# Faculty of Medical Psychotherapy Newsletter

## Spring-summer 2021

FACULTY OF MEDICAL PSYCHOTHERAPY

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## Editor's Welcome

**Pamela Peters**
**Editor**

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The past year has been characterised by monumental changes to our way of life. As we adjust our focus, certain issues come into awareness at different levels – at the personal level, whether or not we have been able to work and changes to our habitual ways of working; interpersonally, restrictions on contact and separation from loved ones and others in our orbit; globally, the impact of the pandemic, climate change, racial and social justice, etc. These have long been bubbling away but are brought into relief by the crisis the world is going through.

In our faculty, we are looking both inward and outwards, seeking the meanings within to illuminate what is going on in the world, but also more than ever before, allowing the external to truly come into the analytic setting, to be looked at and acknowledged, and seeking to influence public conversations and thinking in a positive way.

These themes were beautifully explored in our recent Faculty conference, so ably put together by our Academic Secretary and Conference Committee, giving us plenty of food for thought. The picture above is that used for the Conference, whose significance became apparent in the social dreaming sessions which used a very similar representation, creating a sense of connectedness.

The Royal College of Psychiatrists is also calling for international cooperation and urgent action by declaring a climate and ecological emergency: https://www.rcpsych.ac.uk/members/your-monthly-enewsletter/members-update-13-may-2021/climate-crisis?utm_campaign=2166527_Copy%20of%20eNewsletter%20-%20update%20-%2013%20May%202021&utm_medium=email&utm_source=RCPsych%20Digital%20Team&dm_i=3S89,1AFPB,7BQMVV,4NNIE,1

I have great pleasure in taking on the editorship of the newsletter from Alison Jenaway. My thanks to Alison and to those that went before for their wisdom and advice as well as a guiding template. I feel proud of our active and thoughtful trainee cohort from whom we have many submissions. I would like to encourage you all to send in your contributions for the Autumn/ winter edition by the end of September.

## Message from the Chair of the Faculty of Medical Psychotherapy

**Steve Pearce**
**Chair, Faculty of Medical Psychotherapy**
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Greetings as we enter the second year of the pandemic. Our working lives remain profoundly changed, as do those of our patients. Here in the UK we look forward to a gradual easing of restrictions, and many are contemplating returning to face-to-face therapeutic work. It will be a relief to sit in the same room as our patients again, and to feel the connection which has been stretched to the limit during the lockdowns. Many of us have lost loved ones, as have our patients. Stress has been on the rise, through unsuitable working conditions, illness (including for some the after-effects of Covid infection), poor IT infrastructure, and having to home-school children.

What happens next is unclear. The number of meetings has ballooned, on the back of the ease with which people who would otherwise have to travel long distances have been able to be called together – not always to good effect. No doubt we will do less travelling, more remote consultations, perhaps also remote therapy. We have to hope that the volume of meetings returns to something more like before. Many will no doubt spend some of their working week at home from now on.

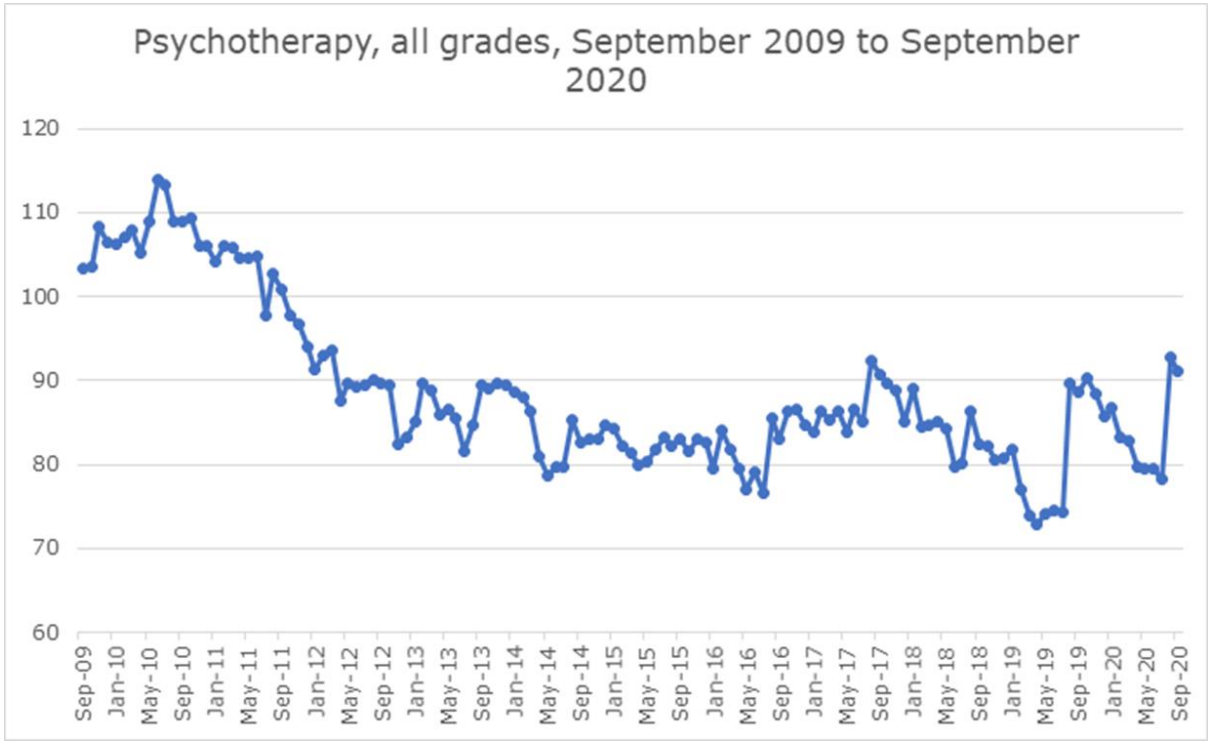
Will these changes be positive? The decrease in carbon emissions over the last year has been extremely modest, whereas the (negative) impact on people's work satisfaction and mental health has been considerable. Online therapy has proved possible, but often problematic, and not always as effective as face to face. Digital poverty has been a problem for many of our patients. Commentators are already writing about two tiers of workers, those given space in an office, and those expected to get by at home. Patients with social anxiety and agoraphobic symptoms have sometimes welcomed the changes wrought by the pandemic but returning to previous habits of social contact may prove difficult, and leave relationships impoverished.

We have an opportunity as our lives return to normal. It may be possible to use our newly acquired technology to make the lives of our patients and our colleagues better, but we

should maintain a keen awareness of the difference between what is necessary, what is useful, and what is neither.

Finally, many of you will know that there has been a gradual decline in the numbers of medical psychotherapy posts. Dr Adrian James, the College President, provided a stark illustration of this for the Executive Committee's recent strategy day, reproduced below. From an initial low base, and one concentrated in London, where nearly half of posts are located, the decline is likely to be partly due to vacant posts, which are then sometimes defunded; we are aware that many consultant posts outside London, for example, struggle to recruit, and can remain vacant for long periods. Medical psychotherapy has a profound impact on psychiatric training where it is available, but the problems of geographical inequality are difficult to address, as they reflect a similar situation in psychiatric training posts generally, which are disproportionately concentrated in the capital.

Medical psychotherapists can also have a profound impact on the provision of services, where expert psychotherapists who also have high level expertise in diagnosis, risk management, and medical treatment, are particularly suited to lead some of the new services in the fields of personality disorder, functional disorders/medically unexplained symptoms, and complex comorbidity. As IAPT moves into providing treatment for people with severe mental illness, including psychosis, bipolar disorder, and personality disorder, it will also increasingly need the combination of psychiatric and psychotherapeutic expertise offered by medical psychotherapists. Our training programmes should reflect the shift from low throughput outpatient psychotherapy services to these more specialised, and sometimes more demanding, roles.



## Message from the Academic Secretary

**Maria Eyres**
**Academic Secretary**

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I am writing on the weekend following our annual Faculty Conference which took place on the 21-23rd of April and attracted 250 delegates. It was our first virtual Conference, and I am very grateful to all our speakers, to our technical team for running it flawlessly, to the Conference Committee for working on it with me and to all our delegates for making it come alive. The informal feedback from the delegates, as well as from the speakers, has been wonderful and we have been bowled over by their comments.

It followed our "lost" 2020 Oxford Conference which was cancelled because of the COVID-19 pandemic.

The Conference was entitled *Survival and Development; Exploring our Internal and External Landscapes*, and it focused on the pandemic, issues of race and social justice and climate change.

I hope that those of you who attended enjoyed it. I will write my reflections on it in the next edition of the Newsletter once I have some time and space to reflect on it more fully.

