



The Student Associate Magazine

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future Ψ



*AT THE END OF THE DAY THERE IS NOTHING,
NOT EVEN SILENCE LEFT, HEART HEAVY WITH
THOUGHTS.*

*ALL DAY LISTENING AND LEARNING AND
LOVING; AND IT RUNS DRY. DRY AS THOUGH
ALL THE LOVE IN THE WORLD WAS WRAPPED
UP IN THOSE MINUTES, THE AIR PREGNANT AS
YOU LISTENED, EACH MOMENT GAPING WITH
MEMORIES.*

*IT'S HARD TO EXPLAIN WHAT IT FEELS LIKE
TO ASK THOSE QUESTIONS, THE PERMISSION
YOU'RE GIVEN, THE GENTLE FLUTTER AS YOU
EXAMINE THEIR DEEPEST THOUGHTS. MORE
INTIMATE THAN THE NAKED BODY OUR
THOUGHTS ARE MORE GUARDED, LESS
MENTIONED.*

*THAT FEELING AS ALL YOUR CONCERN RUNS
TO THEM, LIVING THEIR MOMENTS, FEELING
YOUR WAY INTO THEIR LIFE; THEN STEPPING
BACK, MOVING ON, NEW FOLDER, CHANGE
GEAR. LONGING TO KNOW MORE, TO
UNDERSTAND... THEN HAVING TO GO.*

*SHOWING YOUR HUMANITY WHILST
REMAINING SEPARATE.*

*WANTING TO GIVE ALL YOU HAVE, BUT NOT
FULLY ALLOWED. LEAVING PART OF
YOURSELF EVERY DAY UNTIL YOU'RE WORN
OUT.*

*HOLDING BACK TEARS; THEN WILLING THEM
TO COME...*

AS LIKE A WAVE, THE SALT CLEARS THE DAY.

**A reflection by
Rebecca Horton, UEA**

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Editorial

Ellisiv Clarke, Editor

Tireless efforts from the Royal College have changed the public face of psychiatry and mental health in the past six months, with the launch of the #ChoosePsychiatry campaign making national headlines.

This edition of FuturePsych explores the theme of transformation further. One student from UEA reflects in detail on the transformative power of her psychiatric placement, whilst a Newcastle fifth-year describes the ongoing changes to gender identity services.

Closest to home, we begin with an introduction to the newly inaugurated Professor Wendy Burn, President of the College.

I would like to thank everyone who has submitted to FuturePsych; creating a good magazine is so much easier with such high-quality content.

Happy reading!



Elle is currently in her fifth year at Newcastle University, where she is undertaking a Masters by Research in Epidemiology. Her research project will study substance abuse in families and its effect on child health outcomes.

Elle is the current Medical Student Representative on the Psychiatric Trainees Committee.

Cover artwork by Guy Undrill

Guy is a consultant Psychiatrist working in acute psychiatry (In-patients and a Crisis Intervention and Home Treatment team) for 2gether NHS Foundation Trust.

Guy is also an Honorary Clinical Lecturer at the University of Bristol, SW Division representative for the Education and Training Committee at the Royal College of Psychiatrists, a member of the Motivational Interviewing Network of Trainers and picture editor for The Psychiatric Bulletin. Guy was the Royal College of Psychiatrists 'Trainer of the year' in 2013.

Meet the President

Professor Wendy Burn

Welcome to FuturePsych. I am really pleased that you are reading this and are considering a career in Psychiatry. *I have been a psychiatrist for over 30 years* and have had a fantastic time, *every day is different and I still meet situations that are new to me*. And what can be more rewarding than making a depressed and suicidal person happy or returning someone with paranoid delusions to reality?

You will be entering Psychiatry at an exciting time. Neuroscience research, often led by psychiatrists who also practice clinically, is advancing fast. We are behind the rest of medicine as the brain is the most complicated (and of course the most interesting) organ in the body, but it won't be long before we catch up.

The physical basis of some of the illnesses that we treat will be understood and the stigma of becoming mentally unwell will lift.

This doesn't mean that we will become Neurologists. Although we are likely to work more closely with them, there will always be a need for doctors who are trained in psychological and social interventions as well as physical ones.

We have already had huge help in reducing stigma with the interest taken in Mental Health by the Duke and Duchess of Cambridge and Prince Harry. I recently met them at an event celebrating World Mental Health Day at Buckingham Palace and they are really committed to improving things for our patients. We are going to talk more about how this can be achieved.

During the same evening, I also met Stephen Fry who is keen to help and to meet medical students in the hope of inspiring them to become psychiatrists.

He will be speaking at event titled "Brain, Mind and Body in the 21st Century" at Barts and the

London School of Medicine on 6th February 2018 from 16.00 to 20.00.

