send your contributions and suggestions for the next newsletter – submissions c/o stella.galea@rcpsych.ac.uk.

We are also interested in book reviews, such as a review of the recent and exciting release at The Portman centre in London of the Oxford Handbook of Medical Psychotherapy edited by Jessica Yakeley, James Johnston, Gwen Adshead, and Laura Allison.

Without your contributions the conversation would not continue!

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Trainee representatives – An introduction and thoughts for moving forward.

Dr Kate Highton, Dr Victoria Barker and Dr Ben Robinson

We are delighted to introduce ourselves, Kate Highton, Victoria Barker, and Ben Robinson, as your trainee representatives to the Faculty of Medical Psychotherapy, continuing the fantastic work done by Sophie and Simon.

Although Kate and Ben do happen to be neighbours, our geographical similarity belies the diverse things we bring to our roles: with different working patterns (Kate is a less than full time trainee), two of us are working mums, the other a working dad, employed in different Trusts with different training approaches, at different stages of training, we hope that our separate backgrounds will help us be responsive to the diverse needs of trainees. However, we are limited in that we’re all London-based, so are keen in particular for reflections and information from people around the country.
In fact, our first action has been to send out a request to all trainees via the Medical Psychotherapy trainee email Google group for information on your roles and year of qualification, to get a picture of who we are as a group across the nation. Thanks to all who have replied: with this data, we can help the Faculty plan its approach to enforcing new GMC guidelines on Medical Psychotherapy tutor roles. This should see an expansion of the number of dedicated sessions for psychotherapists, to support the fact that Psychotherapy is now a mandatory part of higher as well as core training.

Two things have struck us immediately having attended our first full meeting of the Faculty: first, that we are part of a highly dynamic, forward-looking and robust group of psychiatrists, and second, that there are challenges for trainees as there are for the Faculty as a whole. As ever, psychotherapy services are under pressure, and the onus is on Medical Psychotherapists to explain who they are and what they can offer. However, several projects within the Faculty are well afoot to ensure the future of Medical Psychotherapy. From the development of a compelling economic case for better provision of psychological treatments for patients with complex difficulties (The Talking Therapies Task Force), following the example of the economic model which led to the establishment of IAPT, to the increasing connections with American and International psychotherapy bodies, to the video explainers of what Medical Psychotherapists do, it feels very much as if the future is in good hands. It is our intention as your representatives to help trainees contribute to and benefit from these endeavours as best we can.

It just remains for us to emphasise that we are a group, and as a group need to support one another and continue to develop a picture of who we are. To that end we have a request: first, reply to Google group emails! For example, you will soon get an email from St George’s trainees asking for your experiences of patients dropping out of therapy. Please do reply: it’s crucial to share these kinds of difficulties and develop a group sense of how they affect us. The future, after all, is ours. Now is the time to start shaping it.

Dr Kate Highton¹, Dr Victoria Barker², and Dr Ben Robinson³

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The Doctor, His Doctor and the Balint Group

Dr Jamie Richardson

On the list of concerns the patient has when attending the Doctor, the emotional impact a visit will have on the Doctor is likely towards the bottom of the list. I was fortunate to have had limited interaction with my Doctor, or any other medical professional, before starting medical school. Aside from the travel clinic and routine vaccinations I was lucky enough to be in good health and almost made a point of avoiding the Doctor intentionally. The times I have needed their help have seemed relatively straightforward, I had a problem and they had the solution. The meetings would be short and to the point, and in the age old tradition of the benevolent paternalist my Doctor would spend more time looking at the computer screen than at me. After my ten minutes was up I offered my thanks and left the room content in the knowledge I would live to fight another day. The idea that the Doctor may have been affected by our brief interaction, if it had crossed my mind at all, would be laughable. After all, it was their job.

