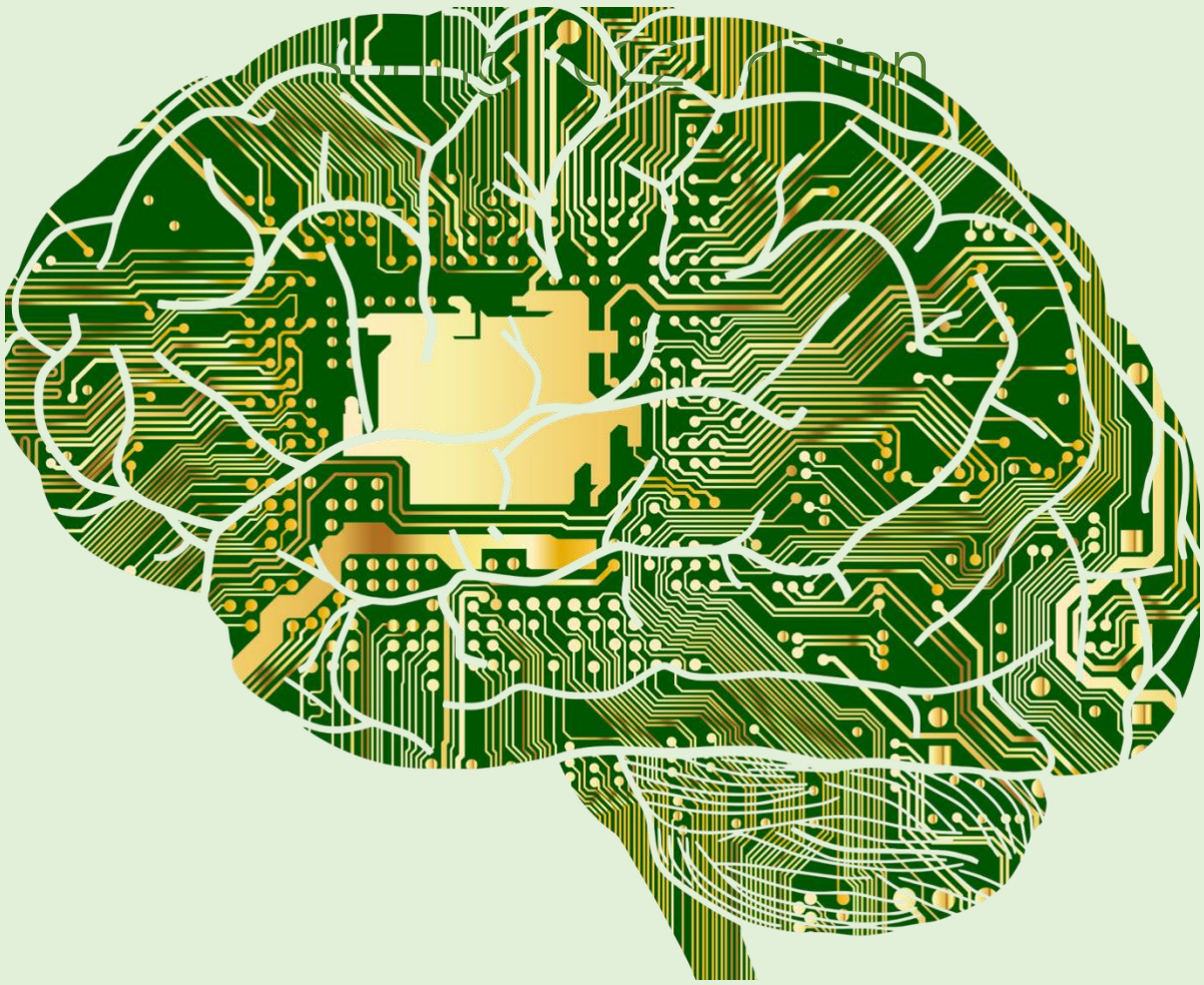
# FUTUREPSYCH

The Student and Foundation Doctor Associate Magazine



Future Ψ

RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

# CONTENTS

# What is intellectual disability and why is it important for medical students?

***You're in an unfamiliar place far from home. It's loud. It's bright. You don't know how long you've been here.***

*You don't understand what's happening to you. People come around for a few minutes to look at you. Different faces come and go each day. Nobody seems to recognise that your tummy is hurting. You hit your head on the wall to distract yourself from the pain. This place makes you feel afraid. Suddenly, something cold on your chest makes you wince as a man comes closer with a long tube on his ears. There's a jolt of pain as you feel something sharp going into your arm and blood comes out. It's going into a small tube; the man takes it away. You don't like it here. You just want the hurt in your tummy to stop. You just want to go home.*