There will also be talks on neuroscience and a career in Psychiatry. Look out for further details and how to book on the College website or email careers@rcpsych.ac.uk to reserve a free place. We are planning to offer some travel bursaries to medical students from outside London who wish to attend.

I'm anticipating that I will meet many of you there and also at the National Student Psychiatry conference 2018 in Brighton, which has a very exciting programme. I love seaside towns in the winter and am looking forward to a bracing walk along the sea front.

I hope you enjoy reading Future Psych as much as I always do. If you have any questions about a career in Psychiatry or anything else you can contact me on wendy.burn@rcpsych.ac.uk or via Twitter on [@wendyburn](https://twitter.com/wendyburn).



Ticking all the boxes

Exploring the future of non-binary care

Kathryn Bell, Newcastle University

Your patient discloses to you that they:

- Are uncertain about their gender
- Feel neither entirely male or female
- Are looking for support to transition

You could find yourself in any of these scenarios, and not just within the realms of psychiatry. As clinicians, we are taught to listen to our patients, understand their needs and provide personalised care. The question, however, remains: are we really willing to listen?

From the 1950s, hormonal and reconstructive measures were becoming available for transgender people.

Shockingly, until the early '80s, categories such as economic stability, social standing, marriage/heterosexual relationship and spousal "unawareness" of their trans status, were the hallmarks of successful treatment.

In more recent times, our patients have led us to provide a free, accessible and non-discriminatory service – **Gender Identity Clinics**. Current standards of positive outcomes include: function to equal that of the natal man/woman (including orgasm), "satisfactory" aesthetic results and access to other emotional/social support which includes gender literacy coaching and voice therapy.

One of the greatest challenges non-binary and genderqueer people face lies within the structure of care; *some are having to state that they are "more trans" than they feel in order to access services, and in the process, receive treatments they did not want.*

Some within this community believe that GICs lack adequate knowledge about their requirements and that professionals lack confidence in advocating for combinations of male and female hormones and bodily characteristics. It's true that there just isn't the same foundation of research evidence for non-

Gender identity A person's perception of their gender, either congruent or incongruent with their birth sex.

Gender expression The way someone expresses their gender identity e.g. by appearance, dress, and behaviour.

Gender role The role/behaviour deemed normal by societal and cultural norms, and appropriate to gender.

Non-Binary Identify with neither, both, or a combination of conventional gender distinctions.

Genderqueer A non-binary identity which can be combined with binary identifiers (a less restrictive term for gender).

M-F Male to Female transition.

F-M Female to Male transition.

Dysphoria The experience of discomfort/distress resulting from a mismatch between biological sex and gender identity.

GIC Gender Identity Clinic.

binary transitions as with M-F or F-M transitions, *but pressure to conform to a binary transition* (as a compromise for the treatments required for a safe and comfortable gender identity) *is a source of clinically significant harm.*

As clinicians, we aim to work to a standard which minimises harm. The shifting age of patients seeking gender identity support highlights the urgency of treatments pre- and peri-puberty, which can cause irreversible and dysphoric changes. Despite this change in service seekers, waiting times for GICs can stretch to years. The result is delays to and hesitancy to initiate hormone therapy, ultimately missing opportunities to prevent damaging pubertal changes. Resources for GICs are scarce, but increasing accessibility would be advantageous and limit patient suffering in time-pressured cases.

For individualised treatment, clinician awareness of the origins of dysphoria, crossing both visceral and social paradigms, is imperative to the alleviation of dysphoric experiences.

For example, deciphering between dysphoria rooted in the physical attributes of the gendered body vs. in response to societal interpretations of gendered characteristics, allows for patient centred treatment.

Societal marginalisation of this community can be scrutinised as the most heavily contributing factor to the high rates of ill health in this demographic. Not only does marginalisation increase the likelihood of anxiety, depression, substance misuse and violence, but it is self-perpetuating: encouraging stigmatisation, social isolation and raising barriers to health services.

In addition, for a patient seeking a non-binary transition, pressure to conform to social norms in trans identities increases marginalisation of non-binary people even further.

Together, we can take steps to reduce marginalisation and discrimination. ICD-11 (due 2018) plans to de-psychopathologise gender non-conformity by redefining trans status, previously a disorder, to a less stigmatising description.

The role of the future clinician:

- Promotion of equality through education and advocacy in both society and the profession to remove barriers to healthcare.
- Willingness to involve ourselves in evolution of the service through innovation and enterprise (and perhaps a little help from virtual clinics) with the needs of our patients in mind.
- Encourage authentic and informed decision making while preserving people’s dignity and autonomy.
- Above all, be supportive! Supporting someone to be their most authentic self may be the most rewarding thing you can ever achieve.