After five years of medical school, two years of foundation training and three years of core training I do not remain under the illusion that the Doctor is an emotionless automaton. One can experience the full smorgasbord of emotional turmoil before lunch, with often few if any appropriate outlets. We can be told in medicine that the Doctor is here to help the patient, to assess them, listen to them and provide the most appropriate treatment available. As part of this role it may be assumed we have to like the patient, accept the decisions they make and the actions they take, for if we did not, how then could we act in their best interest? This seems to be the case even when this can cause significant distress to us and our colleagues. Worse still, we may be led to assume that it is something internal to us giving rise to any feelings of dislike and contempt.

Within this emotional milieu the Doctor, if they are very lucky, may stumble into the Balint group. For some it presents a chance to vent their frustrations, for others it is a place of emotional relief and release, a place to think about those patients we find ourselves taking home and the sometimes significant distress this can cause us. Some may see the group as a therapy session on the cheap, while others see a convenient excuse to leave the ward or an untimely distraction from the ever growing list of jobs to complete. The Balint group may represent all this and more. To me the group provides a space. Space to explore the relationship with my patients, space to learn from the experiences of others, and yes a space to voice some of those less socially acceptable thoughts which pop into our heads from time to time.

I have had the pleasure of attending two Balint groups during my training, before briefly co-leading a group of newly qualified doctors last year. Each of these groups were different, both in composition and functioning, but each provided me with a much needed opportunity to realise that I was not the only person who, to put it politely, struggled with particular patients from time to time. The first group I attended, fresh out of medical school, often seemed a strange and unusual space, discussing thoughts and ideas that were uncomfortable to say out loud. The second, over a longer period of time, became a sort of home away from home where I found myself able to explore both my understanding of the Doctor-Patient relationship and to take the
views of the group on difficult situations where there is little hope of resolution. As you may be able to tell, I thoroughly enjoyed my time in the Balint groups.

This is not the experience of everyone who attends the group, and I would not want to be accused of painting a purely rose tinted picture of joy and happiness. A difficult Balint session, or at least one I found unstimulating, can lead to a reluctance to attend further for fear of a repeat. It is also ironic that I have found that my clinical work, the supposed source of ample sustenance for the life of the group, at times provides a wall to better engagement in the group. How hard it can be to think clearly about the relationships of others, while all the while pondering the discharge summary or admission clerking waiting patiently on my desk. I suspect poor engagement of colleagues at times may have similar origins, and for some the time in Balint is time wasted, or worse detrimental. For those the thought of discussing their emotional state to a group of relative strangers is an anathema to them, and they find themselves utilising the best defence available, silence.

During my participation in the first and second groups I was aware that I occupied a minority of enthusiastic Balinters, but my sometimes irksome positivity made it easy to ignore. Leading the group was a different experience. It was now my role, my duty, to not only observe the participants but to actively engage those who may have fallen into the sceptical category. I saw those who resorted to silence, derision and on occasion hostility. I saw those in the group who offered an opinion, maybe in an attempt to end the session sooner, with little attempt to explore the relationship being discussed. One person even chose to offer the “medical” solution to difficult emotional experiences. Why, I found myself wondering, would a person pass up on the opportunity to better understand the relationships they have formed? Why would they rather sit in an awkward silence than offer a suggestion in a room where all suggestions are considered equal? Why, the register notwithstanding, did they bother coming in the first place?

I don’t pretend to have answers to these questions, and I am sure those reading will have their own hypotheses, but I wonder if attending the group, hostile and silent, is exactly what that person needs at that point in time. I wonder if a chance to say nothing, without fear of reprisal, may be something otherwise lacking from the Doctor’s professional life. As a Doctor we are expected to have all the answers, if only that were true. I am reminded of a time I arrived at the scene of a car crash to offer my services, introduced myself to the crowd as a doctor and watched in amazement as everyone took several steps backwards. At that point I wished I had kept my mouth firmly shut. Perhaps those who choose silence have made a wiser choice than I. I wonder if by remaining silent the enigma of the emotionless automaton can be maintained just a little bit longer.