Intellectual disability (ID), previously known as learning disability, is defined by the World Health Organisation as "a significantly reduced ability to understand new or complex information and to learn and apply new skills… beginning before adulthood". This is in contrast to learning *difficulties*, such as dyslexia or dyscalculia, which affect a specific aspect of an individual's ability to process information. For plenty of people in the medical field, the mention of "ID" conjures up thoughts of "infectious disease" and an exotic range of pathogenic organisms. For the 1% of people in the UK with intellectual disabilities, it means something very different.
ID can vary in its severity from mild to profound. People with ID can experience challenges in many different areas of life: formal education, activities of daily living, and social discrimination. However, one of the most fundamental difficulties that some patients can face is in the sphere of communication.

Verbal and written communication are things that many of us do not need to think about. The very fact you are reading this right now is testament to how embedded this is in the way we live; we can read

books, listen to the news, and convey our thoughts, feelings and ideas through the medium of spoken and written language. But what if you weren't able to do this? For some people with ID, these challenges are a fact of life. Therefore, for patients, *behaviour* is as much a means of communication as talking or writing.

In a healthcare context, this is important to take on board when treating people with ID who may otherwise struggle to communicate. Changes in behaviour can indicate a medical or psychological problem that is yet to be addressed. This has the risk of being overlooked due to *diagnostic overshadowing*, where clinicians attribute behaviour to an individual's ID as opposed to an underlying physical health condition. This contributes to health inequalities, with patients who have ID dying on average 20 years earlier than the general population.
Why is this important for us as medical students? For doctors of the future, patients with ID are people we will encounter irrespective of speciality, be it physical health or mental health, in hospitals or in the community, in psychiatry or surgery. People with ID present more frequently to healthcare services, and when admitted to hospital, have an increased length of stay. As clinicians, we will have the privilege of supporting those we care for. Communicating with patients at a level they understand is the cornerstone to delivering good quality care and ultimately improving the quality of life for some of the most vulnerable people in society.

**Ratnu Vaida**

# Verging on the reality of Virtual Reality

**VR enables users to become immersed in and interact with a computer-generated 3D world.**

Users wear a headset that places a digital screen immediately in front of their eyes, creating the illusion that they are within the world depicted on the screen. These virtual worlds are modelled after the real world; therefore, the growth achieved by a patient in the activities of virtual worlds can empower them to confront the same issues in the real world. However, unlike in the real world, VR allows total control of everything occurring in the virtual world, offering a sheltered environment for patients. Although computer-generated worlds in VR are not real, the experiences within these worlds are real, providing the opportunity to use VR as a therapeutic tool.

VR can act as an intermediate step between the consultation room and the real world, fostering more positive relationships with real-world experiences. Virtual worlds can be custom-made for each patient to directly address their unique issues in ways that connect with them. For example, a soldier with PTSD can have a VR experience created with realistic explosions, billowing smoke and converging audio, 're-exposing' them to the trauma in a controlled environment with inbuilt psychological exercises to overcome their PTSD[1]. However, the sensitive emotional intelligence required must not be underestimated for there is a fine line between achieving a therapeutic effect and worsening trauma.

VR is most established as a means of treating specific phobias due to its ability to provide virtual exposure therapy with a gradation of difficulties. Claustrophobia, acrophobia, aerophobia, arachnophobia and social phobia are all examples of specific phobias that can be treated with VR; being able to immerse patients in virtual confined spaces, at great heights, on

airplanes, around spiders, or in crowds of people, respectively, mean that patients no longer have to wait until distressing events happen in real life to develop resilience against them[2]. The virtual phobic experience can be provoked at the will of the patient as many times as is needed, all the while preserving privacy and confidentiality. Although VR experiences cannot quite match the authenticity of real-world experiences, they offer a bridge for patients to take one step closer to successfully overcoming phobias in the real world.