I would also like to remind you that the group for consultants and higher trainees in medical psychotherapy will continue for another year when it will be reviewed. The group meets on the last Thursday of the month and the next session will be on the 27th of May at 5.30-7pm. If you would like to join, please see details under announcements in the last section.

Unfortunately, we had to say goodbye to Stella Gallea at the end of April who held this position for many years and who many of you know. Her unassuming, extremely knowledgeable and helpful presence has been a real anchor for us all in the Faculty. I was very sad to see her go and will miss her tremendously. She often knew what I didn't know I needed to know, and her supportive stance was next to none. I wish her a happy and fulfilled retirement and I am sure you will join me in this farewell.

We also launched the Medical Student Psychotherapy Essay Prize, the title of the essay for the 2021-22 is:

"Tell us about a patient you have seen, showing how your reflections on psychological issues deepened your understanding of the case and contributed to your personal learning."

The winner will be announced at the next year's Conference and the prize includes £250 and a free pass to the Faculty of Medical Psychotherapy Conference 2022.

More information about the Prize is be available on our website https://www.rcpsych.ac.uk/members/your-faculties/medical-psychotherapy/prizes-and-bursaries?dm_t=0,0,0,0,0

I would also like to report that the work on the College Position Statement on Historical Childhood Abuse co-chaired by Jo Stubley and myself is moving forward. We have one more meeting of the Expert Reference Group left and are hoping that the position will be announced in the summer, so please watch out for it.

Finally, please put 12th November into your diaries for our next Psychodynamic Psychiatry day organised by Jo O'Reilly and Rachel Gibbons, and, we are all looking forward to the publication of the College Seminars in the Psychotherapies edited by Jo and Rachel later in the year.

# Climate change: A painful truth

**Dasal Abayaratne ST6**

**Dual trainee Medical Psychotherapy and General Adult Psychiatry**

**RCPsych Green Scholar**

Reading Kate Dufton's excellent piece in the Autumn newsletter stirred up some uneasy feelings in me and got me thinking. Namely about the painful realities of the man-made climate and ecological emergency (CEE). This might also stir up uncomfortable feelings in you. Hopefully, this despair can be repurposed into productive action.

**Climate change and mental health**

Anthropogenic climate change is real (IPCC, 2013). 2020 was a record year for storms, hurricanes, and forest fires (World Meteorological Organisation, 2021). One million plant and animal species are threatened with imminent extinction (IPBES, 2019). There are minimum forecasts of 250,000 excess deaths annually which are attributable to climate change (Watts et al 2015). Untold scores of people have already suffered and died as a result. We are increasingly understanding the mental health effects of climate change. This includes direct effects, such as the trauma of extreme weather events in the shape of flooding and forest fires and indirect impacts of vicarious trauma, chronic stress, migration, and societal changes (Maughan, Berry & Davison, 2014). We work with the mental health consequences of the CEE, but we are also the cause, not only as individuals, but in the very healthcare systems we work in. The NHS is responsible for 5.4% of UK emissions, equivalent to 11 coal-fired power stations or the entire UK aviation industry (Committee on Climate Change, 2019). This mostly stems from our clinical work, be it prescribing or patient travel to long-term intensive therapy. We ourselves are very much part of the problem.

**Why us?**

I struggled with this thought, even as I became increasingly aware of the links between climate change and mental health. I made some changes in my personal life. I recycled and used public transport more. Enough to assuage some discomfort and guilt, but these changes were small, and I made no changes to my working life, which would far outweigh any personal changes that I made.

Why did I, and many others, not do more given what we know about the CEE? This is where we can leverage our understanding as medical psychotherapists. The CEE is painful. It is normal to feel hopeless and helpless in the face of the facts. Nobody wants to think that their own actions may be contributing to a global catastrophe. We choose to shut this thought out. From a cognitive behavioural perspective, we may understand this process as cognitive dissonance, or in terms of thinking errors. From a psychoanalytic view, we find ourselves using our defence of denial in the face of shared trauma.

Medical psychotherapists however are trained to support those who have been impacted by trauma. We support people to contact difficult feelings and engage with their distress. I argue that we, as a profession, need to work through this ourselves and support others to do the

same, including our patients, colleagues, and institutions. We might then be able to harness these strong emotions for good, to generate hope.

Whilst we may feel helpless individually, together we can make real change. Collectively, our profession has played a role in recognising and combatting many contemporary issues, most notably the college's recent work on recognising structural racism. NHS England has recently committed for a net carbon zero NHS by 2040 (NHS England, 2020) because of collective campaigning. Whilst these commitments and resources are a great step forward, the changes required to meet them has barely begun. It will require commitment, spending and innovation; something many of our trusts, teams and colleagues may understandably feel nervous about. This is again where we can use our skills to help others commit to the action needed to combat climate change. We are experts in not only managing distress, but also working with ambivalence, resistance and shaping behaviour change.

The College's sustainability committee has published a set of sustainability principles that will guide decision making. These include empowerment of individuals and communities, reducing waste and considering carbon in our decision making and service pathways. Covid-19 has led to us reviewing our processes and making widespread changes in the way we work, for better and worse. Many of us have now switched to remote working and therapy, something that inadvertently has reduced the carbon footprint and social costs associated with our day-to-day and will likely be part of our work in the future. Change, however difficult, is possible in the NHS. A powerful College position statement on the CEE will be released by the time this newsletter is published, clarifying our role in this area.

**A Call to Action**

Despite the painful realities of climate change, I feel cautiously optimistic for the future; one in which we can work both as individuals and collectively to combat the causes and consequences of climate change. We, as medical psychotherapists have a role in this as practitioners, and insight to offer into enabling change. We should embrace this opportunity to provide leadership within our teams, trusts and profession.

If you are interested in this area, get in touch with the College's sustainability committee, use its excellent resources and consider integrating sustainability into your work. Other useful resources can be found at the Centre for Sustainable Healthcare and campaign groups such as PsychDeclares. Review your team's processes and pathways to see where concrete sustainable changes can be made, using remote assessments or integrating nature-based approaches for example. Reach out to those around you in your teams and networks and join with those who share similar values and engage those who may feel threatened. There is a growing base of supporters and organisations to learn from and share with. Push for recognition of the CEE and commitment to the steps needed to address it. Several mental health trusts have now declared a climate emergency and are taking steps to tackle it, thanks to the work of professionals pressing for change. Importantly, the window for action has not yet closed.

**References**

IPCC. (2013). *Climate Change 2013: The Physical Science Basis. Contribution of Working Group I to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change*. Cambridge, UK: Cambridge University Press.

Committee on Climate Change (2019). *Reducing emissions. 2019 progress report to parliament.* Retrieved from: https://www.theccc.org.uk/publication/reducing-uk-emissions-2019-progress-report-to-parliament/#supporting-charts-and-data

IPBES (2019): Global assessment report on biodiversity and ecosystem services of the Intergovernmental Science-Policy Platform on Biodiversity and Ecosystem Services. Bonn: IPBES secretariat.

Maughan, D., Berry, H., & Davison, P. (2014). What psychiatrists should know about environmental sustainability and what they should be doing about it. *International Psychiatry*, *11*(2), 27-30.

NHS England. (2020). *Delivering a Net Zero National Health Service*. London: NHS England & NHS Improvement.

Watts, N., Adger, W. N., Agnolucci, P., Blackstock, J., Byass, P., Cai, W., ... & Cox, P. M. (2015). Health and climate change: policy responses to protect public health. *The Lancet*, *386*(10006), 1861-1914.

World Meteorological Organisation. (2021). State of the Global Climate 2020. Retrieved from https://storymaps.arcgis.com/stories/6942683c7ed54e51b433bbc0c50fbdea

# Brief report on the Balint group and the clinician-patient relationship

**Dr Ally Chuan Xiang MRCPsych**

***Speciality registrar in Medical Psychotherapy and General adult psychiatry, West London NHS Trust, London, UK***

Throughout medical school and junior doctor trainings, the "doctor-patient relationship" concept is emphasized as central to being a good doctor. I thought I knew what it meant. I took it to mean that I treat the patient. The relationship is one-way. I am the doctor, the epitome of health and knowledge. The patient, the one who suffers, is the one who needs to be helped and treated. Simple. I realise now how naive I have been. Maybe my ears were not open to the real lessons I should have been listening to, and learning from, my teachers and my patients. I think my eyes, ears, mind, and heart are opening now.