At the start of this article I began by pondering the nature of my fleeting relationship as patient with a Doctor. Even with the benefit of hindsight the role seems to remain one of clinical efficiency in solving my trivial maladies. I suspect, or do I mean hope, that my time with my Doctor did not provide material for a Balint Group discussion. I do however find myself wondering whether they had access to a space to reflect, vent, observe or remain silent, and whether that space allowed the Doctor the emotional relief to then treat me with such speed and proficiency. For whether one
likes the model or not, the Doctor carries an emotional weight within their trusty leather bag, and Balint continues to provide one possible outlet to lessen that load.

Dr Jamie Richardson

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**Tea and Empathy – A national support network for NHS staff.**

Dr Caroline Reed O’Connor

In February 2016, amidst the height of the Junior Doctor Contract (JDC) dispute, a junior doctor called Rose went missing. For a short time, the worst was feared but not yet confirmed. A psychiatry trainee based at the same hospital posted on an online forum offering support, a cup of tea and an empathic ear. They also invited any like-minded doctors across the country, who wished to support their NHS colleagues, to respond with their name, location and the phrase 'Tea and Empathy'. There were over 1000 responses in just a couple of days.

The notion of 'Tea and Empathy' had captured something. Within days a group of disparate doctors (and one medical student) had set up the 'Tea & Empathy' Facebook page - a national peer-to-peer support network aiming to foster a supportive and compassionate atmosphere throughout the NHS. The network has grown organically to over 2,350 members and includes an inspiring mix of people from different professional backgrounds, grades and specialities and several key names from the field of doctors' health. A bewildering array of topics come up - from breastfeeding at work to career choices, from joyful encounters to suicidal thoughts.

From its earliest hours post-conception Tea & Empathy (T&E) was designed to spread beyond its internet-base to encourage more meaningful personal interactions in the workplace and beyond. Like a newborn instinctively turning their gaze to fix on the mother's face. Or a toddler leaving their secure base to explore the delights of the world. There have been multiple face-to-face meet ups across the country on an individual and group level. There have been well attended courses run on supporting a colleague in crisis. One hospital has even set up an on-call T&E system so that any staff member can call switchboard and ask for some Tea and Empathy when needed most. Areas of higher stigma are covered in more private groups - such as addiction and making mistakes at work. There is a growing undergraduate group and one for 'New Consultants' - a group whose specific vulnerabilities are becoming more widely recognised. A happy band of over 30 volunteer 'admin' act as facilitators and a few more experienced clinicians provide supervision to members as required. And all this is done in an atmosphere of compassion and empathy felt to be so stifled in the NHS of late.

So I find myself wondering why now? The desire for (and lack of) compassion within an ever-compromised health system is not a new phenomenon. But with the Junior Doctors Contract forum doctors across the NHS were united and connected in a way not seen since 'the good old
days of the medical firm and the 120-hour weeks’. The internet allowed for mass group identification and the hope derived from facing a common foe (and foe) together. Amidst the pain and dissolution doctors started to feel their individual neuroses comforted by the collective.

But the forum that existed soon began to strain under the increasing pressure and chaos of the socio-political system at large. It’s containing parental presence started to fracture and split with increasing frequency - entering a more psychotic phase - like a mother overwhelmed by the uncertainty of the future and the very safety of their child. The resultant fall out left many of the children feeling un-held and insecure. They felt attacked, and afraid of the previously nurturing source of support.

And out of this fray came Tea and Empathy, like an empathic nurturing grandmother, ready to hold the chaos and the fears. To support and impart wisdom from years of experience. Not there to change the circumstances but simply to say 'I’ve been there too, it is OK'. Not a perfect grandmother, but a good enough one.

What had started out as a message from one doctor to another had tapped into something much more universal than doctors' distress. It tapped into the many basic human needs of anyone involved in caring for another. The need for rest. The need for succour. The need for acceptance and love and connection. A space is provided, and permission is given, for the innate human compassion within each of us to flourish. The very stuff that brought many of us into the NHS and is so sadly stifled by conditioning, expectations and sheer workload is here allowed to bloom. The group is formed, continues to norm and from time to time throws up a storm (as in a teacup). But perform? My word it does perform! It brings NHS professionals together to think and support each other, when these previously existing spaces both physically and emotionally are being eroded in the NHS.