Kathryn is a fifth-year medical student at Newcastle University. She nurses a keen interest in gender services, and hopes to work in this area in the future.

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Quickfire Careers

Experience of junior teaching fellow posts in psychiatry

Psychiatry Teaching Fellow posts allow junior doctors the opportunity to gain experience in both medical education and clinical psychiatry.

Post holders are assets in delivering and developing undergraduate medical education, and as such are enabled to gain valuable educational experience, improving their teaching skills and often undergoing postgraduate study, whilst also delivering clinical care.

Dr Helen Hargreaves talks to Dr Farah Hussain and Dr Tim Strange about their experience as junior teaching fellows in psychiatry.

H: Tell me about your training to date. Were you always interested in psychiatry and/or medical education?

F: I was interested in psychiatry but was unsure about fully committing to the speciality, so when I saw that this post combined psychiatry and medical education for 12 months, I thought it would help me make a decision about my future career plans.

T: Having finished my foundation training I remained unsure regarding future career aspirations - I was yet to find a speciality that excited me. Psychiatry attracted me in that its approach is more holistic. I found that this not only extends to patients but also to trainees. Indeed, the speciality encourages trainees to have a broad array of interests and they value life experience outside of medicine.

H: What was your experience of teaching prior to your teaching fellow role?

T: Foundation training afforded me formal and informal teaching opportunities mostly focussing on clinical skills. The students also shadowed me as a junior doctor in their final year. It was always something I enjoyed but had not considered as a career option at this stage.

F: I was mainly involved in teaching students on the ward about certain conditions and then helping them with clinical exams and histories.

H: What do you enjoy most about the role?

T: The variety of the job affords freedom to develop both within psychiatry and medical education. In particular I enjoyed integrating technology within the delivered teaching, something which has received great feedback and we are looking to present at a conference.

F: The fact we have dedicated time to develop teaching for medical students and have the independence to create new and innovative ways of teaching the curriculum. It also allows you to gain a lot of transferable skills, alongside completing the post graduate certificate and presenting at conferences.

H: What attracted you to a teaching fellow post in psychiatry?

F: I always had a liking for psychiatry, and my foundation training highlighted to me how much it assimilates with all specialities. In terms of medical education, I always enjoyed teaching medical students that came onto the ward and helping out with OSCEs, and knew it was something I wanted to pursue in the future.

T: As a junior doctor, I often felt like a small cog in a big wheel and service provision can naturally take precedence. The job as a teaching fellow looked an exciting opportunity for freedom to think and to put into perspective recent experience and inform future direction.

H: What are your typical commitments?

F & T: Clinical work is 1.5 days a week and medical education the rest of the time. We are well supervised clinically with roles in community and inpatient teams.

Our medical education role mainly involves developing, delivering and evaluating undergraduate teaching sessions, and completing the postgraduate certificate in medical education.

There is also a great deal of freedom for creativity in the form of developing innovative projects.

H: What are your future plans?

T: I am looking to diversify my skills and complete a Masters degree, likely in medical anthropology with a focus in mental health, and then return to psychiatry and teaching with a view to hopefully apply for an academic teaching fellow post.

F: To pursue a career that is heavily involved with medical education.

H: What advice would you give to somebody interested in medical education and psychiatry?

F & T: Apply to a teaching fellow job!



Helen Hargreaves, Senior Teaching Fellow, NTW NHS Foundation Trust (twitter: @helenhargreav10), **Farah Hussain and Tim Strange**, Junior Teaching Fellows, NTW NHS Foundation Trust (Farah.Hussain@ntw.nhs.uk; Timothy.Strange@ntw.nhs.uk , twitter: @MedEdTim)

Reflection

Cobwebs, compassion and our grip on reality: A virtual ward round

By Rebecca Horton, UEA

A medical student reflects on her psychiatry placement. Patient details have been changed for confidentiality.

I began my psychiatry placement with many questions, and left with a whole new set. The symptoms I'd been reading about seemed so tightly bound up in relationships, worldview, personality; I had absolutely no idea what to expect.

How could I balance the need to be both professional and compassionate? How much was fair for me to ask? How could I know if what I felt was mine or theirs? How could thought become pathological? And how much did I consider what really mattered to my patients?

Here are some reflections on what it was like from where I was sitting...

He's crouched in the corner, and when I approach him he shrinks back a little. Black jeans, oversized hoodie, anxious expression. He tells me he speaks five languages, he's worried he's big headed, he knows they are talking about him, he hears them. Occasionally he breaks our conversation and stares, and talks to someone behind me.