I am learning exponentially during my higher psychiatry training. From the basic psychoanalytic concepts and exposure to the thinking and supervision of senior doctors and psychotherapists, to my personal therapy and the detailed and intimate clinical work I am learning and providing to patients, I am starting to approach my clinical and personal thinking differently to how I saw life and people in the past. Every person and story has a past, and the formative early years of a person with their primary caregiver(s) shapes many later patterns of behaviour and emotions unconsciously as well as consciously.

I think a real turning point in my emotional development was becoming a parent overnight. This was (excuse the birth analogy) like coming out of a tunnel and not knowing what the other side of life would be like with a new-born. The early years of my child's life taught me so much as a person, for example, that I am responsible for a new life and that I am attempting to hold, provide and contain an infant and my own emotions simultaneously and continuously. Having my own baby taught me so many new things that a textbook could not have, and my child continues to do that even after I returned to work. I cannot help seeing the parallels between the parent-infant relationship and the closeness that patients (and indeed many adult humans), particularly ones who have been traumatised and neglected, wish to have and return to, that is a safe and caring primary caregiver who is believed to be able to take any emotional pain away temporarily or permanently.

When I returned to work, I found myself more emotionally affected by the patients I saw. I was astounded by how open I was to the patient's distress. I started to try to figure out my countertransference and what it could mean about my patient and the unconscious information my patient was trying to let me know about how they felt. My own Balint group helped me immensely in digesting my experiences and making sense of them. The Balint

group was the watering hole to refresh oneself before going back into the desert of clinical work. It is a tremendous support for clinicians. Participating in the Balint group, I became to realise that we as doctors are not immune to difficult emotions and the harshness of life, and that we may similarly be intensely affected by the patient's history and behaviour.

There is a real recruitment and retention crisis in psychiatry training at the moment (maybe in the whole of mental health as well). I wonder if the emotional and psychological impact of our work with difficult patients plays a major factor in doctors leaving the profession. The emotional work is tough, relentless, and not immediately rewarding (these traits have a slight similarity to being with a new-born infant too).

I want to say that my perception of "the doctor-patient relationship" changed in a thunderbolt moment for me. This occurred in one Balint group for higher psychiatric trainees. The structure of the group, which follows the traditional Balint method, allows the presenter to present whatever has disturbed them about the patient or had "got under their skin". The presenter then sits back as the group starts to explore their own feelings and thoughts about what has been said and to help make sense of the patient and the doctor's response with the encouragement and facilitation of the leader. Listening to my peers and facilitator, I form my thoughts and figure out my feelings and we piece together meanings behind the account provided.

I could give an example. I presented a male with delusional thoughts who I had seen as part of a Section 136 assessment (this is the police power for detaining a person under the Mental Health Act temporarily for his or her safety and mental health) whilst on-call overnight. I had given a detailed account to the group of how my on-call started with the call about the patient, through to my assessment of the patient in person and then the after-effects in me. I had felt very open to the patient's experiences and I had felt vulnerable physically and emotionally when I saw the patient in the Section 136 suite. To the Balint group, I had regurgitated the facts of the night and my feelings without thinking about what exactly I was feeling underneath.

Consciously, I knew I was anxious about seeing the patient (having listened to parts of the history given by the core trainee doctor and how the team had experienced the patient already). I knew I was tired from the start of the on-call having worked a usual day already. What didn't register with me at the time was that I was feeling afraid of the patient, particularly as I was continuing to keep that patient on the Section which he did not wish to be on. This fear manifested more acutely for me as my taxi was involved in a minor traffic accident on my way home. My disturbed feelings stayed with me long after I had returned home and went to work the next day. I felt I really had had a near-miss with the car accident.

My recount to the Balint group of the night's event felt disjointed and anxious and I couldn't piece together why. The group and facilitator helped me see how much the whole on-call experience linked with my anxiety in seeing the patient and the on-going reverberations following the encounter, which left me shaken and fragmented. This seemed in parallel with the patient's experience of his own fragmented mind, as well as being taken against his will to the Suite. He, no doubt, had felt afraid for his physical and emotional safety too. This was

the patient directly impacting on the doctor, a communication through the impact of the patient's words, thoughts, feelings, and behaviour (Casement, 1985). I had experienced similar emotions to what the patient had felt. I just did not realise that at the time when I had seen the patient. My Balint group helped me reflect on this and make sense of my undigested thoughts and feelings.

This discussion and many others that followed in subsequent Balint groups, led me to realise that my relationship with patients was not one-way. I was not just treating the patient, without any effect on myself. In order to be an effective and empathic doctor, I had to be affected too, or allow myself to acknowledge the more difficult emotions that rose in me from seeing a patient. I now realise that throughout my early medical career, I have been affected by patients. I just did not consciously acknowledge that to myself. I had seen a patient, applied the treatment rules and moved on to the next patient. This effect psychologically on a doctor can accumulate over time, this may explain professional burnout in emotionally exhausted doctors.

I am starting to bring into words and thoughts the unconscious feelings I have had. I am now trying to understand more about the feelings I feel, they may be my own, derived from my own stories, or they may be the patient's feelings, that is, perhaps the patient is making me, or others feel how he or she feels by unconscious communications. This is an added tool to my doctor's treatment bag; one I had all along and did not realise. I am not just a doctor using an external objective manual to treat my patients. I have an internal subjective feeling manual. I am with the patient, I am registering my feelings and I am trying to work out which feelings belong to me and which to my patient, and I am trying to metabolise these feelings the best I can unconsciously and consciously in the moment (and afterwards in supervisions and in my own life) with the eventual aim of speaking and being as helpful as I can to the patient.

I am trying to model to the patient an understanding and caring figure (most of the time if I am not too defensive). This is the true doctor-patient relationship, this is the true therapeutic nature of the relationship and it has stood the test of time and advances in medical treatments. It is about me and another person in a room. It is about trying my best to understand the other person. By understanding my own emotions, I aim to help the other person to understand him- or herself better too.

**Acknowledgments:**
I wish to thank the Balint groups I have been part of and the facilitators of these groups in enabling me to metabolise challenging and emotional aspects of my psychiatry work.

**Reference:**

Casement P (1985). Forms of interactive communication. In: *On Learning from the Patient*. Tavistock Publications Ltd

## TRAINEE VOICES: MEDICAL PSYCHOTHERAPY TRAINEES SECTION

**Edited by:**

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# Freedom

***Dr Alasdair Forrest, ST8 in Forensic Psychiatry & Medical Psychotherapy***
***The State Hospital, Carstairs, and the Royal Cornhill Hospital, Aberdeen***

The theme of the contributions to the Trainee Voices section this time is, I think, freedom, and the paradoxes it throws up. The last year has put us very much in touch with the complexity of what freedom is and isn't. No one tied to a ventilator is very free. In curtailing your freedom—our freedom—do you increase the freedom of others? Do you increase your freedom in the long term?

As psychotherapists, we probably think that our patients can be gripped by ways of being and relating that hamper their freedom. The repetition compulsion is about just this. Sidra Chaudhry looks at some of these psychological defences in herself as way of illustrating this. We, and our patients, can restrict our emotional experience in a way that helps us get through something—or badly gets in our way. Do we lock some freedom of emotional expression away in order better to serve our ability to act as freely as we would wish? Dasha Chemo, an Art Therapist, looks at an extreme version of this: times when a part of us can be so completely in lockdown that relatedness of any kind seems like a bold proposition. How do we, as psychotherapists, engage with patients in that kind of situation? Kai Scott-Bridge, a medical student, provides a poem that is about just this, and about the times when relational difficulties take on a very overt, bodily form.

And do we use concepts to defend ourselves? If so, what is so wrong with that? Do we increase our freedom to act by locking away too much ambiguity? I think we do, but what are the downsides of this? AJ Howe looks at this with the analytical psychology approaches in Schizophrenia. Are we free to think about the paradigmatic psychiatric condition in a different way—one more structured on conflict than on deficit?

Our clinical work teaches us something that our personal lives now show us. A lockdown is hard, it is grinding, it is painful. But it is not anxiety-provoking. It certainly does not involve

trust or negotiating new or old freedoms. Change is anxiety-provoking, but if we are of any use it has to be our stock-in-trade.

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## Jung and the Psychological Treatment of Schizophrenia

***Dr A J Howe, Psychiatric trainee, South London***

As part of a larger work on analytical psychology and psychosis for my masters dissertation, I have spent time reading around Jung's theories and psychotherapeutic treatment of Schizophrenia. Jung is one of the unsung contributors to our modern understanding of the condition. In the short report below I present a brief outline of his theories and, perhaps of more interest to readers of this newsletter, his suggested psychological and psychotherapeutic interventions[1].