Contact/ further info
Facebook group: Tea and Empathy
Twitter: @Tea_EmpathyNHS

Dr Caroline Reed O’Connor

ST5 Dual trainee in General Adult Psychiatry and Medical Psychotherapy (CBT), at South West London deanery.

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In the winter 2015 issue of the Faculty newsletter, the American Psychiatrist, Eric Plakun contributed an article on the position of psychotherapy within American psychiatry. Eric is the current president of the recently formed Psychotherapy Caucus of the American Psychiatric Association (APA). Following publication of his article, the Caucus invited our Faculty to form a link with them. In their roles on the Faculty Executive, Maria Eyres and Sue Stuart-Smith agreed to take on the role of working with the USA Caucus to strengthen a link between our two organisations. Since then Maria and I have been learning about the work that they do mainly from Joe Wise, their secretary and hearing about their concerns about the place of psychotherapy within American psychiatry. In turn, they have been learning from us about the work of our Faculty and the kind of issues that concern our membership.

The Caucus was set up three years ago as a "grass roots" effort within the APA to promote psychotherapy being practised by psychiatrists. The drive to form a group emerged in response to growing pressures from the US healthcare and insurance systems for psychiatrists to provide almost exclusively pharmaceutical treatment. It currently has about 300 members and is hoping to gather more. It considers itself a "big-tent" group, without preference for any particular psychotherapy modality and is open to psychiatrists practising psychotherapy of any type psychoanalysis, CBT, group and family therapy etc.

Their members have been interested to learn about the change of title in the UK to Medical Psychotherapist and wonder if this has allowed for more flexibility to be retained within our roles. American psychiatry does not consider psychotherapy a sub-specialty, rather it is regarded as another type of intervention, one which is threatened by the current pressure on psychiatrists to limit their role to diagnosis and prescribing. Trainees do however have to complete some psychotherapy training in the main therapy modalities. Another consequence of the pressures on American psychiatry is that organisations such as the American Psychoanalytic Association and the American Group Psychotherapy Association have become increasing non-medical in their membership.

Maria and I hope that out of this link some scope might grow for collaboration on projects and that it might lead to participation in each other's conferences as well as facilitating links between professionals in the field. One important difference between our two groups is that the Caucus membership is made up of psychiatrists mainly in private practice. But in spite of the different organisational landscapes we practise in, the kind of pressures we are experiencing are not all that
dissimilar, particularly given the current financial situation in the NHS and the adverse impact this is having on the provision of psychotherapy.

We also learned of the link the Caucus has formed with the recently reinstated Psychotherapy section within the World Psychiatric Association (WPA). Joe Wise introduced us to Cesar Alfonso, the current secretary of the Psychotherapy section. From him we learned that the Psychotherapy Section of the WPA membership consists of international academics and clinicians, both young and experienced, interested in promoting the practice, training, study, and cultural adaptations of psychotherapy with diverse patient populations. Cesar provided us with the following information about their aims:

The WPA Psychotherapy Section goals include to:

1. Provide a forum for constructive exchange of ideas for psychiatrists practicing a variety of psychotherapy treatment modalities.
2. Study core factors, commonalities and differences among psychotherapies.
3. Coordinate through intersectional collaborations presentations, publications and similar activities in regional and international WPA meetings.
4. Determine standards for competency in psychotherapy adequate for the practice of psychiatry.
5. Explore innovative ways of teaching and assessing psychotherapy competency.
6. Disseminate important advances in psychotherapy theory and technique.
7. Innovatively use computer-assisted technologies to advance psychotherapy
8. Explore ways of meeting psychotherapeutic needs of diverse populations in an economical and culturally sensitive way.
9. Understand the biological underpinnings and contribution of neuroscience that validate psychotherapy theory and technique.
10. Explore standards of cooperation for treatment jointly provided by clinicians from diverse disciplines, such as physicians, psychologists, social workers, nurse practitioners, religious advisors, counselors and others.