He seems to have forgotten I am in the room and I'm left watching the fast changing emotions play across his face, listening to a conversation in which I do not play a part. The moment gapes as it hits me that maybe our grip on reality isn't so fixed as I'd imagined. And that realisation leaves an aching sense of vulnerability.

"What you had was a psychotic episode. Do you understand what that means?"

Psychosis is a condition where you lose touch with reality.

Not knowing what is true.

Hearing voices. Unable to think straight.

You could try to imagine it, but perhaps you don't want to. I know that I don't. Imagine being bombarded with 10 voices at once, imagine having no idea which one is real, and not being able to respond to any of them. Imagine not being able to trust your own mind.

You examine their thoughts; "Do you feel like your thoughts are your own?" "How is your mood?" each question helping you piece together their experience. And what they tell you is precious, like a gift you're hesitant to accept, too valuable, not quite believing it's for you. It's like accepting a cobweb, you unravel it with them; too much and it will break, not enough and the pattern remains a mystery.

And the beads of their story are strung out along the cobweb, and you hold them gently and try to understand, and you see where their illness started to seep into their life. And sometimes it's sad, but sometimes it isn't. And you want to grasp what is good. And the rhythm of their thoughts dances through your mind.

The tempo changes as you reach the next patient, slotting in line with theirs. She's slight, shy, seems unsafe. You ask after her dreams; "What happened last night?" and the pause draws out her thoughts. The air is stifled, we sit side by side, she fiddles with a piece of a puzzle. You watch as the cardboard turns in her fingers. "I don't know". Comes the answer. Your eyes meet as you wait.

An 18 year -old walks in with her daughter in a pram, "I don't want to bring her to a mental health place" she says. She tells me of her life in care, she wants to be a good mother, but her cleaning has got out of hand. Sweat drips down the nape of my neck as I try to make sense of what she is saying, but her words seem to come faster than my ears can receive them and they build up in the air between us like a house of cards. "I know it is senseless but I need to, I must, I can't stop". And all you think is how you really really care and in that silence, you hold their thoughts.

When a symptom affects so much of someone's identity, asking questions feels almost like an invasion. And the pauses hang heavy in the air.

AN 80 YEAR -OLD WOMAN WITH A COUGH
 A 22 YEAR -OLD MOTHER WITH AN ACUTE ABDOMEN
 A 45 YEAR -OLD TEACHER, ADMITTED AFTER A SUICIDE ATTEMPT
 A 16 YEAR -OLD GIRL, WITH FLASHBACKS AFTER BEING RAPED
 A 30 YEAR -OLD BUSINESS OWNER, SURE SHE WAS BEING TRACKED BY AN AGENCY.

PNEUMONIA, GALLSTONES, DEPRESSION, PTSD, SCHIZOPHRENIA.

BREATHLESS, IN PAIN, HOPELESS, DESPERATE, TERRIFIED.

And how much do we consider what really matters to our patients? How much do we really know about them? Do we know what they care about at the end of the day, how they see the world, what they hope for, what they consider valuable? And perhaps those things are not truly ours to know. But maybe, just maybe, we slip into reducing them to their age and condition.

And I wonder; how often do we stop to think about who they are. You try to balance being relational and being objective. *Feeling your way into their life, then stepping back, moving on, new folder, change gear.* In those moments you care for them, deeply. You block out the details in the busyness of your home life... but when you're sitting down quietly your mind is pulled back into their lives. Realising you'd forgotten gives a jolt of guilt; but how am I even supposed to feel?

In the morning there are more patients, more lives, more stories. Each time you listen it's like riding their thoughts, as though they were waves, the tide of their emotions pulling you as you try to figure out what has gone wrong. You skim

through textbooks in your mind to match it, whilst still listening as a fellow human. *Empathise, categorise, empathise, categorise. Then comes the time to step back, change gear. Next.*

And the next patient walks in and you clear your mind, shovelling thoughts to the side for later. Where is the line between your feelings and theirs? How can you know if you understand or if you're going on your own preconception? So, you try not to see them as a folder, remember who they are, remember who you are; and you are both very valuable.



Rebecca is a fifth-year student at Norwich Medical School, where she is currently intercalating in molecular haematology.

Rebecca is from Hertfordshire and has two sisters. She spends her spare time practising ballet, cycling and writing.

Rebecca's Christian faith plays a big part in her life and medical reflections.

Holistic Medicine for the Curious

Experience of a Foundation Year 1 Doctor in Psychiatry

Dr John Carroll (Foundation Trainee)

Psychiatry made my foundation year 1. During my first eight months as a newly qualified doctor I rotated through what was originally set to be a full 12 months of medicine and surgery. It took under half that time to anticipate I would soon desire a change of setting. Through an internal swap with a colleague, I secured a psychiatry job for my third and final rotation.

