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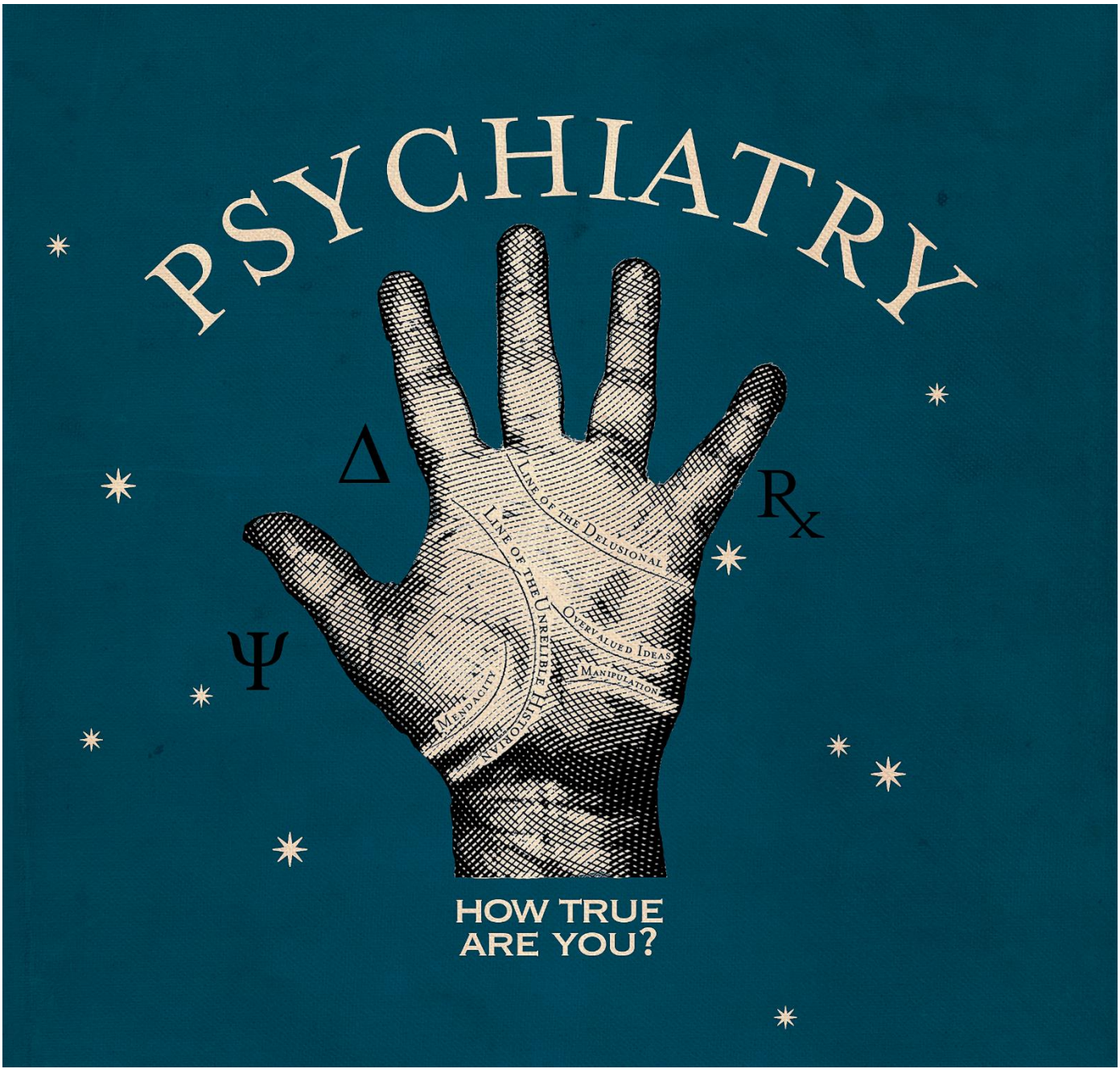
FuturePsy



Brainstorm

It starts with a jolt, a bolt from the blue,
That familiar lurch, an unmistakeable cue.
Erased from memory for sanity's sake,
The old foe returns, sheer fear starts awake.