VR has also demonstrated efficacy in helping patients with schizophrenia reduce auditory hallucinations and associated distress by allowing patients to interact with an avatar that embodies the source of their hallucinations[3]. Additionally, eating disorders driven by body dysmorphia have been successfully treated by enabling patients to view their body from an outside observer's perspective[4]. Beyond mental health needs, VR has been used to help patients with autism develop social skills, such as by immersing them in virtual job interviews[5].

VR can also be used as a learning tool for students and the general public to develop empathy for patients by allowing users to experience their first-person perspective of mental illness. Furthermore, VR enables the teaching and practicing of skills in a virtual world, which can develop the confidence and competency needed for performing these skills in the real world. This is particularly useful during periods of social distancing and restricted access, such as during the COVID-19 pandemic.

As long as VR experiences are proven to be cost-effective for healthcare providers and easy-to-use for healthcare professionals, they offer a controlled environment for patients to begin confronting real-world issues. The introduction of VR into patient care may be better facilitated by not viewing VR as an alternative therapy, but rather a technological adjunct that can help to deliver more personalised, engaging and effective care.

**Manu Sidhu**
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*Final-Year Medical Student at Imperial College School of Medicine*

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# Psych for 6th: a national PsychSoc scheme?

**Irrespective of the pandemic circumstances we have arrived in, I wonder how much our secondary school curriculum prepares us with the right awareness of illness and disease, let alone any grasp of what a mental health condition is?**

I'm sure many medical students like me, with no family background in healthcare, will resonate in our confusion of what we were really setting ourselves up for when filling out that UCAS form.

With the loom of uncertainty during COVID-19 taking away the opportunity for thousands of sixth-form students to engage in medical work experience, our Psychiatry Society committee at King's College London thought about how we could provide an experience which could provide a competitive edge in their upcoming applications.

Named Psych for 6th, we ran an initiative of interactive online workshops, tailor-made for aspiring medical students, to give a flavour of a day in the life of a medical student, through the lens of psychiatric health conditions. Structuring our content to be clinically focused, our sessions allowed students to get to grips with the style of learning they would encounter in the medical curriculum, preparing them for their journey ahead of being lifelong learners.

The first session began with a half an hour dive into the nature of five questions: what is psychiatry; what is health; what is illness; what is mental health; what is a mental illness? This open-floor discussion broke the ice over Zoom and sparked back-and-forth conversations between the students that have left even our facilitating PsychSoc committee members debating to this day.

Rather than thinking how the biology and chemistry inform the science of disease, we introduced the students to the clinical framework, of thinking through symptoms, diagnosis and management.

Showing a picture of a doctor taking notes and a pregnant lady, they brainstormed on everything they'd like to know about this patient, segueing into our main topic for the

session: history taking. The bread and butter of our practice, our PsychSoc felt it was important for these students to have a feel of what it is like to think through the structure. Splitting into two break out rooms, our committee members became actors with scenarios, and our students had the chance to each take a turn going through a part of the SOCRATES schema for focusing on the presenting complaint. “Being the doctor for that one moment felt so frightening yet empowering”

The second session built on the first, by our committee members teaching them about clinical depression in the same way we would be taught as medical students. Jotting away as if they were in our own lecture hall, we explained the condition through its epidemiology, proposed pathophysiology, presentation and treatment strategies, even touching on the differentials.

*“You treated the students as if they were your own colleagues taking part in a peer learning session. These are insights they would never have gotten otherwise, and it will really guide them in deciding whether or not this method of thinking is the one for them.”*

- Head of the Sixth Form

Breakout rooms with us as actors allowed for the students to take turns getting a bit of the psychiatric history - and us actors didn’t hold back from any threats and outbursts! Not only does this safe space gives them the chance to develop their clinic curiosity and see what is relevant to know from a patient, it helped them to see the importance of developing a strong rapport.

Feedback suggested one thing: to offer more such sessions. The impact of this has been seen in the students writing about this in their personal statements and discussing it in their recent interviews.

All twenty of our participants responding yes to considering psychiatry as a future career path proved the success of this initiative. What next? We want all the PsychSocs in on this! As KCL continues to work with schools and put on these workshops, we dream for this to become a national scheme that all PsychSocs can own and champion together, kindling the light of psychiatry from the start.