All psychiatrists with an interest in psychotherapies are welcome to join the WPA psychotherapy section. There is no fee and if you wish to join you can send your CV to Cesar at cesaralfonso@mac.com and he will add your name to the Roster. There is an expectation that members will (at least occasionally) attend WPA international meetings and participate in symposia and workshops. The section is also interested in sponsoring advance psychotherapy
training workshops and seminars to expand the pool of psychotherapy supervisors in psychiatry residency programs worldwide.

This year the WPA World Congress takes place in Berlin in October and the Psychotherapy section is planning to contribute to it and is encouraging members to make submissions. You can find more information about the Congress on the WPA website at www.wpaberlin2017.com

Dr Sue Stuart-Smith  
Medical Psychotherapy Executive Committee Member  
Contact Sue and Maria c/o stella.galea@rcpsych.ac.uk

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**Book Review**

Dan Beales and Andrew Shepherd

**Medical Psychotherapy - Oxford Specialist Handbooks in Psychiatry**

Edited by Jessica Yakeley, James Johnston, Gwen Adshead, and Laura Allison  
Oxford University Press  
Published: 08 September 2016

Sometimes great things come in small packages and this much-anticipated volume, edited by members of the Faculty, is one such object. There may be a better metaphor for marshalling over 60 contributors, the majority of them medical psychotherapists, than the cliché of herding cats, but whatever it is we should all be grateful for such an important and brilliantly realised collection of both theory and practical clinical wisdom. Thanks to the vision and tenacity of the editors I would be surprised if every reader of this newsletter did not find either something useful or thought-provoking in this key volume, which I would recommend as an essential text both for medical psychotherapy trainees and all psychiatric trainees. This is such an important book that a further review will follow from a trainee in the next Newsletter.

In addition, consultants and other grades from all specialities will also find much of relevance in the succinct presentations on areas as diverse as: “Medical Psychotherapy: what is it?” to “Life: Cradle to Grave”; to “The System”. There are useful lists of recommended reading at the end of each mini-section, making these easily accessible.

The editors have taken a broad and inclusive approach, and they fulfil their stated aim of creating a “compendium of psychotherapies commonly delivered in the NHS by medical psychotherapists, psychotherapists, psychologists and psychiatrists” that “provides a link between different professions and ways of thinking about the problems of being human”. The contributors are drawn from an even wider range than that already stated including art therapists, counsellors, drama therapists, music therapists and service users.
There are some gaps (e.g. a consideration of Tyrer’s nido-therapy, or discussion of the difficulties around the classification of personality disorder and potentially significant changes to this in ICD11) but that is to quibble. Now that the heavy lifting of delivering what will, hopefully, become a developing and evolving collaborative endeavour is done, further editions will be able to fill these gaps and keep the text relevant and up to date, something that can always be at risk with comprehensive multi-author volumes. An expanded contents section would also allow even easier access to the sub-sections.

For me perhaps the most important part of this book (as I am currently working with others to try and ensure the maintenance of a medical psychotherapy post in one of the largest mental health trusts in the country) is the section: “Why medical psychotherapy?” Why do we need the expensive “tripartite training” integral to this of the doctor, psychiatrist and psychotherapist? The arguments put forward are convincing, but the Faculty and College need to ensure that they are given robust strategic and practical support at a national, regional, and Trust level to not only avoid the erosion of the speciality in the complex and unstable ecology of the NHS, but also to address the disparities in access across the country that continue to exist. This would ensure that the profoundly creative work illustrated by this volume can continue to evolve and develop as integral part of holistic mental health care.

Dan Beales
Consultant Medical Psychotherapist and Forensic Psychiatrist
The Pathfinder Service
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Anthony Ryle obituary

Jason Hepple

Tony Ryle, the originator of Cognitive Analytic Therapy (CAT), died on the 29th September 2016. The loss will be felt deeply by his family and by those in the CAT world in the UK and in many countries overseas. The Association for Cognitive Analytic Therapy (ACAT) is holding an event on 10th March 2017, in London, to celebrate the legacy of its honorary president (see www.acat.me.uk for more details).