As a foundation trainee at King’s College Hospital, my psychiatry rotation was attached to South London and Maudsley (SLaM), who provide the widest range of NHS mental health services in the UK. *From the outset, the high quality of training available to psychiatry trainees was striking.*

As a foundation trainee at SLaM I benefitted from an excellent induction programme split over three days. This was comprised of interactive lectures, psychiatry simulation and physical safety training. In addition to the induction, I received a monthly half-day of teaching which encompassed history taking, risk assessment, psychopharmacology and psychotherapy. Each half-day included an hour of facilitated group reflection where foundation trainees discussed challenging cases with one another.

Aside from this formal training, SLaM also runs a successful peer mentoring scheme. All foundation trainees are paired with a psychiatry trainee for informal support and advice. Matched according to location and interests (both within and outside of psychiatry), we were encouraged to meet once per month. *This was a truly invaluable opportunity and I especially benefitted from careers advice.*

AM	09:30 Screening	09:30 Screening	09:30 Screening	09:30 Screening	09:30 Screening
	11:00 Clinic	11:00 Multi-disciplinary meeting	11:30 Journal club & grand round	11:00 Home visits	11:00 Clinic
PM	13:00 Clinic	13:00 Clinic	13:00 Home visits	13:00 Teaching	15:00 Supervision
				14:00 Audit / Tasters	

Figure 1: Example of a general adult psychiatry (community) weekly timetable in foundation year 1.

The job itself was general adult psychiatry based in a community assessment and liaison team. I worked as part of a dedicated group of community psychiatric nurses, a GP trainee and two consultant psychiatrists. *It was refreshing to work in such a friendly environment, which felt less hierarchical than most medical settings.*

My working week offered great variety (see Figure 1). Each morning started with a screening meeting during which all referrals from the day before were discussed and prioritised. After this, I benefitted from patient contact supervised by different team members in addition to my own list of patients who were stable enough to see on my own.

My timetable incorporated activities at the Institute of Psychiatry, Psychology & Neuroscience (IoPPN) which is attached to SLAM. During term time, they run a weekly journal club, where a psychiatry trainee presents a research paper for critical appraisal, and a grand round in which interesting cases are discussed. In addition to all of these educational opportunities, I was given permission to attend some of the formal teaching for the psychiatry core trainees. I was very impressed with the standard of these lectures, often delivered by world experts in their field and on such a diverse range of topics covered within the psychiatry curriculum. *The core trainees I met seemed stimulated and happy with their career choice.*

Perhaps one of the strongest advantages of psychiatry training is the 1-2-1 consultant supervision. *Every trainee receives a protected weekly hour of face-to-face supervision with their consultant.* This is a chance to ask clinical questions, receive teaching and feedback, and help highlight areas the individual trainee would like to develop. Unlike other medical specialties, this ensures psychiatry trainees get high quality guidance from the start.

My foundation year 1 job in psychiatry was a great experience and left me wanting more. A four-month job was enough to demonstrate that

psychiatry offers an exciting and varied career, encourages curiosity and focuses on treating the patient as a whole.



John is an FY2 doctor in South Thames Foundation School. John enjoyed psychiatry at medical school but is now fully committed after a great experience in his FY1 job. He is currently applying for core training and is excited to start a stimulating and varied career as a psychiatrist.

Dispatch from Sheffield

Benefits to 'mentorship'

Medical student perspective

Eleanor Shaw

My six-week student selected placement with the early intervention service (EIS) has been an incredibly enriching and valuable experience for me as a medical student.

I opted to do a psychiatry based placement due to a long-standing fascination with mental health which has developed throughout medical school. I hoped that the placement would assist me in identifying whether psychiatry would be a career I would like to pursue and give me some insight as to what the training involves.

I was fortunate to have the chance to shadow a core trainee, Dr Fearnley, throughout the placement. This gave me a good idea of some of the things involved in training and was really useful in helping me to feel integrated within the team and provided a varied experience. The most interesting part for me was shadowing a weekend on-call shift.

During this I was able to join Dr Fearnley in reviewing some patients in seclusion.

I had never seen such an acutely unwell patient and whilst I found it quite shocking and could see the patient was distressed, I felt privileged to have been involved.

This was because I had never had the opportunity to take part in assessing and interacting with a patient experiencing such acute psychotic symptoms before.

I was also able to shadow Dr Fearnley assessing and reviewing patients in the community. Through observing his consultations and talking through cases, my confidence increased enough to begin leading consultations myself.

This was very valuable as it refreshed my psychiatric history taking skills and allowed me to have a more 'hands-on' role.

