THE REGISTRAR

The Psychiatric Trainees' Committee magazine

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The Psychiatric Trainees' Committee

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Editor's introduction

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Hello everyone and welcome to the latest issue of *The Registrar*! This issue's articles covers broad and diverse topics related to mental health and psychiatry.

First up, we have an article about the National Psychosis Unit in Bethlem Royal Hospital. Amongst other things, the author discusses how the 'beauty of Bethlem' i.e. nature (in all her glory!) is conducive to mental health recovery and resilience. (If you have never visited Bethlem Hospital, I would urge you to do so. It is no exaggeration that Bethlem Hospital may very well be the most beautiful hospital in the world!)

Next up we have an intriguing article about patriarchal parental upbringing in the 21st Century. This powerful piece illustrates the impact that parental emotional abuse has on gender inequality and the development of unresolved trauma. This is a challenging topic but one that we in psychiatry cannot shy away from. Indeed, many of our patients are victims of Violence Against Women and Girls (VAWG) and we must, at the very least, be aware of the adverse consequences this type of discrimination has on mental health.

As part of our Profile Series, I have included an interview with Dr Rashid Zaman FRCPsych. In this piece, Dr Zaman talks about the importance of mentoring and how it can be the difference between a trainee realising their potential or not. Indeed, Dr Zaman has steadfastly been mentoring me since I was a medical student and was the main reason why I decided to #choosepsychiatry as my career (thank you Dr Zaman!)

The fourth article is a review of science writer Alex Riley's debut book *A Cure for Darkness: The story of depression and how we treat it*. I will succinctly say that *A Cure for Darkness* is the best book about mental health and psychiatry that I have ever perused and should be recommended reading for all psychiatrists across grades.

Next, we have an article about the benefits and drawbacks of online learning. Since the pandemic began much of our training and indeed the provision of patient care has shifted onto digital platforms.

The sixth article is about the power and perils of Twitter. Many psychiatrists, including our College Presidents (past and present), are active on Twitter and this platform has been described as a force for good. In this article, we discuss the pros and cons of opening a Twitter account.

The final article is our 'Long Read' in which our College Dean Professor Subodh Dave and our PTC Chair Dr Rosemary Gordon are interviewed about the College and PTC values and the vision they have for the future of psychiatric training and care.

I sincerely hope that you enjoy reading this latest issue of *The Registrar* as much as I have enjoyed compiling it. We welcome and encourage you to submit ideas for articles for us to consider for future issues. As always, please remember to protect your minds and your hearts.

Best wishes,

Ahmed

PTC officers' update

Dr Rosemary Gordon,
PTC Chair

Dr Sharon Holland,
PTC Vice Chair

Dr Oli Sparasci,
PTC Secretary

It is hard to believe that another year has passed, and we now have a brand-new Psychiatric Trainees' Committee. We are fortunate to have an eclectic mix of both new and experienced representatives and officers this year. So, we are really looking forward to our 2022 together and taking full advantage of the opportunities that lie ahead! We want to quickly introduce ourselves here and we hope to get to meet many of you over the next 12 months (hopefully, this might even be in person). You can see our full biographies on the PTC website.

Our new Chair, Dr Rosemary Gordon, has been a PTC Officer for two years, spending the last 24 months as our Secretary. The highlight of her time on the PTC so far has been organising last year's trainees' conference 'Breaking barriers to recruitment and retention'. Rosemary is an ST4 in General Adult Psychiatry working in southeast Scotland.

Our Vice-Chair, Dr Sharon Holland, is a relative newbie to the PTC and she has decided to keep it brief in this update in return for the times she will fail to contain her loquacity at meetings, conferences, and any other occasion that provides a platform to speak! Sharon is an ST7 in Dual General Adult and Old Age Psychiatry, currently based in Durham.

Our Secretary, Dr Oli Sparasci is an ST4 in Old Age Psychiatry, currently working in Oldham. He has been on the PTC for 2 years and thought he would test his organisational skills to the max by throwing his hat into the ring to be this year's Secretary.

The last year has been incredibly busy for the PTC and we would like to say a massive thank you to our previous Exec team; Surgeon Commander Luke Baker and Dr Shevonne Matheiken, as well as our previous divisional reps. We extend our gratitude to you all for your persistence and commitment. It was also a hugely productive year, so please do check out some of the fruits of our labour: the Trainees' Mentoring Guide and the 'You Are Not Alone' wellbeing podcasts.

This year we want to focus on local engagement with trainees. We hope that you were able to attend our CT and ST welcome events throughout England and the devolved nations. If you were too preoccupied providing high-quality care at the time, despair not for recordings are

available to view online at your convenience. We want every trainee to know who their local representative is, the role that trainees play within our College, and how to ensure that everyone's voice is heard. You can find out more about the PTC on our Psychiatric Trainees Committee's webpage and can look out for our bi-monthly newsletter in which you will find the latest information and trainee news.

As always, we would like to say a huge thank you to our fantastic editor Dr Ahmed Hankir for his dedication and devotion to *The Registrar* and for collating such a broad and diverse range of articles. Please do get in touch with any ideas or potential articles for us to consider for publication in future issues: ptcsupport@rcpsych.ac.uk.

We really want to hear from all our trainee colleagues out there in order to represent you as best we can. So please do contact us:

- Through your local representatives
- Individually via social media
- By email at ptcsupport@rcpsych.ac.uk

Best wishes,

Rosemary, Sharon and Oli

The PTC Officers

Bethlem Royal Hospital grounds

The National Psychosis Unit
– Dr Shanthuru Pirethivirajan

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Society's views towards psychiatry can often include words like 'incurable', 'depressing' and 'sad'. In all honesty, when I first joined the National Psychosis Unit (NPU) at the Bethlem Royal Hospital, I held the same views. At first glance, the picture was even more bleak as I came across patients who had been suffering from schizophrenia for decades.