I was fortunate enough to have contact with Tony in the years after his retirement in 1992 as consultant psychotherapist at Guy’s and St Thomas’ hospitals, and was able to gain some understanding of the motivations behind CAT’s ‘integration project’ culminating in a paper for ‘Advances’ in 2014 to celebrate thirty years of CAT, to which he contributed.
Tony started his professional career as a GP and became interested in how many of his patients repeatedly brought emotional and relational problems to his surgery. He questioned why people keep doing the same things again and again that lead to unhappiness (the ‘non-revision of dysfunctional procedures’). During his time as director of student health at Sussex University he began to develop a new model of psychotherapy that not only addressed symptoms from a relational perspective but also sought to provide an original account of psychological development that was researchable and in keeping with advances in developmental psychology. This led to an integration of the cognitive collaborative stance (most influenced by the work of George Kelly) and object relations theory (naming Thomas Ogden and Donald Winnicott as key sources).

CAT, however, then moved beyond the limitations of an integration of the ‘C’ and the ‘A’, and due to Tony’s close collaboration with the Finnish psychologist Mikael Leiman, has found its dialogic heart with reference to the work of Lev Vygotsky and Mikhail Bakhtin. CAT now provides a stand-alone and unique model of psychotherapy that is able to address trauma and early development and speak to the ‘post-psychiatry’ agenda with its lack of emphasis on symptoms and diagnostic labels and respect for the categories that are brought to therapy by the patient. The CAT model, as devised by Tony, uses dialogic narrative and diagrammatic tools and stances that are still unfolding in their richness as the model develops around the world.

Tony, perhaps due to the example of his eminent medical father John A Ryle, was deeply committed to public healthcare and the social and developmental understanding of ill health. In developing CAT he was determined to provide an in-depth psychotherapy that could be delivered within the resources of the NHS to those at most need. CAT has subsequently become one of the named specialist interventions in the IAPT-SMI personality disorder stream and is available in many parts of the UK within the NHS; for those with more complex presentations, historic abuse and neglect, learning disability and eating disorders. I know that he was proud of the place that CAT has found at the heart of the NHS.

As psychotherapist and leader, Tony was always accessible, non-hierarchical, encouraging, compassionate and in possession of the sort of mind that can cut through a problem with a simple word or phrase. His last appearance at a conference was via a video recorded in his home where he encouraged us, above all, to stay true to the humanitarian aims of the CAT project and to work harder in recording and researching our work and documenting good practice.

Testimony to his vision and creativity is the success of CAT around the world led by his co-presidency of the International Cognitive Analytic Therapy Association (ICATA) and the establishment of national associations in the UK, Finland, Greece, Ireland, Australia and New Zealand, Spain, Italy, and India. Tony’s legacy is in safe hands.

Goodbye Tony and, most sincerely, thank you.

Jason Hepple FRCPsych  
Chair of ACAT  
Contact Jason c/o stella.galea@rcpsych.ac.uk
**Notice: Building on the legacy and contribution of Gill McGauley**

The Forensic Psychotherapy Special Interest Group is planning a meeting at the College to honour the contribution of Gill McGauley to the field, who died so tragically in 2016.

We would be grateful if any Faculty Members who would like to participate and/or contribute to this would they please contact Dan Beales (daniel.beales@nhs.net), the Chair of the SIG, or Brian Darnley, its Financial Officer (brian.darnley@nhs.net).

**Events, Notices & Dates for your Diary**

**Faculty of Medical Psychotherapy Annual Conference 2017**  
5 – 7 April 2017, RCPsych, London

The overall theme of the conference will be ‘Dissociation, Trauma and Psychosis’ and speakers will include Ira Brenner (USA), Jaakko Seikkula (Finland), Valerie Sinason (UK), Remy Aquarone (UK), Brian Martindale (UK), Richard Brown (UK), Tim Reid (UK).