I really enjoyed being able to speak to many different patients as I feel that sometimes medical students are limited in how involved they are in patient care due to the sensitive and sometimes high-risk nature of the discussion.

I joined the nurses on home visits in the community which helped me get a more holistic picture of people's lives.

Spending time with psychologists and CBT therapists also enabled me to gain a full picture of the multidisciplinary team (MDT), thus allowing me to gain a real understanding of what EIS can offer and how it can benefit patients.

Overall, the placement was a fantastic experience and I really am grateful for all the effort that all the staff and especially Dr Fearnley put in to make me feel welcome and part of the team.

I genuinely feel as though I 'learnt something new every day' and feel very fortunate to have had some fairly unique learning experiences and opportunities throughout.

Core trainee perspective

Dr Edward Fearnley

Supervising Eleanor over the six-week placement presented several challenges but was an enjoyable experience. I was given the day-to-day responsibility for her supervision.

As aforementioned, we reviewed many patients together, with Eleanor often taking focused aspects of the history. For example, this included a medication review and personal history.

Likewise, Eleanor presented a case at MDT for discussion. She has shadowed care coordinators during difficult home visits, further integrating her within the team. Eleanor also wanted to

experience inpatient psychiatry, so we organised for her to be on call over a weekend.

This provided an opportunity to review patients in seclusions, clerk admissions and experience a variety of medical and psychiatry emergencies. I also organised for Eleanor to observe electro convulsive therapy and to attend an ECT training day in Sheffield.

On reflection, I believe that the serendipitous opportunity to supervise a medical student has provided me with a variety of skills.

I now feel more confident to create, collaborate and review the specific learning needs of students. The context of the perennial psychiatry recruitment crisis is an issue that I am also mindful of and sense that good undergraduate experiences can provide part of the solution.

This has already been demonstrated via the advent of mentoring schemes, such as those created in Liverpool(1) and the Psychiatry Early Experience Programme Sheffield (PEEPS) run with Sheffield Medical School.(2)

Work is therefore clearly being done and the causes and solutions to recruitment and retention are multi-factorial.

And while anecdotes are not statistically significant, they do illustrate that individual teams and trainees have the capacity to invest more into the overall student experience.

Exposure to a positive, modern and varied 'buffet' of psychiatry is vital to counter negative stereotypes and to cement the specialty within the mainstream undergraduate curriculum.

This may appear superficially cumbersome in the context of community psychiatry, but this article attempts to provide a working example of how this is easily attainable.

In conclusion, I felt supported by the EIS clinical leadership as I transitioned into becoming a supervisor, and was able to use my own consultant-trainee supervision time as an environment to discuss my performance.

It was also encouraging to witness Eleanor's confidence and clinical skills develop during the placement and I hope that she feels encouraged toward a future career in psychiatry.

REFERENCES

(1) Psychiatry Buddy Scheme: Linking Medical Undergraduates with Core Trainees, PTC newsletter, (p8), Declan Hyland, June 2012. (2) <http://www.rcpsych.ac.uk/workinpsychiatry/divisions/trent/enewsletters-trent/enewsletter-summer2016/psychiatryearlyexperiencepr.aspx> (Accessed 29/11/17)



Eleanor is a 4th year medical student studying at the University of Sheffield. She has nursed a keen interest in psychiatry since the beginning of medical school and hope to train in the area. Eleanor is heavily involved in delivering high quality sex education to young people with Sexpression UK.

Adverse event reporting in behavioural intervention

By: Katharine Manning

The benefits of behavioural interventions are widespread throughout a range of health complaints¹; however, we need to be aware that treatments are not always both “psychoactive and harmless”.

At present, it is estimated that 5% of psychotherapy patients experience negative or harmful results².

This can be due to anything from inappropriate therapeutic method to unsuitable patient therapist pairing. In clinical medicine, there is always a degree of uncertainty when we intervene, leaving us in danger of underestimating the consequences, and the support that will be required if we do not appreciate that adverse events may occur³.

The term adverse events covers all untoward medical occurrences from a rash or feeling increasingly irritable or tired, to those categorised as serious and unexpected such as sudden death. These are widely recognised and reported within pharmacological clinical trials⁴ due to strict definitions and reporting guidelines².

However, these definitions and guidelines do not exist for clinical trials with psychological interventions.

I conducted data extraction as part of a student selected component of a research attachment, this demonstrated that only 60%^{5,6,7,8,9,10} of trials gave some indication of recording adverse events, mirroring results of B.Vaughan¹¹. Only 1 of these studies assessed for relatedness when the event was deemed serious⁷. This means that there may be a huge spectrum, ranging from not recording this information at all to recording everything, including unhelpful data.