Adrenaline rising, neurones misfiring
Flailing for help from a prison of silence.
Searching for breath, eyes all lost at sea,
A few soothing words to help me break free.
Lips turning blue, the panic in their eyes
Relying on them and their confident lies.

Reassuring only themselves coz my gut isn't buying it.
I've been here before, smells exactly the same.
At least one sense preserved in this fog of confusion,
Overwhelming façade or an active delusion?

Mine, or theirs.

Familiar faces morph into strangers,
Conscience erupts like an active volcano.
Flashbacks are flying, what's real and what's fake?
The maelstrom is becoming just too much to take.

A sensory sham, thoughts playing tricks.
Won't someone please bash me over the head with a stick?
So it stops.
Make it stop.

The curtain comes, the sweetness of peace.
Pleaded, and begged and was granted release.

The spirit has fled, so the body takes over.
Thrashing and groaning, biting and moaning.
Eyes rolling back, in devilish release,
Muscles torn, skin shredded; then suddenly limp.

Soul and body surrendered. Not mine and not his.
A momentary ceasefire before the fight-back begins.

Lids blink, thunder-struck, like swimming through treacle.
Resurfacing, gasping, a glorious reprieve.
Then the circle starts over and I begin to believe
In recovery – until… it starts with a jolt.

By Dr Hannah Emerson
Foundation Year 1, Queen Elizabeth Hospital

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Editorial

Dear Readers,

Closing my revision notes to create the Winter 2020 FuturePsych makes for a welcome break. I share your passion for mental health and the chance to join the Psychiatry Trainee Committee was therefore an easy decision. I have had the fabulous opportunity to explore behind the scenes how the College works tirelessly to encourage the next generation of doctors to *#choosepsychiatry*.

I was inspired by the committee's dedication and passion for engagement and I consequently decided to run a Psych Soc Twitter Takeover in October 2019 for UK medical students. For one fantastic hour medical students discussed mental health, and Psychiatrists shared career advice across nations; I quickly realised whilst sat in my room in Belfast I was not alone in wanting to pursue Psychiatry. Following the success of the event (never having met any of the Psychiatrists in real life!), the only conclusion that can be drawn is that a career in Psychiatry is enormously supportive and diverse, with something to suit everyone. Furthermore, the engagement is testament to how welcoming the field of Psychiatry is to young doctors.

The Choose Psychiatry campaign, now in its third year, has attracted and inspired the best young minds to go above and beyond the medical undergraduate curriculum and contribute to the field of Psychiatry early. My evidence for this is the wealth and breadth of knowledge medical students and foundation doctors have demonstrated in the following articles. Our first interview demonstrates this in abundance. Moreover, however, the interview with Haridha, RCPsych Medical Student of the Year 2019, demonstrates how Psychiatry is a unique and welcoming medical specialty; she highlights that there are opportunities waiting for you around every corner.

Regardless of your academic or clinical standing, it is never too early to get involved in Psychiatry. 2020 can be the year you begin to think about your personal goals and development. Remember, above all, these goals are for yourself; see what you can accomplish! Thank you to everyone who contributed to this edition of FuturePsych.

By Patricia Vinchenzo, *Medical Student at Queen's University Belfast*

@TrishVini

Would you like to submit an article to the Summer 2020 edition of FuturePsych magazine? We are always interested to hear from you! We welcome reflections, case studies, opinion pieces, reviews, elective reports and interviews with equal applaud. For more information, please email:

careers@rcpsych.ac.uk

Medical Student of the Year

Haridha Pandian is a final year medical student at King's College London. In November Haridha was awarded 'Medical Student of the Year 2019' - congratulations! Alongside 200 voluntary hours for Nightline, Haridha was considered 'exceptional' during her psychiatric rotation, has been President of her university psychiatry society and has actively contributed to the recruitment of future psychiatrists.

We were able to speak with Haridha to ask her how you, too, can go above and beyond your medical school curriculum.

Congratulations on your award Haridha! How were you first inspired to pursue psychiatry?

Psychiatry as a career had never occurred to me before starting medical school. I was first inspired when undertaking an optional study module 'Beautiful Mind' at my university. The module explored mental illness through the disciplines of social sciences and humanities; covering topics from the history of mental asylums, art therapy, and study visits to the Bethlem Museum of the Mind. I was astounded by the value placed on the arts in recovery within psychiatry and quickly realised that the specialty has wonderfully broad horizons. I love that psychiatry celebrates creative practice, communication and holistic management.