Carl Jung's Analytical psychology is particularly well placed to discuss the psychodynamics of schizophrenia, even if it is not a common part of psychotherapeutic practice today. This is due to Jung's experience with psychotic patients at the start of his career as a psychiatrist. He came to work at the Burghölzli psychiatric hospital in Zurich under Eugene Bleuler in 1900. While Jung was working under Bleuler he was able to write his key works on schizophrenia. This included Jung's first and largest written piece, *'The Psychology of Dementia Praecox*[2]*'* which was the culmination of three years experimentation and observation at the Burghölzli (Escamilla, 2016). Bleuler would later be the first to use the term Schizophrenia and, along with Kraepelin, is regarded as a key figure in the condition's history. Despite Jung's contribution to the subject, to which Bleuler often referred readers of his work, he is not viewed with the same esteem. For Jung, these early professional years would come to form the bedrock of analytical psychology after he broke away from Freud. Jung's unique concept of archetypes, for example, came from his observations of psychotic patients and the content of their hallucinations which demonstrated cultural knowledge they would not have otherwise learnt (Jung, 1976, para. 151).

Jung saw the presentation of dementia praecox as a manifestation of unconscious content that overwhelms the ego. He described the condition as one that 'pierces holes in the ceiling of consciousness' allowing us to see unconscious processes at work (Jung, 1960, § 256). In contrast to our modern conception, he saw Schizophrenia as a normal process within the psyche that had a purpose for the individual (Ibid § 336). He saw parallels in psychotic content with dreams, going as far as describing psychosis as a waking dream (Ibid § 298). He saw meaning to symptoms and delusions, both on a personal and archetypal level (ibid § 333,347,449,544). This meaning could then be interpreted for the benefit of the patient in

[1] For those who want to delve into the subject I would recommend Jung's Collected Works Volume 3. Paragraphs, which should be the same in any edition, are given within references of this work.

[2] Dementia Praecox is a roughly equivocal condition to Schizophrenia. It was conceived by Emil Kraepelin but the term was superseded by Bleuler's Schizophrenia in 1908. This was due to the lack of dementia and/or precocious presentations in many patients that otherwise satisfied criteria for the condition.

the same way as any other unconscious content. Jung considered the organic and non-organic causes for the condition, within the confines of the biological understanding of the time. He settled on Schizophrenia being a psychological condition in the first instance, which impacted on his ideas on treatment (Ibid § 570). Given the nature of this newsletter, we will now focus on these psychological treatments, which included psychotherapeutic interventions. Jung was one of the first to suggest that therapy was even possible with such individuals.

**Treatment**

Jung's ideas around treatment of psychosis stem from it having a psychological cause. This psychological predisposition allows Jung to have suggestions for interventions in psychosis from psychotherapy to ward design. Jung considers the environment, design and management of psychiatric hospitals to be a key part of successful treatment. He reminds us that if conditions would lead a 'normal' person to a mental disturbance, then why should this not be the same for those with dementia praecox. He suggests that the worse cases of the condition are to be found in badly managed and overcrowded asylums. It is therefore important to make wards as homelike as possible including, for example, flowers at curtained windows (Ibid § 472). Ward activities are also of paramount importance, with Jung suggesting that the chronic cases of catatonic patients have 'disappeared' because they have been given something to do (Ibid § 539).

Jung hypothesises that the prodrome of psychosis is due to internal conflict and that psychosis sets in when the patient feels there will be no solution to this and panics. From a treatment standpoint, intervening with some form of psychological treatment during the conflict stages, he suggests, can avert the resulting psychosis (Ibid § 480). When it comes to actual psychotherapy for psychosis however, Jung, given his experience, remains unoptimistic (Ibid § 482). He describes one case where it took him hours to 'break through' to the psychological cause of the patients' difficulties. He notes that this kind of time devotion is seldom available to the ward doctor (Ibid § 487-488). In this acute phase Jung sets narrow limits on what psychotherapy can achieve. He also cautions against the idea that there are specific methods to be used. It is instead 'the personal commitment, the serious purpose, the devotion, indeed the self-sacrifice, of those who give the treatment' that is important. The aim in this acute phase is to 're-establish psychic rapport' with patients and by this method effect improvement and, albeit rarely, a cure. He comments that one does not need to be medically or psychotherapeutically trained to do this, a nurse or layman fitting the above criteria can be just as successful. The only limiting factor is if 'one's own constitution holds out'. If this fails however Jung suggests that there is a danger of 'psychic infection' which can be presumed to mean the person giving treatment exhibiting symptoms of psychosis themselves. He states that he has seen three such cases of this happening (Ibid § 573). Jung also cautions about the loss of enthusiasm during psychotherapy because as mentioned, this is of paramount importance (Ibid § 539). Coming out of the acute phase, Jung advises discussing the patient's psychotic experience with them in detail, covering all that they can remember about the experience (Ibid § 575). It seems Jung's pessimism is restricted to cases that are severe enough to reach the psychiatric ward. He suggests that there are many patients that do not reach the asylum. These 'latent psychoses' are much more amenable to analysis and Jung felt overall positive about their treatment. In terms of method, he gives them 'as much psychology as they can stand',

although this is a vague statement. Even if it does not result in a cure, he suggests that an increased psychological understanding lessens the intensity of future relapses (Ibid § 539).

Jung did not disclose much about his therapeutic interventions that were specific to psychosis. However, he did give an example of talking to the voice or delusion which is most reasonable and engaging with this part of the patient in order to build rapport and effect treatment (§ 540,574). The therapist should also adapt their language to the patients, if they talk of angels and demons, so should the therapist (Ibid § 540). Jung perceived a danger that those who were in psychotherapy for psychosis may relapse or become acutely unwell. The therapist should be mindful of this deterioration and pay particular attention to any destructive dreams the patient brings to therapy. In these situations, drastic action is not always required, however the patients mind must be given distance from the comparatively stronger unconscious part. This can be done by painting or drawing their current situation. Jung suggests that painting is one of the most effective tools as the colours allow feelings to be better included within the picture (Ibid § 562).

This use of non-verbal forms of communication is another key aspect of analytical psychology. He was a proponent of non-verbal communication and creative expression in all areas of his psychotherapy. In *The Transcendent Function* (Jung, 1975, para. 180) he explains that the hands 'know how to solve a riddle' even if the mind does not. He notes that when his patients draw, paint, or model their dream and fantasy content with their hands, they are often able to work further with and eventually integrate the problem. In the same work, he comments that dance and movement can allow access to unconscious material. He suggests that the therapist record movements on paper in order that they not be forgotten. It is reasonable to assume that Jung would have used these methods in his treatment of psychosis in an attempt to understand unconscious content.

In this brief account Jung's depth psychology informed treatment of psychosis has been described. Post Jungian work on psychosis[3] has continued but compared to treatment of other conditions it has received relatively less attention. In the present day, psychodynamic therapies for psychosis are not a routine part of NHS care. This could be to the detriment of patients. Analytical psychology could offer unique insights into methods of treatment that could be used in a variety of clinical settings by various healthcare professionals. It is therefore a subject that warrants further study.

**References**

Escamilla, M., 2016. Bleuler, Jung, and the Creation of Schziphrenias, 1st ed. Daimon Verlag.

Jung, C.G., 1976. The Collected Works of C.G. Jung Volume 5. Princeton University Press.

Jung, C.G., 1975. The Collected Works of C.G. Jung Volume 8. Princeton University Press.

Jung, C.G., 1960. The Collected Works of C.G. Jung Volume 3. Princeton University Press.

[3] See works by John Weir Perry who wrote the largest body of post-Jungian work on psychosis.

## The Vault

***By Kai Scott-Bridge, University of Sheffield***

*(This is the opening extract from a collection of a 4th year medical student)*

*Fifty-six diazepam*

*Was not enough*

*To shorten your lifespan*

*By enough*

*You sit and stare, deadpan*

*Voice gruff*

*Foot slough picking, thinking new plans*

*But I see you sad, angry man*

*Not the drug seeker or hitman*

*I see the fear in your eyes as they scan*

*These visions of your own old man*

*But still you bite and steal,*

*Reject meal, smoke spice and deny your foot to heal,*

*Want to die, to stop living the lie*

*That you're okay, that says 'I can'*

*In this I am the middleman*

*Between you and your master plan*

*Who wants to deal in better than*

*What you want for yourself now*

*But me in my naivety*

*Of youth and incredulity*

*Had hopes that you'd not use and flee*

*Flung as wide as those ward doors*

*As you ran, and so began, the long career as a mind medicine man*

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## Monsters and Unicorns

***Dasha Chemo, Arts Therapist***

In this article, I describe the impact of trauma on children's development. As an art therapist working with children and young people with adverse childhood experiences, I have observed that many female children, when they feel threatened by internal or external sources, withdraw from creating a meaningful contact with their therapist and retreat into a 'world of unicorns'. As a point of reference, I use John Steiner's theory of 'a psychic retreat' (Steiner, 1993) which, I think, represents the 'world of unicorns'. Traumatised and deprived children often have undeveloped emotional intelligence and verbal communication. Therefore, art materials can be used by them as a means of communication. The images and objects created within the art therapy space are considered free associations through which the unconscious mind communicates. Children can freely use the art materials to visualise anything that comes to their minds.