For example, if a patient had an allergic reaction whilst receiving psychotherapy, or were to break

their leg, it would be generally be considered unlikely that these events would be clinically relevant to the trial. However, it seems many studies that do record information include outcomes such as these.

Of those which recorded serious adverse events, only 1/3 showed they had made some form of expectation assessment before conducting the trial^{9,10}.

This shows a lack of consideration before conducting clinical trials as to potential adverse events that could occur.

All of this raises questions around the attitude of researchers towards behavioural therapy. Despite our understanding that treatments are not always both “psychoactive and harmless”² for many clinical trials there appears to be an assumption, based on the lack of recording, that there will be no harm caused by interventions.

Indeed, there could be a lack of awareness that there could be negative consequences as a result of therapy.

Ultimately, this is a matter of patient safety. In order for a patient to provide informed consent, consideration of both the positive and negative effects associated with the treatment, are required. However, if researchers are not recording this information, there is no way for providers to relay this information to their patients. This begs the question of whether there should be stricter guidelines regarding the reporting of adverse events in psychotherapeutic trials and other non-drug trials.

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Katharine is in her second year at Sheffield Medical School.

She is particularly interested in the mental health of young people and likes to keep herself active through lacrosse, skiing and walking in the Peak District to fuel her own mental wellbeing.



Psychiatry Early Experience Programme
Sheffield

Abiramie Ravindiran, Sheffield Medical School, South Yorkshire

Aim of PEEPS

The stigma associated with mental health alongside the lack of psychiatric exposure, throughout medical school, continues to contribute to the recruitment crisis in psychiatry.

Consequently, PEEPS aim to give medical students early exposure to psychiatry beginning in the first year of their medical training.

Throughout the 5 years of their degree, Phase 1 medical students are attached to a Core Trainee in South Yorkshire for a shadowing placement once every six months. This provides students the opportunity to shadow the trainee throughout their full training to maximise the range of psychiatric exposure students gain.

More importantly, this will increase their confidence when dealing with psychiatric problems in their future careers.



Beginning of PEEPS

The PEEPS project was founded in 2015, by Consultant Dr Helen Crimlisk, undergraduate lead for psychiatry at Sheffield Medical School, and Dr Gaelle Slater, ST5 trainee at the time. The first PEEP project was piloted by the Maudsley and Kings College London. However, both, Dr Crimlisk and Dr Slater, passionate about promoting psychiatry as a career, decided to set up PEEPS in Sheffield, with their initial recruitment of students in October 2015.



The recruitment of students involved an introductory talk delivered by Professor Steve Peters followed by student selection.

Dr Slater was responsible for the recruitment of medical students and trainees to be involved in the project, as spaces are limited. To ease students into the project, an introductory social and 'Psychiatry Speed Dating' event was held to provide an opportunity to network and gain further insight into psychiatry outside of the fast-paced working environment.

Outcome of PEEPS

Now going into its 3rd year, PEEPS has proven to be a promising and valuable project.

Since its commencement, the impact of PEEPS on student attitudes towards psychiatry has been continuously monitored via surveys.

Currently, there is insufficient data to comment on its effect on psychiatry specialty recruitment as students have not yet graduated, however, to date, the results have been encouraging.

Following their placements, students have shown a much more positive attitude with a heightened interest in the field of psychiatry. Thus, the introduction of PEEPS has encouraged more consultants and trainees to work together and share their journey into psychiatry with student doctors. The project has now been taken over by Dr Kelsey Fletcher and Dr Rebecca Humphries.

If any medical students or psychiatry trainees are interested in setting up a similar project at your medical school, please do not hesitate to contact Dr Slater on Gaelle.Slater@shsc.nhs.uk.



Abiramie is currently a Phase 2a Medical Student with a keen interest in Mental Health and Psychiatry, participating in the PEEPS project.

From the College:

If you're interested in what it's like to be a psychiatrist, have a look at our series of short films, available on our You Tube channel or via rcpsych.ac.uk/choosepsychiatry.



These include interviews with psychiatrists in many different specialties, an exploration of "what is psychiatry" and a series of "days in the life" of psychiatrists.



**CHOOSE
PSYCHIATRY**

Performing Psychotherapy as a Junior Doctor

By Rhema Immanuel

"I would like you to help with my skin", she said, as she took off her gloves to reveal hands covered in scars, scratches and scabs from years of picking.

It was the initial assessment with my first psychotherapy patient, and I found myself faced with numerous questions. I had read books on the subject and discussed the case at length with my supervisors. Still, I was filled with doubt about how much I would be able to help with something that was clearly a physical manifestation of something psychologically driven.