What advice can you share with our medical students who would like to get involved in psychiatry early on?

Join your university student psychiatry Society! This is a great way to network with like-minded interested students.

Try to take up student-selected components in psychiatry. These should help you to gain a broader, more varied experience of mental health. You may even be able to submit essays or projects completed in these SSCs for competitions and conferences run by the College- there are lots of incredible opportunities listed on their website.

Whilst you're browsing the College website, make sure to look for student bursaries to attend conferences and meetings. These can provide an insight into sub-specialties in psychiatry such as forensic psychiatry and are great fun! There are also many free psychiatry summer schools run across the country which provide tasters of the specialty, interesting lectures and social events.

Finally, consider applying to college schemes such as *Psych Star* and *Psychiatry Foundation Fellowships* - these provide funding, mentoring and support in developing your interest in psychiatry at medical school and beyond.

You have been a committed member of your university's Psych Soc for several years. Why should medical students get involved with their Psych Soc?

Being involved with the King's Psychiatry Society (Psych Soc) has been one of my most rewarding experiences at university. Working with other students passionate about mental health and psychiatry has broadened and deepened my own interests. It has helped me to make new friends, network with local psychiatrists and gain leadership, organizational and team working skills.

Psych Soc events can be hugely diverse, covering topics outside of the undergraduate curriculum. For example, at King's we have hosted events on evolutionary psychiatry, psychosexual medicine and addictions psychiatry. Psychiatry is wonderfully broad - if you're interested in a particular area of mental health, joining your local Psych Soc may be your chance to showcase it to your peers!

How can students make the most of their medical school psychiatry rotation?

The best way to gain the most from your rotation is to spend time on wards. Familiarise yourself with psychiatric history-taking and the mental state examination; always ask questions if you are not sure! Offer to speak with patients, hear their fascinating stories and check their case notes so you can build up a full picture. Try to follow patient journeys from start to finish - this may be hard in short placements but give it your best shot.

After each patient encounter consolidate your learning by reading up on their condition - I used a combination of 2 textbooks: '*Psychiatry PRN: Principles, Reality, Next Steps*' and '*The Oxford Handbook of Psychiatry*'.

Lastly, try to get as varied an experience as possible. Psychiatrists work in many settings and sub-specialties, and it can be helpful to be exposed to as many of these as possible.

Thank you, Haridha. There is no doubt you will continue to inspire others to *#choosepsychiatry* for many more years.

Good luck in your future career!

@haridhap1

Pregnancy on the Autism Spectrum –

The need for patient advocacy

Women have autism too; it is easy to forget this when looking at the largely male centric media representation of the condition and published research in the area[1]. Current literature quotes the male to female ratio of autism spectrum disorder (ASD) as 3:1[2]; but statistics do not paint a complete picture. In 2019 I attended the Neurodevelopmental Psychiatry Special Interest Group Annual Conference. It was here that I began to understand that prevalence statistics can be misleading; with the true incidence of ASD in females likely obscured by their 'atypical' presentations[3]. As a result, the unique challenges facing women and young girls with autism are largely overlooked, with comparatively little support and recognition of the developmental challenges autistic females face; including puberty and pregnancy[4].

At the aforementioned conference, Dr Alison Stansfield highlighted the challenges facing autistic mothers during pregnancy; a topic that I, as a medical student, had naively never even considered before. The changes that women can experience during pregnancy are numerous; spanning both the physical and social areas of her life[4]. Yet a characteristic of autism is a gross dislike for change, and need for consistency which is understandably disrupted during pregnancy[5]; thus potentially causing distress and anxiety for these women. Additionally, for some expectant mothers on the autism spectrum, a hypersensitivity to bodily sensations leads to increased anxiety surrounding the health of their baby[6]. Furthermore, many autistic women report the sensory overload experienced on delivery wards in hospitals as being a key factor in choosing at-home deliveries[6]. Finally, the large number of new medical staff a woman is expected to meet during pregnancy and labour can be particularly concerning for these women; many of whom find social situations challenging[7]. These factors combined, can isolate autistic mothers, and leave them in conflict with medical staff who do not recognise or understand their condition[8]. While we as medics can, however, hypothesise about the potential challenges facing autistic women during pregnancy, there is no substitute for real patient experiences.