To illustrate my theoretical speculations, I will use a short vignette from session X with a child patient I call Sasha. Her identity has been hidden as I do not have permission to identify the patient nor do I have permission to use examples of what happened between us in our sessions. Moreover, due to Sasha's complex situation, asking for permission might not be helpful.

Sasha is of primary school age. I have been seeing her for weekly individual art therapy sessions for more than a year. She was referred to me during her family's breakup. She had difficulties with learning and remembering new information. She had difficulties with sleeping and seemed to be in a permanent daydream. In the art therapy room, she would refuse to think or talk. She cut off my attempts at verbal contact by telling me, 'I don't want to talk', 'I don't know' or 'I forgot.' She had built an impenetrable wall around herself.

Her behaviour indicated an infantile or regressed state of mind; she would talk in a 'baby voice' and move in a bizarre way that was out of tune with her age. She worked awfully hard to be liked, which made me feel uncomfortable. She would always ask for permission even when she didn't need to. At the beginning, the negative transference emerged, and I thought that I didn't like this child, which made me feel very guilty. I often thought that her fear of being rejected or abandoned by me must feel overwhelming to her. Consciously, I kept reminding myself of her history, which was of profound early childhood deprivation, neglect, domestic violence, multiple separations, rejections and, finally, abandonment by her primary caretakers. She is separated from her parents and doesn't have any contact with them; they have repeatedly failed to re-establish contact with her.

From the very beginning, Sasha seemed obsessively interested in mixing different art materials and make what I thought of as 'scientific experiments.' It seemed that this activity was associated with her memory of her and her mum playing with various materials found at home. Her messy, slimy, sticky, poo-ish, and hardened substances were left for me to take care of. To begin with, I kept them in a different container in a safe place, but soon they started taking up a lot of space. Within a week, some of them would be covered with mould and spoil. She would continuously produce messy paintings. 'I think you are trying to figure out something,' I would repeatedly say to her. However, she met this with silence, and I felt deliberately ignored.

Sasha missed only a few sessions. Every week, she eagerly waited for me. On the way to the art therapy room, she would skip. It was obvious that she really liked her sessions. With this process, my transference too began to take a positive turn. Sasha began to think and talk about her painful reality; however, when I got too close to her, she would shut me out.

Almost one year into her treatment, during the coronavirus pandemic, in one of our sessions we began to think about Sasha's anger towards her biological mother. In her phantasy, she wanted to 'punch her.' When I told her that she might feel guilty, she responded with silence. My mind wandered towards the pandemic, and I said that, perhaps, she might be worrying about who will take care of her if something bad happens to me. Again, she did not respond. We sat in silence, and I watched how she was mixing different coloured modelling materials together. She began making an object that soon began to resemble an erect penis, on top of which she put eyes, a nose, and a wide-open mouth full of sharp teeth. When I asked what she was making (in my mind, I wondered if she was attempting to make something that resembled herself), Sasha said a 'monster' and repeated that the 'monster is very hungry.' This was followed by a long silence. I felt sadness. We continued to sit in silence for a while, when Sasha looked at me and said, 'When I feel upset, I think of unicorns.'

John Steiner describes 'psychic retreats' as a system of defences of pathological organisations of the personality that provides '*the patient with an area of relative peace and protection from strain when meaningful contact with the analyst is experienced as threatening'* (1993, p. 1). He suggests that when patients find themselves in a state of mind that makes it difficult for them to tolerate the anxieties and pain of either the 'paranoid-schizoid' or 'depressive position' (Klein 1946; Segal 1964), they employ complex defences by taking refuge in a third position, which he calls 'a borderline position'.

I think that Sasha felt threatened by the external reality of the deadly coronavirus pandemic and fears for our existence, which left her petrified and vulnerable. This external reality evoked her internalised anxieties, which were linked to her early childhood deprivation by her mother, which had left Sasha with 'a problematic relationship with her internal objects' (Steiner in Weiss, 2020). This prompted her consuming guilt to rise, visualised in a monster. Heinz Weiss in his book 'Trauma, Guilt and Reparation' postulates that 'the child feels responsible for the state of his objects and the damage done to them' (2020, p.1). I think that Sasha felt guilty and blamed herself for her mother's failures, but, at the same time, she began to recognise that her mother wasn't the mother she should be, and she was able to be angry with her. She spoke about an incident when her mother physically hurt her, which she described as abuse. She thought that she wasn't a good enough daughter and, therefore, her mum got rid of her. This was observable at the end of each of our art therapy sessions when she was cleaning the paintbrushes and the palette, desperately wanting to do a good job. Steiner points out the importance of the guilt that lies beneath the hatred, which can utilize a patient's capacity to love and to forgive (Weiss, 2020, p. ix).

I think that, in session X, Sasha experienced anxieties of the 'paranoid-schizoid' and 'depressive positions' simultaneously. The battle of the world with the deadly coronavirus raised in us fears for our survival. At the same time the fears of the destructive impulse raised in her, the damage she might cause to her objects, and the anger and guilt that accompanied the fear of the potential loss of the objects became too much for Sasha to bear. Sasha withdrew into an eternal and idealised anxiety-less world of unicorns. In this *'area of the mind the reality does not have to be faced, phantasy and omnipotence can exist unchecked and basically anything is permitted'* (Steiner, 1993, p. 3). However, this does not mean that being in 'psychic retreats' is painless. It can be experienced as a cruel and persecutory place, and the deadly nature of the situation is recognised by the patient. It can be very isolating but also gratifying in narcissistic, sadistic, and masochistic ways (Steiner, 1993, pp. 1–24). But, more often, as in Sasha's case, the retreat is idealised.

Steiner (1993) integrated Freud's ideas of the primitive destructiveness of the 'death instinct' and the Kleinian concepts of projective identification, object relations and mechanisms of 'paranoid-schizoid' and 'depressive position' to explain the pathological organisations that are employed alongside fantasised object relations. Freud, in some of his writings, implied the existence of the early ego, the early defence mechanisms, and the hallucinatory wish fulfilment, which can be understood as the ego's ability to form a phantasy object relation (Segal, 1986).

'In the paranoid-schizoid position anxieties of a primitive nature threaten the immature ego and lead to the mobilisation of primitive defences' (Steiner, 1993, p. 26). Klein

followed Freud's ideas of the 'death instinct' and 'life instinct' that rise from within. In our case, the destructive primitive anxieties seem to be too much to bear, and Sasha projects them onto the therapist, creating a hostile object relationship; hence, the negative transference. I think that Sasha's persecutory thoughts surrounded her fear of her hate towards the people involved in her care, and she worried that I would reject or abandon her because of her anger and hostility, just as her biological parents did. On the other hand, the rise of the 'life instinct' prompted the primitive sources of love, which are also projected onto me, creating a 'loving object relationship.' Thus, both love and hate are directed towards me simultaneously, which is characteristic of the 'depressive position'. '*The infant comes to recognise that the breast which frustrates him is the same as the one which gratifies him, and the result is ambivalence - that is both hatred and love for the same object'* (Steiner, 1993, p. 27). Sasha worried that something bad might happen to me, which threatened her own survival. At the same time, she feared that her feelings of hate damaged me which gave rise to guilt.

Steiner (1993) postulated that there are two stages of the depressive position. In the first stage, the patient identifies with the object and, through this identification, the loss of the object can be denied. I believe Sasha's identification with her chaotic mother is evident from her obsessive and repetitive scientific experiments, which represent her 'reparative wish' (Steiner, 1993). Through this, she can control, possess and preserve the 'archaic object' (Caper, 1995), thus Sasha and the object are one, not separated from each other. If her "'good' and 'bad' archaic mother" (Caper, 1995) is preserved and kept alive, Sasha will also feel alive. Identification with the object means that if the object dies, Sasha will die with it and vice versa. If Sasha is to survive, the loss of the object must be denied.