Conference website

**CAT, Past, Present and Future: The legacy of Tony Ryle (1927 – 2016)**  
10 March 2017, 9.30am – 6pm at Regents University London

The Association for Cognitive Analytic Therapy would like to invite you to a one day conference in memory of Tony Ryle, and to celebrate his great contribution of Cognitive Analytic Therapy.

Further details and registration
CBT Medics SIG BABCP Annual Conference
17 March 2017, 10am – 5pm, Devonshire Hall, Leeds

- Working with Medically Unexplained Symptoms, Professor Christopher Williams
- PTSD and its complexities, Dr Stuart Turner
- Adaptations of Cognitive Behavioural Therapy Required for Treating Anxiety in Patients with Chronic Obstructive Pulmonary Disease, Dr Jaime Wood.
- Doctors’ Health and Wellbeing and the role of Medical Psychotherapists, Dr Caroline Reed-O’Connor

Further details and registration

Association for Psychoanalytic Psychotherapy in the NHS
2017 Annual General Meeting and Phil Richardson Memorial Lecture

Meeting website

ISPS, International Congress in the UK
30 August 2017 – 3 September 2017, Liverpool, UK

Interested in Psychosis? Interested in real change for the better? The International Society for Psychological and Social Approaches to Psychosis 2017 conference in Liverpool, UK is for you, whatever your discipline and if you are a service use or carer. The ISPS conferences have an outstanding reputation for vibrancy, conviviality, breadth of presentations and social events.

Registration: We anticipate a full house, so why not make an early bird registration. Please go to www.isps2017uk.org to book and for more information.

Further details and registration

….More on the ISPS conference from Brian Martindale

Psychological Understanding, Therapies and Psychosis

One of the tragedies in the mental health field is the lack of understanding and attention to the psychological issues lying behind psychosis.

Though there have been and will be continuing huge advances in the neurosciences, it is only just beginning to dawn on our profession that the brain contains a ‘record’ of our personal and social experiences throughout life and more than that: the very structure of the brain and its
connections are fostered or impaired by positive and negative personal and social experiences. The environment can even turn on and turn off genetic expression. The manifestations of our minds express with various degrees of distortions traces of our past and present experiences and this is true for all of us.

If we cannot readily make sense of our patients, we tend to ‘classify’ them as psychotic. One colleague contacted me saying of her patient ‘she has had awful history and I can sense where her problems come from, she cannot therefore be psychotic, she needs psychotherapy’!

In the UK, it remains exceptional for psychosis teams to have persons trained in psychological approaches to psychosis for individuals and families but almost mandatory for patients to be recommended lifelong medication in spite of the serious side effects of many of these medications. It is rare indeed for a psychological formulation to be central in ordinary practice. A current patient of mine spent five years attending a clozaril clinic with no other input at all.

For decades now the ISPS, the International Society for Psychological and Social Approaches to Psychosis has been promoting the subject of this brief article. In 1997 the Royal College of Psychiatrists played a keep part in bringing the ISPS international conference to the UK for the first time and now 20 years later the ISPS international conference returns to the UK (August 30th- Sept 3rd) in Liverpool and the College is supporting the conference and will be represented.

As this article indicates the field of psychosis needs a radical re-think in its fundamental approaches and the ISPS Liverpool conference theme is indeed MAKING REAL CHANGE HAPPEN. We anticipate there will be upwards of 600 participants and we hope to see many psychiatrists. www.isps.org for more details.

Brian Martindale

Faculty of Medical Psychotherapy CPD Event
Following on from the successful CPD event on 3rd November 2016 the Medical Psychotherapy Faculty is pleased to announce there will be another day of talks and discussion about psychoanalytic ideas and their application to psychiatry at the Royal College of Psychiatrists in London. The date is Thursday 2nd November 2017 and further details will be circulated by the College nearer the date.
Your contributions to this Newsletter are welcome!

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

We look forward to hearing from you.

Maria and Harriet

Contacts...

Contact the Faculty, editors and any of the contributors c/o Stella Galea: Faculty Committee Manager
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