In this under recognized field, one book stands out for its frank and honest account of pregnancy for mothers with autism. Lana Grant's 'From Here to Maternity: Pregnancy and Motherhood on the Autism Spectrum' outlines these issues further, drawing on her own experiences with pregnancy and childbirth as a woman on the autism spectrum. Lana is one of many women not diagnosed with autism until after having children of her own and consequently she had many negative

experiences with healthcare professionals who did not understand her needs[9]. I would highly recommend this book to anyone working with people with autism. It can be tempting to think that by studying a condition we in the medical profession are best positioned to tell patients about their own experience. Lana emphasises in her book the need for doctors to listen to mothers with autism and *ask them* what they need rather than presuming[8].

As medical students it can be hard to know what we can do to advocate for patients with mental health conditions. This book, however, suggests that a good place to start can simply be approaching clinical rotations with an awareness of the barriers and challenges individuals with neurodevelopmental conditions like ASD may experience in healthcare. Ultimately, a greater awareness of autism in all medical fields, not just psychiatry, will mean future patients like Lana Grant are better understood and supported.

By Isabella Conti

Medical Student at Queen's University Belfast, currently intercalating in Psychology at King's College London. After learning about mental health in greater detail this year she has developed an interest in psychiatry which she hopes to pursue in the future.

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A Special Summer

Interested in psychiatry, and want to learn more about the speciality? You need look no further. Leeds Psychiatry Summer School's annual course gives you a fascinating and insightful view about all things related to this often misunderstood area of medicine. This year, the week-long course took place in July. Attendees to this free event came from as far as Northern Ireland and Malaysia and ranged from sixth-formers to final-year medical students.

The presenters were exceptional. Professor Wendy Burn, the keynote speaker, gave a passionate talk on the strong future of psychiatry, peppered with anecdotes and statistics. The current core training fill-rate of 92% is testament to her successful tenure as President of the Royal College of Psychiatrists. It also reflects well on the Choose Psychiatry movement, of which this summer school was part.

The week was host to a wide range of workshops and seminars, from high-energy career speed-dating, where participants could ask experts about their fields, to a sombre and introspective Balint group. Students were exposed to a huge diversity of opportunities and schools of thought within psychiatry and given a reminder of the specialty's holistic approach to mental health. Talks included cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), philosophy, academic psychiatry, and also neuropsychiatry – the neurology behind psychiatry - heralded by some as the future of modern psychiatry. We were left with a clear message: a career in psychiatry is made of many paths.

After the day-time lectures, the evenings were dedicated to socialising. Students bonded at organised events, starting with a hearty meal at a local Thai restaurant. Other evening occasions included venting their natural competitive spirit at the local junkyard mini-golf (see picture) and long visits to students' popular watering holes. Course participants from different backgrounds were able to talk openly about themselves, their experiences and their reactions to the course.

Beyond the career advice and insights into how psychiatry is practised, students also enjoyed non-clinical lectures, such as the relationship between migration and psychosis, or how mental health is represented in film. These sessions were a salient reminder of the far-reaching effects of psychiatry, beyond the consultation room.

Psychiatry often suffers an unfairly negative reputation, which has been shown to dissuade students from contemplating such a profession. This Summer School, however, and the Choose Psychiatry campaign as a whole, are proof that psychiatry is a fascinating, challenging, and rewarding profession for the doctors of tomorrow.

By Rahul Mehta, *Norwich Medical School*

Special thanks go to Dr Richard Johnson and Dr Anne Cooper.

Lessons from Mental Health Nursing

Before I was a medical student, I was a mental health nurse. The three-year degree instilled in us the value of seeing the person – never 'patient' – as an equal, a fellow human being experiencing a deeply unpleasant part of the human condition. There were always two experts in the room: the nurse might have the expertise of training, but the person was the expert in their life, what had happened to them and what was still happening. That kind of expertise deserves respect.