In almost every session, Sasha uses different materials to produce a new substance that she leaves with me for safekeeping. However, they have got spoiled by mould and need to be thrown out. Sasha is recreating a 'good' mother who was once playful and creative. However, she turns 'bad' the moment her substances are spoiled and ruined. At the same time, the new process of identification with her therapist who is her new object is set in motion. Sasha slowly identifies with her therapist who represents a new 'good' and 'bad' object. On the one hand, I feel I am reliable and consistent in providing food for growth but, at the same time, I believe I am cruel for setting limits, for being caring, making her aware of her own mother's failings. Sasha's upbringing in the therapy is a very painful experience. The realisation that she could have different experiences when growing make her angry against the objects (both archaic and new) as well as guilty for wishing to harm the objects. The confrontation of the loss from within is associated with death and, to deny the fear of the loss of the object, she retreats. I feel my interpretation of her feelings of guilt was premature and threatened Sasha. As a result, I have now become a murderous therapist from whom she must hide. Her fear for my own existence can be seen when she is trying to help me out by suggesting I withdraw.

The following weeks the nation was forced into the collective retreat of self-isolation. Our art therapy changed to weekly phone therapy sessions. Since we could not see each other, I would ask Sasha to describe what she was drawing or making. This was not an easy process for her, and she would need a lot of prompting. I would use my imagination to visualise what she described but felt blind. During this time, Sasha regressed into the 'paranoid schizoid

position' again. Any attempts to think were cut off by her saying, 'I don't know' or 'I forgot'. She would cut me off similarly as at the beginning of the therapy. The development seemed limited. I felt she was not only stuck at home but also in her mind. In every session, she would draw a unicorn; however, the idealised world of the unicorn became more elaborate. When Sasha told me that the unicorn is very hungry and is 'eating a lot of doughnuts', I thought 'Oh no, that's not good.' I said, 'Perhaps it is less painful to think about unicorns than about real life', to which Sasha answered 'yes'. When I said 'it is okay to be sad', she said, 'I know'. During this time, I felt I was extremely cruel for maintaining a weekly therapeutic contact with her, feeling that her mother did not show any interest or worry for her. I felt that in each session, I was pointing out the cruelty of her mother. In the countertransference, the therapist can be seduced into an ambivalent alternative world of unconscious phantasy (Steiner, 1993, p. x). In my sleep, I had recurring dreams where I stand at the edge of very beautiful places with astonishing architecture carved into mountains and beautiful and peaceful gardens, which seem to be bottomless, but fear that I may fall in and will not be able to find my way out. This may correspond with the awfully painful reality, which, in the very eerie atmosphere that has descended upon us with the shift of time, feels very unreal.

Steiner suggested that confrontation to control the internalised object is crucial. This involves working through her denial of the painful reality that her mother cut off contact with her and does not show interest in her while the therapist is a separate and independent object. To achieve this separation between self and object, the process of mourning for 'the loss of the object' is necessary which can be achieved through reality testing when, over time, 'all libido shall be withdrawn from its attachments to that object' (Freud 1917:245) (Steiner, 1993, p. 35). This leads to differentiating self from object. Projective identification can be reversed, and parts of the self previously ascribed to the object can be returned to the ego. *'In unconscious phantasy, this means that the individual has to face his inability to protect the object. His psychic reality includes the realisation of the internal disaster created by his sadism and the awareness that his love and reparative wishes are insufficient to preserve his object, which must be allowed to die with the consequent desolation, despair and guilt'* (Steiner, 1993, p. 34).

However, as Sasha's mother is very much alive in the outside world, this process of separation is more complicated. At this moment, I think that we are in the first phase of the 'depressive position', where Sasha fears for the loss of her objects; this can be an overwhelming experience, from which she defends herself by retreating. However, when she is able to endure the pain and maintain contact with her therapist, thinking about her anger and confronting her own guilt is critical in reparation of her internal objects, which will allow her to grow.

References

Caper, R., 1995. On The Difficulty Of Making A Mutative Interpretation. *International Journal of Psycho-Analysis,* Volume 76, pp. 91-110.

Klein, M., 1997. *The Psycho-Analysis of Children.* 3th ed. London: Vintage.

Segal, H., 1989. The Depressive Position. In: *Klein.* London: Routledge and The Institute of Psycho-Analysis, Karnac Books, pp. 78-90.

Steiner, J., 1993. *Psychic Retreats, Pathological Organizations in Psychotic, Neurotic and Borderline Patients.* 1st ed. Sussex, New York: Routledge.

Weiss, H., 2020. *Trauma, Guilt and Reparation.* 1st ed. Oxon, New York: Routledge.

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## Working during COVID-19: Defence Mechanisms at Play

***Dr Sidra Chaudhry (ST4, South Yorkshire)***

England went into lockdown on 16th March 2020. At the time I was a CT3, preparing full steam ahead to attend my Membership Ceremony at the Royal College of Psychiatrists in London and soon after would be appearing for my ST4 interviews. The news of the lockdown rained on plans I had to celebrate my membership with my family, who would be visiting us from abroad. It also led the ST4 recruitment to temporarily come to a halt. With a Tier 2 Visa expiring in 5 months' time and the entire nation in lockdown, I must admit things did not look very positive.

I first went into a state of **denial**. "This could not be happening. How could the world come to a standstill? This little virus couldn't be that deadly? Well, this won't happen to me." Then I tried to **laugh** it off, "oh well, at least I will get to work from home! I won't need to drive! I spent around 5 months working from home, running clinics from my dining room, and only attending the hospital for my on-calls. I found myself unable to compartmentalise my day. I was washing dishes between my clinic appointments, folding laundry during team meetings with my camera turned off, and by the end I was running two shows in parallel to each other leaving me absolutely knackered by the end of the day. I did not see the "point" of taking annual leave at a time when I could not do anything but took it to prevent myself from burning out. I realized how tired I was only when I got time to process and reflect on the relentless "showing up" albeit virtually. I was trying all I could to keep stress at bay – from trying new recipes, to painting in my garden and going for walks. I was a CT3 in a community post and soon this would change.

In August, I started as a ST4 on an inpatient ward. A new role, a new workplace, and the challenges of working in the middle of the pandemic on an inpatient ward where patients were often too unwell to engage in the safety protocols of sanitizing their hands, social distancing and wearing masks. As the warm summer months crawled into autumn and winter, there was a tangible dip in morale everywhere. A dip in morale does not necessarily present itself with someone acknowledging openly how rubbish they feel, it is in the subtle signs – feeling tired, unmotivated, compassion fatigue, irritability, and lack of enjoyment for example. And it's different for every individual. Some of us are better at keeping a lid on things while some are open books, with every emotion on their sleeve. The first defence mechanism that came to me naturally was **repression**. It was very difficult to counter imposter syndrome, which I suffered with greatly when I started as a new registrar. But I continued to show up

and function to the best of my abilities despite the constant self-critical thoughts I experienced, which I tried to push far back into my mind. This alternated with **rationalisation,** where I was able to hold an internal dialogue with myself to validate my feelings and tell myself that I was still a trainee and that it was okay not to know everything. I was learning and learning never really ends. However, the feelings of anxiety and self-doubt stayed, but I was adamant I would leave no stone unturned to counter them.

Hence came **sublimation**, which started with trying new recipes in the kitchen (No, not banana bread!). Eventually I joined the gym and spent an hour regularly with a personal trainer to burn off the stress. However, this was short-lived because the lockdown came into effect again and everything shut down. The sublimation continued as I started seeking non-clinical opportunities to build and develop my portfolio instead. The constant thought of being "inadequate" pushed me to venture out of my comfort zone and pursue leadership and management roles, which I would have shied away from previously.

Along the way, there were several occasions where I did experience symptoms of burn out, however using **intellectualisation**, I tried to remove all emotion and focused on "powering through". I reached out to my colleagues and realized we were all in this together. I wasn't alone in feeling the way I felt at all. We are not invincible. We are vulnerable too. As doctors, we must admit that we can be quite bad at looking after ourselves. Therefore, it is essential that we can take a step back to reflect on our day's work to see how it is impacting us. It is also very important to be aware of the avenues of support available should we need to seek further help.

The pandemic has changed us all in very different ways. I did not realise the impact it would have on me, but a year on, I can see how it has directly and indirectly affected me in subtle and not so subtle ways. On a positive note, it has brought us together and taught us how similar most of us are on a human level and that labels of race, gender, ethnicity, religion, and culture are very porous when it comes to universal emotions of fear, anger, disappointment and even happiness. This year has changed my perspective on a professional and personal level. My personal journey as an international medical graduate of BAME background working in the midst of a global pandemic has motivated me to share my experiences with others through my work and make whatever contributions I can to make the training experience safe and fulfilling for everyone.