**Samyak Pandey**

# Narrative medicine: The stories we tell and the need to understand

**“Narrative based medicine shifts the doctor’s focus from the need to problem solve to the need to understand[1].”**

On a rainy Wednesday in October, I skipped an afternoon of lectures (they were recorded, don’t worry) to attend a workshop on narrative medicine.

Prior to this, I had been feeling rather lost at medical school, disillusioned with the endless workload doctors and healthcare staff around me seemed to be facing daily, and the 10-minute consultations I was holding on my primary care placement, which never seemed to be enough to fully understand. I was in a funk and I desperately wanted to get out of it. That’s why I attended, to gain perspective and maybe learn a communication skill along the way.

Narrative medicine premise is that the patient, when they recount the history of their illness, is telling you a story. Like a story you may find in a novel, it has a setting, a plot, characters, imagery – even the patient’s silences are telling. By paying close attention and deconstructing these elements, we can do a close reading, and begin to understand.

Our facilitator started the workshop by asking us to tell our own story, to describe our experience in six words. This could be playful, expressive, insightful… Normally the thought of reflecting and sharing makes my toes curl, but a non-judgemental environment helped, and I went for it. A cultural mix; figuring things out. That was mine.

We then went on to look at paintings. The paintings chosen and their artists were completely unknown to me, which actually made the exercise more approachable. What do you see? What do you not see? What relationship do the subjects have to one another?

In ‘The Doctor’ by Luke Fields, it intrigued me that some sensed unease while others saw a moment of peace and tranquillity in the

painting of a doctor by the side of a young girl in her last moments of life.

This exercise piqued my curiosity. When we were all sharing our points of view on the paintings, I began to consider how difficult it is to determine which narrative is correct, and that during consultations, the determination of fact is rarely the most important thing.

We went on to analyse a poem (my GCSE English teacher would have been proud), write about a time of unease in our lives (a candid form of self-reflection), and finally, collectively write a poem of our own.

One might class the approach narrative medicine takes, and the content of the workshop as bizarre, and wonder whether for the busy medical student, it's wasteful of their time.

However, after having engaged with the philosophy, I think it's invaluable.

My current placement is in Psychiatry and one of my favourite things about the specialty is that spending 1-2 hours with a patient is normal, and that inherently provides the time to understand context and delve into deeper issues affecting them. It's not a specialty of quick-fixes, but one where we see the incredible value in forming a strong therapeutic relationship, providing stability, and taking the time to understand.

I am finding that close reading is affecting the way I ask questions and follow leads, and consciously being in contact with my emotions during and after consultations (a cornerstone of both psychiatry and narrative medicine) have led to some surprising results. Borrowing techniques of analysis one would use more commonly in English Literature has helped me feel more connected with the patients I'm speaking to, and most importantly, remember why I chose to become a doctor in the first place.

**Gayatri Tadikamalla**
*5th Year Medical Student*

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Recommended Reading:

- Luke Fildes 'The Doctor'
- Kathe Kollwitz 'Woman with dead child'
- Julia Darling 'Sudden collapses in public places'
- Narrative Medicine: Honoring the Stories of Illness : Charon, Rita

# Movies, Myths, and Mental Illness

**Entertainment films and media are often the only source of information members of the public have access to in relation to mental health provision and care and are therefore an important educational platform[1].**

Literature has cited the finding that the portrayal of mental health within cinematic films reflects the prevailing stigmatized public attitudes towards psychiatry[2]. It can be argued that films such as One Flew Over the Cuckoo's Nest (1975) are useful in serving as historical reminders. Unconstructive television depictions of mental illness, however, can potentially override personal experience of pleasant past interactions with service users[3].

Understanding how films preserve and propagate stigma via stereotypes has important implications for public policy[4]. For example, Schizophrenia is the ninth leading cause of disability in the world and media analysts have criticized movies for their overrepresentation of schizophrenia with violent and unpredictable behaviour[5,6]. The association between mental health and criminality aids to only engrain the falsehood that all psychiatric service users are difficult and unrewarding to treat, in contrast to patients with physical disease[7]. Not only has research repeatedly found mental illness is not necessary to cause violence but more often, people with severe mental illness are in fact the victim of violent crime rather than the perpetrator[8,9]. A meta-analysis of 41 films depicting Schizophrenia found that of 42 characters in the movies analysed, 35 displayed some form of violent behaviour, from which 13 of these engaged in homicidal behaviour[1].