To demonstrate the respect we feel, to level the power imbalance of the clinical setting, and to bring union between nurse and person, therapeutic use of self is crucial[1]. Where appropriate, a nurse will often share things that helped them recover from depression or eating disorder or self-harm. I should know, I have done it. When used judiciously, this type of self-disclosure could strip away all the professional barriers, just for a moment, and allow genuine human connection.

This genuine human connection is, of course, an essential component for building a therapeutic relationship[2]. Many studies have shown how therapeutic modality (e.g. cognitive behaviour therapy) matters much less for a person's recovery than the therapeutic relationship itself[3]. It is difficult to develop this type of relationship with a person made of steel, so why is self-disclosure discouraged in medicine?

Do we fear the people we work with wouldn't trust us? Would not respect us? Would shrink the pedestal upon which they hold us, just a bit? When giving of ourselves can contribute so greatly to the therapeutic relationship, and therefore a person's recovery, are we putting our own needs first? I wonder how much we are contributing to the burden of stigma surrounding mental health.

The recognition of the value of the wounded healer seems to be growing in psychiatry[4]. Dr Ahmed Hankir, author of The Wounded Healer, is renowned for his passionate use of self, openly discussing his own experiences and mental health issues. In nursing, the recognition is that the wounded healer is all of us, for nobody makes it through life without dark days.

I am not trying to dismiss the very serious trauma and distress that we bear witness to in psychiatry. I cannot think of many people who're struggling with hearing voices or misusing substances who want to hear a medical student whine about workload. However, medical schools are rife with mental anguish[5], and many of us bring experiences from before study; many more of us pick them up afterwards. When used appropriately, and always for the benefit of the other person, mental health nursing has taught me that therapeutic use of self is the largest contributing factor in developing empathy and informing a person's recovery[3].

I hope psychiatry will learn this lesson from mental health nursing.

By Felicity Allman, *Newcastle University Medical School*

References for this article can be found on page 16.

Learning to Listen

Meet Miss Smith: a 65-year-old nature lover, seasoned traveller and book-worm - a daughter, a sister and a friend - a dreamer, a writer and an artist - and now, a patient with a new diagnosis of Alzheimer's Dementia.

Miss Smith was admitted to the acute Old Age Psychiatric Unit with a diagnosis of psychotic depression and severe anxiety; this previously independent lady was now shackled to the invisible chains of her mental illness. Several months into her admission, Miss Smith displayed short-term memory problems and subtle cognitive decline which led to a diagnosis of early Alzheimer's Dementia.

On my first day as an FY1 junior doctor on the ward, I met Mrs Smith. She had been an inpatient for many months already and was better acquainted to the ward than I was; she offered me a cup of tea and showed me to her room where we had the first consultation.

During this first consultation, I explored her psychiatric history. Miss Smith was referred by the GP following a 6-week history of progressively worsening symptoms of low mood, anhedonia, anergia, poor appetite and disrupted sleep. Cognitive symptoms included poor self-esteem and hopelessness and a generally negative perception of herself self, others and the future (Beck's Cognitive Triad). I explored the patient's background including a full personal history. She took me through the journey of her life to the present day. I was struck by her intelligence and introspective nature; she was multilingual and artistically inclined.

From my initial assessment, I was able to gather a lot of information and from this construct a formulation, identifying precipitating, predisposing and perpetuating factors. With guidance from my Consultant Clinical Supervisor, I was encouraged to continue my weekly consultations which continued through-out my rotation. My patient formulation provided me with a framework to guide my consultations.

Prior to each consultation, I prepared my objectives. A goal of one of my early consultations was to counsel the patient on her new diagnosis of Alzheimer's. This new diagnosis was causing Miss Smith a lot of anticipatory anxiety and was thus impeding her engagement in discharge planning - she was in a state of denial. I offered her information leaflets on dementia to read at the end of a session which she gratefully accepted but did not read! I very quickly learnt to appreciate that time and patience would be my most valuable tools.

Over several consultations, I used a basic CBT model to explore the patient's cognitive distortions, the associated feelings that arose and the subsequent effects on her behavioural, physical and cognitive health. Being psychologically minded, Miss Smith was able to understand the model and showed a lot of interest in it. This low-intensity psychological intervention proved to be somewhat effective – she showed better engagement with the discharge team by attending residential home viewings; she was able to reconnect with her brother from whom she has been estranged for many years after we worked through some of her cognitive biases.