I would also like to take the opportunity to thank everyone working relentlessly in mental health services for their contributions during this very difficult time to keep services running and being there for our patients and their families. Although the clapping has stopped, your efforts won't be forgotten for times to come.

## ZOONIA NAZIR PSYCHOTHERAPY PRIZE

The Zoonia Nazir Memorial Prize was established in 2019 in memory of Dr Zoonia Nazir and ran for the first-time last summer. A Consultant Psychiatrist in Medical Psychotherapy in the Birmingham and Solihull Mental Health Foundation Trust (BSMHFT), Dr Nazir worked as Psychotherapy Tutor for many years before her sudden and untimely passing and was known for her commitment to training and psychotherapy. The aim of this new prize, funded by Caring Minds, was to stimulate interest in psychotherapy amongst psychiatric trainees.

Trainees of all grades working within BSMHFT were invited to submit entries relating to any form of psychotherapy including clinical, theoretical, applied, audit, quality improvement or research topics. This essay is the winning entry.

# Reflections on recovery in transitional spaces

*Applying the concepts of DW Winnicott to a complex care unit.*

***Dr Ravinder Kaur Hayer***

Does anyone on this unit *actually* get better? This was my initial thought as I walked down the ward corridors on my first day, trying to keep up with the manager as she enthusiastically orientated me to my base for the next 12 months. I was to work on an older adult in-patient unit, but unlike others I had experienced, this was one dedicated to those service users with complex care needs. This was a ward for service users who often had a combination of functional and organic disorders, further complicated by significant behaviours which challenged those around them. Here they could stay, often for longer than would be possible on an acute ward, whilst we tried to stabilise their mental health and identify suitable placements for them within the community.

In the months that followed, service users' progress was slow and discharges infrequent. I found myself quickly having to manage my own expectations of what 'recovery' here would look like. In between reviewing rashes and prescribing for constipation, there were admittedly times a therapeutic nihilism crept in which I was acutely aware of. This said, when a discharge was achieved, the immense feeling of reward was undeniable. Indeed, it was celebrated by the entire MDT who had invested so much of themselves in the process.

The start of the Covid-19 pandemic brought with it the sudden and unexpected closure of the ward. Upon hearing the news, I found myself left processing quite an unexpected emotion – not one of relief to be excused from the role of ward doctor to sit again within the familiar

confines of the CMHT, but one of real sadness. In fact I must concede, that during a moment of still amidst the chaos of clearing the ward, I found myself wiping away quiet tears before admonishing myself and getting back to whatever task was needed to be done at the time. I vividly recall being particularly affected by the fearful expressions of some of the service users as they were gently coaxed off the ward by the nursing staff; staff that had cared for them, in some instances, for years. Some clearly vocalised that they did not want to leave, whilst others who perhaps weren't able to communicate verbally demonstrated their distress in the other ways we had become accustomed to. Within a week, the service users had all been transferred, the staff redeployed, and the ward left empty.

Admittedly, whilst trying to negotiate whole new ways of working during a pandemic (and the challenges of home schooling), I did not have a chance to really consider the ward again until recent weeks. I had stumbled across some old books from a University project on the Northfield Experiments and the origins of the Therapeutic Community which had got me reflecting upon my own experience of the unit again. Whilst I did not think for a minute the complex care unit was analogous to a Therapeutic Community, with its complete absence of group meetings, a clinical as opposed to informal ambience, top-down decision making and service users being unable to act as auxiliary therapists to each other due to the nature of their illnesses - I had come to realise that there was *something* clearly therapeutic about the ward that went beyond the limitations of what we achieved with medication.[4] A book by DW Winnicott, *Playing and Reality,* caught my attention and I started flicking through and re-familiarising myself with some of his key principles. Thus began my re-conceptualisation of the ward and my perception of it; was the complex care unit in fact a *transitional space* for those within it?

Dr Donald Woods Winnicott (1896-1971), a British paediatrician and psychoanalyst, developed his most innovative and fruitful work in the 1950s.[5] In his studies of children he made special reference to the three-plus months period during which the child is particularly concerned with what is 'me' and what is 'not-me' in their world of identity.[6] Winnicott described the function of an early "transitional object", for example the teddy bear or piece of cloth, as closely owned by the child at that time and beyond, in acting as a psychological reliever of the internal and external anxieties of weaning.[7] Through loving, cuddling and playing with the object the child is able to move from the narcissistic love and dependency of infancy, to selfless love for others and independence.[8] He also described the importance of the "transitional space" as the space available, within the pressures of everyday life, for an individual or a group to engage in learning about themselves and others.[9]

Upon setting myself the task of exploring this further, I discovered a paper by Michael Casher examining the significance of Winnicott's work in relation to modern in-patient psychiatric

[4] D. Kennard, *An Introduction to Therapeutic Communities.* London: Routledge and Kegan Paul, 1983, pp. 7-11.
[5] A. Ambrose, 'An introduction to transitional thinking', in G. Amado and A. Ambrose (eds.), *The Transitional Approach to Change.* London: Karnac, 2001, p. 26.
[6] H. Bridger, 'Groups in Open and Closed Systems'. Paper presented to the International Institute on the Therapeutic Community Today, Castelgandolfo, Italy, August-September 1984, p. 3.
[7] D.W. Winnicott, *Playing and Reality.* Middlesex: Pelican books, 1971, pp. 3-7.
[8] T. Harrison, *Bion, Rickman, Foulkes and the Northfield Experiments, Advancing on a Different Front*. London: Jessica Kingsley Publishers, 1999, p. 212
[9] D.W. Winnicott, *Playing and Reality.* Middlesex: Pelican books, 1971, pp. 3-7

treatment.[10] He reflected that Winnicott's concept that a baby cannot exist in isolation supports the notion that an admitted service user does not exist in a vacuum - rather there is a *dyad* of patient and doctor. Indeed he took this a step further and proposed the concept could be extended to the inherent relationship between patient and the in-patient unit – they are both inextricably linked.

The complex care unit, with its longer stays and emphasis on improving the physical condition and regaining social skills, is comparable to a rehabilitation ward, and Thomas and McGinnis feel Winnicott's work is particularly applicable to these settings.[11] This is because rehabilitation clearly requires a restorative environment. The complex care unit could also be considered a *holding environment* for those service users within it, comparable to Winnicott's description of an infant who is totally dependent on its environment.[12] There is no denying that the service users on the unit relied on the ward for all of their basic needs, but it also nurtured their higher order ones. This is particularly important as Winnicott saw *holding* as part of a process which ultimately leads to an integrated sense of self and the ability to relate to others.[13]

When reflecting upon Winnicott's concept of transitional objects, I recall a particular service user on the unit who had a functional illness and would carry a rather worn looking doll with her at all times. Indeed, she would often sleep in a chair at night, offering the doll her bed. This is seemingly quite an obvious example of a transitional object, however I am reminded of the work of Harold Bridger, one of the founders of the Northfield experiments, who described that *environments* can have a 'teddy bear effect' too for the people concerned; relieving their anxieties as they were weaned off their dependent stage of illness.[14] The occupational therapy interventions on the ward were central to this, serving as an alternative to acting out and creating a bridge between the service user's state of self-absorption to an engagement with the outside world.[15]

With all the above now borne in mind, I have come to appreciate that the complex care unit was therapeutic in so many inconspicuous, but important ways for the service users within it. One need only look to the distress displayed by the service users during the unit closure for evidence of the profound impact of the loss of this transitional space. The ward environment provided a safety net and alleviated their fears of being dropped on what Grolick described as the 'circus floor'; undoubtedly creating a space in which they felt safe to "experience oneself, and *be* one's self".[16] The sudden withdrawal of this safety net due to the ward closure – albeit to be substituted for a similar one – was therefore bound to have significant destabilising effects.

[10] M.I. Casher, "There's no such thing as a patient": Reflections on the Significance of the Work of D.W. Winnicott for Modern Inpatient Psychiatric Treatment, *Harvard Review of Psychiatry*, 2013, **21(4):** 181-187.
[11] K.R. Thomas and J.D. McGinnis, The psychoanalytic theories of DW Winnicott as applied to rehabilitation, *Journal of Rehabilitation,* 1991, **57**: 63-66.
[12] S.A. Grolick, *The work and play of Winnicott*, Northvale, New Jersey & London: Aronson, 1990, pp. 29-30.
[13] D. W. Winnicott, *The maturational processes and the facilitating environment: studies in the theory of emotional development,* London: The Hogarth Press and the Institute of Psycho-Analysis, 1965, pp. 42-47.
[14] Planned Environment Therapy Trust Archive and Study Centre, Cheltenham. (T)CF325.
[15] M.I. Casher, "There's no such thing as a patient": Reflections on the Significance of the Work of D.W. Winnicott for Modern Inpatient Psychiatric Treatment, *Harvard Review of Psychiatry*, 2013, **21(4):** 184.
[16] S.A. Grolick, *The work and play of Winnicott*, Northvale, New Jersey & London: Aronson, 1990, p 30.