I was also worried that I would struggle with communication, especially because of her mild learning disability (LD), with which I had little experience.

Communication was initially difficult, as I soon began to realise that just asking questions did not mean she was simply going to engage with them.

My patient found it very easy to avoid talking about difficult and painful subjects like her experiences with LD and her thoughts around her skin picking.

She would easily default to talking about the play she was going to participate in and her upcoming Christmas holiday; whenever I asked her a question that required her to access deeper thoughts and memories, I was often faced with "I don't know" or "I can't remember." This was my first challenge, and in overcoming it, I learned that persevering, saying less and using silences, encouraged her to take in information, process her thoughts and articulate them.

Sometimes, my patient could not really express herself in spoken words and I had to aid her expression by enabling her to write or even draw pictures.

I found myself and my patient evolving with every session and she opened up and I learned more about her feelings and experiences.

I found that at times, I could work out the interpretations to her statements; at other times, I needed help during supervision to see it from a different perspective, and even think about how I was going to present these interpretations to her in the next session.

Before too long, I became familiar with transference and countertransference. Within just three sessions, she posed ideas of wondering if I cared for her and if miracles could happen to cure her skin. As I dealt with such ideas, I had to be aware of not falling into the easy trap of suggesting that everything would get better with time or that I could help "fix her skin", as she often phrased it.

She said several times during the sessions that she "feels different now" and that the sessions were "helping" her. I would be naïve if I said that by the end of our sessions she had nearly stopped picking her skin, but I do believe that the change in her perceptions and the awareness of deep emotions linked with this physical and very visible affliction of hers did mean that she picked her skin at least a little less.

I began to appreciate that the true uniqueness and power of my therapy was simply the fact that I provided a listening ear and a safe space to talk about and reflect on experiences and emotions, even the unpleasant ones.

From my experience, psychotherapy is the process of facilitating a person's internal dialogue and reflection with a simple modality that we all engage in everyday – conversation. Being part of this conversation has been enriching personally and professionally; has given me a glimpse into the fascinating world of the mind and the subconscious and above all has been enjoyable and fulfilling.



Rhema is currently a foundation year 2 in William Harvey Hospital.

She enjoys painting (mainly abstract) art in acrylic medium and also runs a fashion Instagram in her spare time.

FUTUREPSYCH

When	What	Who	Where
January			
27/01/2018- 28/01/2018	National Student Psychiatry Conference	BSMS PsychSoc	Brighton & Sussex Medical School
February			
19/02/2018	Transcultural SIG Conference	RCPsych	RCPsych, London
26/02/2018	RSM Career Day	RSM	Royal Society of Medicine, London
March			
28/02/2018- 02/03/2018	Faculty of Forensic Psychiatry Annual Conference	RCPsych	Nottingham
07/03/2018- 09/03/2018	Faculty of Old Age Psychiatry Annual Conference	RCPsych	Newcastle Gateshead
April			
11/04/2018- 13/04/2018	British Geriatrics Society Spring Meeting	BGS	NCC, Nottingham
13/04/2018	Gatsby/Wellcome Neuroscience Spring Conference	RCPsych	Downing College, Cambridge
25/04/2018- 27/04/2018	Faculty of Medical Psychotherapy Annual Conference	RCPsych	Cardiff
26/04/2018- 27/04/17	Faculty of Addictions Psychiatry Annual Conference	RCPsych	Belfast
May			
16/05/2018- 18/05/18	Faculty of Liaison Psychiatry Annual Conference	RCPsych	Liverpool
Spring 2018	Psychiatric Trainee Committee's Bursaries open	RCPsych	Nationwide
14/05/2018 – 15/05/2018	RCPsych's Foundation Doctors Engagement Event	RCPsych	RCPsych, London
June			
24/06/2018 – 27/06/2018	International Congress	RCPsych	Birmingham
September			
13/09/2018- 14/09/2018	Faculty of Neuropsychiatry Annual Conference	RCPsych	London
20/09/2018- 21/09/2018	Faculty of Child and Adolescent Psychiatry Annual Conference	RCPsych	Glasgow
27/09/2018- 28/09/18	Annual Medical Education Conference	RCPsych	London
October			
08/10/2018	Faculty of Old Age Psychiatry Winter Meeting	RCPsych	RCPsych, London
11/10/2018- 12/10/2018	Faculty of General Adult Psychiatry Annual Conference	RCPsych	RCPsych, London
November			
02/11/2018	Faculty of Eating Disorders Psychiatry Annual Conference	RCPsych	RCPsych, London
15/11/2018- 16/11/2018	Faculty of Rehabilitation and Social Psychiatry Conference	RCPsych	RCPsych, London