Despite my minimal experience of talking therapies, I discovered that there is an innate therapeutic nature to simple storytelling; construction of narrative and form provided a sort of emotional catharsis for the patient. This narrative enabled Miss Smith to contextualise her condition and explore self-perceptions as well as of those around her. Narrative reconstruction was a process by which the patient was able to assemble a sense of order and meaning to her life from the fragmentation caused by mental illness. My rotation in psychiatry has taught me the value of truly *listening* to my patients and it is a skill I continue to develop and use with every patient I encounter.

N.B. Alias is used for patient and no patient identifiable details have been included.

By Dr Saara Adam, *Leicester Medical School Graduate, Foundation Year Two LNR Foundation School*

Child and Adolescent Psychiatry Medical Student essay competition – *"In these times of widening gaps in society between richer and poorer communities, how can deprivation and poverty affect child mental health?"* – Closing 6 April 2020

Forensic Psychiatry Medical Student essay competition – *Topic related to Forensic Psychiatry* – Closing 20 September 2020

Neuropsychiatry Medical Student Systematic Review prize – *"Unbiased evaluation of the potential benefits of cannabis in neuropsychiatric conditions"* – Closing 30 April 2020

Rehabilitation and Social Psychiatry Medical Student essay – *"Do psychotherapeutic models have a role in rehabilitation and recovery"* – Closing 29 March 2020

Rehabilitation and Social Psychiatry Bursary Foundation Year one doctor to attend conference – Email CV – Closing 1 June 2020

Global Mental Health: Closing the Gap

The concept of, "there is no health without mental health" is one that is true *worldwide*. Recent Global Burden of Disease studies have identified mental health and substance misuse disorders as leading causes of disability worldwide[1], contributing to a median of 10 years of potential life lost and amounting to 14.3% of worldwide deaths each year[2]. Thus, the care of patients suffering from such prevalent and disabling disorders should be a priority when designing and implementing public health policy and practice to address preventable mortality.

Reviews show, however, the existence of a global 'treatment gap' for disorders such as schizophrenia, depression, anxiety and alcohol abuse, where many of the individuals in need are not receiving treatment for their conditions[3]. This becomes even more apparent in low- and middle income countries (LMICs), where there are fewer (and of smaller scale) effective interventions for these disorders[4]. In fact, surveys have estimated that 76 to 85% of mental disorders in lesser-developed countries were untreated, as compared to lower estimates of 35-50% in their more developed counterparts[5]. Although to some extent these inequalities undoubtedly stem from structural barriers, including lack of funding and thus lack of service availability in these countries, there are other factors that should be considered; namely, so called 'attitudinal barriers', including varying cultural and societal beliefs, such as low-perceived need for medical treatment and/or stigma, which have indeed been shown to have an impact on treatment seeking and dropout rates in LMICs[6].

In order to address these needs and treatment gap, the World Health Organization (WHO) first developed the mental health gap action programme (mhGAP) in 2008, which was followed by the 2010 Intervention Guide. These two written guides seek to provide action plans and assessment tools for the development of mental health services in LMICs[7,8]. Specifically, they provide clinical decision-making protocols for a number of so called 'priority conditions', which include depression, dementia, self-harm/suicide, psychosis, alcohol and drug use disorders. A recent systematic review of 33 studies shows favourable evidence for the incorporation of the mhGAP intervention guide across a variety of uses - including for staff training and in direct clinical context- across Africa, Asia and South America[9]. One of the principal advantages include its ability to be used by non-specialist healthcare providers in formats that are of particular benefit in resource-poor settings; for instance, on a mobile phone application. An example of this function is its use in rural Kenya, where it has been applied in screening for symptoms of priority mental health problems, such as depression[10], and in training non-specialized workers such as traditional health practitioners to successfully deliver psychosocial interventions for said patients[11].