In a climate where there is a significant demand for in-patient mental health beds, the prioritisation of timely discharges and shorter in-patient stays is inescapable. Where this is not possible, due to the complexity of the service users in question, I experienced the ease with which one can be left holding feelings of inefficiency and failure. In instances such as these, the value of the in-patient environment *itself* as being therapeutic is often overlooked. I was guilty of this very charge, however, am sure that these reflections will provide a new vantage point for considering in-patient units and the service users within them in the future.

**References**


A. Ambrose, 'An introduction to transitional thinking', in G. Amado and A. Ambrose (eds.), *The Transitional Approach to Change.* London: Karnac, 2001, p. 26.

Bridger, H. 'Groups in Open and Closed Systems'. Paper presented to the International Institute on the Therapeutic Community Today, Castelgandolfo, Italy, August-September 1984, p. 3.

Casher, M.I. "There's no such thing as a patient": Reflections on the Significance of the Work of D.W. Winnicott for Modern Inpatient Psychiatric Treatment, *Harvard Review of Psychiatry*, 2013, **21(4):** 181-187.

Grolick, S.A. *The work and play of Winnicott*, Northvale, New Jersey & London: Aronson, 1990, pp. 29-30.

Harrison, T. *Bion, Rickman, Foulkes and the Northfield Experiments, Advancing on a Different Front*. London: Jessica Kingsley Publishers, 1999, p. 212.

Kennard, D. *An Introduction to Therapeutic Communities.* London: Routledge and Kegan Paul, 1983, pp. 7-11.

Planned Environment Therapy Trust Archive and Study Centre, Cheltenham. (T)CF325.

Thomas, K.R and McGinnis, J.D. The psychoanalytic theories of DW Winnicott as applied to rehabilitation, *Journal of Rehabilitation,* 1991, **57**: 63-66.

Winnicott, D.W. *Playing and Reality.* Middlesex: Pelican books, 1971, pp. 3-7.

Winnicott, D.W. *The maturational processes and the facilitating environment: studies in the theory of emotional development,* London: The Hogarth Press and the Institute of Psycho-Analysis, 1965, pp. 42-47.

**Author: Anna Crozier from Essex Partnership University NHS Foundation Trust**

# Change

***Reflecting on my experience of Personal therapy***

***(To the tune of 'Mine eyes have seen the Glory of the coming of the Lord')***

Today I paused to think about this Thing called Therapy
And wondered what if anything, to date it's done for me?
Apart from opening my eyes to things I didn't want to see
And implying I should change.

I thought I was ok before, no major issues burning.
The worst of problems dealt with well; for nothing I was yearning.
Now I find I can't say that I like what I am learning.
I never asked for change.

I'd thought this quite a good idea. I liked it once in theory.
The practice has been something else entirely quite scary.
If I'm honest with my self, before each session I'm quite wary
Of this process they call change.

I'm not that sure I really want my inner landscape changed?
There's comfort in the life that is familiar though deranged.
But do I really want to live like this in my old age?
Which I will if I don't change.

And am I only here since someone else said that I should?
Or am I able to make choices purely for my good?
Can I engage, let things unfold and slowly understood?
And allow something to change?

I've learnt with some dismay and no small measure of alarm.
That all my coping mechanisms are in fact self-harm.
But without them I'd be vulnerable and terribly disarmed.
If I allow some change.

It seems that I've been living all these years in strong denial.
My defence of choice for my emotional survival.
Those painful feelings borne out of an early life revival
Is why I won't risk change.

What will I do when they arise; old feelings so long buried?
Of what am I so fearful of? Of what am I so worried?
What is it I'm not feeling as I rush around and hurry
That holds me back from change?

Can I open up to feelings if the pace is slow and steady?
Or will I proffer more excuses such as 'I am still not ready'.
A different life just seems both so impossible yet heady.
Can I find some faith in change?

Or can I turn back time and give my Therapist the sack?
Sadly no as I can never give the knowledge back
That under the defence, with painful feelings I am wracked.
It's begun this thing called change.

So is there any hope for me before I meet my hearse?
Or will this process really only serve to make me worse?
Is it worth the time plus open-ended lightening of my purse?
And other costs of change?

Maybe when I falter and I wonder how I'll cope
And turn to old behaviours sliding back that downward slope,
This is when my Therapist hangs onto both our hopes
That one day I may change.

Could my internal Landscape become rich and full of colour?
Could I take care of my true self as would a loving mother?
Be emotionally engaged when in the company of others?
For this I need to change.

So is this too much to ask from this Thing called Therapy?
Maybe not if I can open up some space to simply be.
If I persevere and welcome endless possibilities.
Then one day I will change.

## BOOK REVIEWS

## Editors: Dan Beales and Andrew Shepherd

## Call for future book reviewers and contributions

The book review section is a relatively recent addition to the Faculty newsletter. Thus far, the section has been somewhat ad-hoc, but we are hoping to grow and develop it further in the future. For this to happen, we need contributors and fellow bookworms. We have several ideas on how this section could be developed, e.g.:

- books you would like to review;
- books you wouldn't do without/classics revisited/hidden gems
- addressing a theme/ debate

We are keen to hear from you – if you have an idea for a review, a series for discussion or other contributions to make. We have made contact with several publishers in the field and are able to negotiate access to review copies in many cases.

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

**Andrew Shepherd and Dan Beales**
**Contact Andrew and Dan** c/o Catherine.langley@rcpsych.ac.uk

## EVENTS, NOTICES AND DATES FOR YOUR DIARY

### First ever RCPsych member survey

The College is launching its first ever comprehensive membership survey which will be open to all members between **19th May and 13th June 2021**

Look out for emails from Research by Design
containing a link to complete the survey.

The RCPsych is your College, please help shape its future.

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**To members of the Medical Psychotherapy Faculty**

**Innovations in the understanding and care of people with psychosis:**

**a symposium in honour of Professor Julian Leff**

Wednesday 26th May: 1pm – 5pm

ALL WELCOME

To register, click here

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**CoroNerve Study:**

The CoroNerve Studies Group wishes to thank everyone who have submitted cases to the CoroNerve surveillance study which is assessing COVID-19-associated neurological and psychiatric conditions.

Case data already submitted to the study have led to a publication in Lancet Psychiatry and a new Case Report Form manuscript which is currently under review. All those who have submitted cases are cited and searchable by name in PubMed as members of the CoroNerve Studies Group.

This near real-time surveillance platform is more important than ever, and Members are encouraged to continue reporting cases.

The recently updated survey is now capturing details of potential psychiatric and neuropsychiatric (as well as neurological) complications resulting from the SARS-CoV-2 vaccine in addition to COVID-19.

The survey only takes a few minutes to complete and is critical to building knowledge and research in this important field.

If you take part, you'll be invited to fill in a more detailed Case Report Form with full clinical details which will take approximately 20-30 minutes to complete.

CoroNerve surveillance survey | Royal College of Psychiatrists (rcpsych.ac.uk)

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## Medical Student Psychotherapy Essay Prize

The title of the essay for 2021-22 is:

**"Tell us about a patient you have seen, showing how your reflections on psychological issues deepened your understanding of the case and contributed to your personal learning."**

The winner will be announced at the next year's Conference and the prize includes £250 and a free pass to the Faculty of Medical Psychotherapy Conference 2022.

More information about the Prize is available on our website https://www.rcpsych.ac.uk/members/your-faculties/medical-psychotherapy/prizes-and-bursaries?dm_t=0,0,0,0,0

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## Medical Psychotherapy Faculty Large Group

Following a hiatus for the groups that took place in the Faculty Conference in April, these meetings are recommencing monthly. Diana Menzies and Chris Holman will continue as Conductors of the group.

The administrative arrangements for the group have changed, the group now being administered by Mark Morris. The link sent monthly will be for that meeting only, and a new link and password will be sent for each meeting.

The group is open to medical psychotherapists and higher trainees in practice in various settings. New colleagues wishing to join should contact Dr Morris at mpfacultylargegroup@gmail.com and an invitation to the next group will be forwarded.

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**Psychodynamic Psychiatry day** (organised by Jo O'Reilly and Rachel Gibbons) 12th November 2021

## YOUR CONTRIBUTIONS TO THIS NEWSLETTER ARE WELCOME

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

## CONTACTS

Contact the Faculty and any of the contributors c/o Catherine Langley
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