Cinematic films often focus on characters with schizophrenia experiencing vivid visual hallucinations when in reality negative systems such as affective flattening and avolition predominate[10,11]. A Beautiful Mind, (2001) a bibliographic adaption, supports this misrepresentation where the salient symptoms of the lead male character John Nash are

his hallucinations. A Beautiful Mind, however, can be congratulated for many artistic achievements, including educating the public on aspects of schizophrenia such as the character's struggle to adapt and his ability to regain normality and function[12]. The public may, however, be misled by his ability to overcome his psychosis by simply ignoring his hallucinations. Although this may have been true for this one individual, many patients are unable to do so[12].

Exploring the portrayal of mental illness within media platforms, inclusive of the portrayal of psychiatrists and the stigmatisation of mental illness allows us to acquire a deeper insight of the challenges psychiatry faces. The influence of film media on undergraduate medical students' attitude towards mental health is still largely unexplored. For this reason, the use of film in medical education is now increasingly offered to medical students as an elective/student selected component to highlight the importance of social and cultural context of mental health[13,14]. The notion that perhaps media and film portrayal of mental illness supports these prejudicial attitudes may not only begin to help explain less effective national campaigns but more importantly give a starting foundation to build positive attitudes towards psychiatric treatments, not only by the general public but future clinicians alike. The latter notion allows us to proposition how medical education and the Royal College of Psychiatrists may work towards reducing these falsehoods directly decreasing stigmatization of mental illness.

If you too are interested in the portrayal of mental health within media I recommend contacting your University PsychSoc, who may hold film nights with subsequent time for discussion. Films I most recently watched and recommend include: The Machinist (2004, Sleep Disorder), Flight (2012, Substance Use Disorder), Iris (2001, Dementia), Silver Lining Playbook (2012, Bipolar Disorder) and Still Alice (2014, Alzheimer's Disease).

**Patricia Vinchenzo**

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# From the Editors

## Nikki Nabavi

Nikki is the new PTC Medical student representative, sitting on RCPsych committees such as the Choose Psychiatry Committee and the Psychiatric Trainees Committee. Her role includes liaising with medical students and PsychSocs across the UK, and helping edit issues of FuturePsych.

Nikki is a medical student at The University of Manchester, who has recently taken a year out between her third and fourth years to take on her role as BMJ Editorial Scholar 2020/21, which included heading up operations for BMJ Student, looking after all the content for students and junior doctors; such as writing articles, editing student content, discussing pitch ideas, leading on social media, and planning and hosting the student podcast, Sharp Scratch.

Nikki was awarded The Royal College of Psychiatrists' North West Division Medical Student of the Year 2019, and has been Co- President of UoM PsychSoc, running events such as a National Psychiatry Summer School in July. Her interests include mental health and wellbeing, public health, medical ethics, and medical journalism.

You can get in touch with Nikki via twitter (@nikkixnabavi) or by email (nabavinikki@gmail.com).

## Stephen Naulls

Stephen Naulls is the new foundation doctor representative for RCPsych Committees such as the Choose Psychiatry Committee and the Psychiatric Trainees Committee. His role includes liaising with other foundation doctors across the UK with an interest in psychiatry and mental health, and helping edit issues of FuturePsych. Stephen will be editing the upcoming issue of FuturePsych, so please send any submissions to him at careers@rcpsych.ac.uk

Stephen is an FY2 based in East London, originally from Grimsby. Before joining the PTC, he spent two years as the deputy chair of the BMA medical student committee, where he led on initiatives relating to mental health and EIC. He hopes to use his time on the PTC to build a better network of communication with foundation trainees and continue to build on the momentum brought about by campaigns including Choose Psychiatry.

**Would you like to submit an article to the next edition of FuturePsych magazine?**

**We welcome artwork, reflections, case studies, opinion pieces, reviews, elective reports, and interviews.**

**Please email submissions to: careers@rcpsych.ac.uk**