The diagnostic and interventional potential of the mhGAP provides great

promise for a cost-effective and non-specialist means of addressing the needs for those suffering with mental disorders. However, there are still barriers to the effective delivery of these guidelines and interventions, including challenges associated with the cultural and historical/political context, as well as impediments within the institutions - or as determined by the trainee recruitment, supervision, and existing skill set, and potential solutions to these[12]. Additionally, a balancing act is required to ensure that the cultural and contextual adaptations that may be placed on the mhGAP training do not compromise the evidence-based protocols on which they are founded.

In conclusion, I believe that it is important that as health professionals, regardless of our country of practice, we are aware of global health issues including existing inequalities and treatment gaps and that we can utilise our knowledge and skills to elicit global change.

For those interested in learning more about global mental health, enter essay prize competitions, access special resources and training, sign up to the volunteering and international psychiatry special interest group (VIPSIG) community online on: https://www.rcpsych.ac.uk/members/special-interest-groups/volunteering-and-international.

By Lucia Almazan Sanchez

Final Year Medical Student, GKT School of Medicine, King's College London

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Foundation Doctor of the Year

Dr Thomas Hewson is an academic junior doctor in Manchester. The Royal College of Psychiatrists felt that Tom has demonstrated a high level of commitment to pursuing a career in psychiatry, and in November the college awarded him 'Foundation Doctor of the Year 2019' - congratulations!

Thomas is a Foundation Fellow of RCPsych and co-founded the PsychStart mentoring scheme, providing role models and support for students considering psychiatry. He has published and internationally presented research examining decision-making in offenders with mental illness. We were lucky to meet Tom and ask him why you too should consider a career in psychiatry.

Congratulations on your award Tom! When did you first become interested in psychiatry?

Thank you. It was a huge honour to receive this award and I feel very privileged and grateful to have been selected.

I really enjoyed learning about mental illness as part of my A-level psychology course, but it was not until my second year "Introduction to psychiatry" module at medical school when I realised that this was the career for me. I recall feeling inspired by the holistic approach to patient care and the potential to make a huge difference to patients' lives. Speaking to patients with mental health problems alerted me to the potentially all-consuming nature of mental illness, and I could easily appreciate how rewarding it must be to assist them in their journeys to recovery. My passion for mental health was then reinforced on several occasions throughout my studies. Various talks and events hosted by the student psychiatry society further captured my interests, and opportunities to explore the different sub-specialties and witness the breadth of psychiatry additionally confirmed my career decision.

Do you have any advice for our readers who may have an interest in becoming involved in research?

It is never too early to get involved in research! I would definitely urge anybody with an interest in academia to contact local academics and find out about the opportunities available in your area. There are usually multiple research projects already in existence that you could get involved in, or you may wish to create your own research proposal with support. I think it is important to pick a research project that is right for you - think about what you are passionate about, the time you can dedicate to it and the skills you may need to develop. The journey of working on a research project through to publication is incredibly rewarding and I think it provides you with skills and insights that are highly transferable to your clinical work. My main piece of advice would be to just go for it and don't hesitate to contact researchers within your field of interest – I have always felt very supported and inspired when I have done so!

What advice do you have for foundation doctors who do not have a psychiatry rotation but are keen to experience psychiatry?

There are plenty of opportunities to get involved in psychiatry outside of completing a rotation in the specialty. Mental illness is

especially prevalent within the hospital setting, and I have cared for patients with mental health problems in each of my rotations thus far. I would therefore not worry too much if you don't have a psychiatry job as you will naturally learn more about the specialty throughout your training regardless, and there are plenty of other opportunities to get involved.

I would urge you to make your interest in psychiatry known early on and speak with local psychiatrists who can guide and support your career exploration. You could consider arranging a "taster week" in psychiatry where you spend time outside of your current rotation to explore a specialty of interest. You could even use this to explore a particular sub-specialty that you are most interested in! I would also suggest attending local psychiatry conferences (and foundation trainees often benefit from discounted rates). The Royal College has several competitions whereby you can apply to win free attendance at various national conferences and events, and these are definitely worth applying for. Other options could include completing an audit or quality improvement project on a topic related to mental health. To do this, you could speak to your clinical and educational supervisors about project ideas or even contact the liaison psychiatry department at your hospital.

Thank you, Thomas! I am sure our readers are inspired! Good luck in your future career in both psychiatry and academia!

@t_hewson

Lessons from Mental Health Nursing References

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