After working at NPU for six weeks, I can honestly tell you the reality is very different. The Bethlem Royal where the NPU is situated is probably one

Dr Shanthuru Pirethivirajan

of the few hospitals in the world that can actually be described as beautiful, with its scenic views of nature, abundant orchards and even a museum. This environment in and of itself is conducive to mental health recovery and resilience. I was astonished by how pleasant it was to work there! I didn't go into work feeling bad for patients who might have felt trapped in dull, almost prison-like institutions – my personal view derived from the cramped and poorly lit wards I have seen prior to this placement. On a psychological level, this is perhaps the most potent cure – what better incentive to strive for the future when you can literally see the beauty of life all around you.

On a medical level, the NPU excels even further. The NPU caters to a specific kind of patient, one who is known to have treatment-resistant schizophrenia. These are people who have a long history of severe mental illness with many failed treatment plans behind them. In this regard, the NPU is almost a last resort, and it doesn't disappoint. On my first day I was blown away when I learnt how, despite suffering from side effects in the past, patients would still be treated with clozapine. Unlike before, they would be monitored so that a balance could be achieved by which they could reap the therapeutic benefits without suffering adverse consequences. This, in combination with the ward's willingness to consider trialling medications above the BNF's advisory limits where necessary, has achieved amazing results. I have seen improvements in several patients even in the six weeks I have been here. Their moods have improved and their psychotic symptoms have diminished. Most of them are engaging in more activities and their functional level has increased significantly as well as their quality of life. The NPU has changed my view of psychiatry altogether. It takes broken people and puts them back together again. There may still be some cracks here and there and 'chinks in their armour' but patients are able to enjoy life once again. Considering they once lost all hope that this would ever happen, this is a huge achievement.

Woods at the Bethlem Royal

As a junior doctor I can't say I have had much exposure of psychiatry, but I can say with confidence that the NPU is singular and special. This opinion is reinforced by my experience as a medical student in Bulgaria. Psychiatry in that Eastern European nation is more psychopharmacological and this is dictated by financial resources or lack thereof. This means the limited resources available are only offered to those who are extremely unwell. As such they are given intense pharmacological therapy and very little psychological therapy. I saw many patients admitted and readmitted, their threshold for discharge was low, so they would come in and out in an endless cycle. I remember thinking that drugs alone wouldn't and couldn't suffice, but what alternative was there? It wasn't like you could have a ward that was both pleasant to be in and encouraged people to develop activities of daily living with input from occupational

therapists and psychologists. That would take dedicated effort over several months with focus on the individual's every needs. That just wasn't possible. Right? Wrong! On the other side of the continent the NPU existed and I hope it continues to thrive for many generations to come. It is a testament to the success of psychiatric treatment that adopts a holistic approach grounded on a biopsychosocial model. Every doctor interested in psychiatry should visit here at least once, even if only briefly. My experience at NPU taught me that there is light at the end of tunnel.

Patriarchal upbringing styles in the 21st Century

The impact of parental emotional abuse on gender inequality and the development of unresolved trauma

– Miss Melissa Abi Rached and Dr Ahmed Hankir

Miss Melissa Abi Rached is a Forensic Psychology graduate at the University of Roehampton, London. Melissa also holds a Master of Science degree in Biotechnology – Forensic Sciences, and two Bachelor of Science degrees in Forensic Sciences and in Biochemistry. Her interests are in the forensic, psychology and neuroscience fields. In her spare time, she enjoys staying fit, reading and travelling.

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Violence Against Women and Girls (VAWG) (physical, sexual, and psychological/emotional) is a type of sexism that violates the basic human rights of females on a global scale. Emotional abuse, which often starts in childhood, is now widely recognised as the most prevalent form of VAWG. However, although victims of emotional abuse suffer terribly and perpetrators often evade accountability. Emotional abuse is

under-reported because this type of violence is underestimated and often overlooked (Engel, 2002; National Society for the Prevention of Cruelty to Children [NSPCC], 2021), and underestimation happens, in part, because emotional abuse is normalised by victims who are mostly women and girls. The normalisation of VAWG is propagating and perpetuating biased perceptions of sexism. The intergenerational transmission of parenting styles – which is an important contributory factor for child development – often includes gender-stereotyping norms or patriarchy. Patriarchy-based childrearing includes controlling behaviours by parents, which is more commonly enforced on females than on males (Hadjar *et al.*, 2007). Patriarchal parenting styles consolidate gender-stereotyping perceptions that undermine women's values and promote sexist attitudes and behaviours against women and girls (Finzi-Dottan *et al.*, 2006).

Hostile sexism vs benevolent sexism

Perceptions of sexism comprise two attitudes: benevolent and hostile sexism. Both attitudes mutually and synergistically reinforce ideologies and complement the subordination of women, albeit in two different ways (Cross & Overall, 2018; Glick & Hilt, 2000; Hammond *et al.*, 2018). Perceptions of hostile sexism are characterised by overt aggressive attitudes and beliefs against women and girls and are endorsed by men in misogynistic cultures. Benevolent sexism, however, generates perceptions of sexism by discretely promoting patronising beliefs about women. Therefore, when benevolent sexism is being applied, people are less likely to recognise it (Barreto & Ellemers, 2005). The consequences of benevolent sexism, however, can be just as egregious as more blatant expressions of gender-based discrimination (i.e., hostile sexism), if not more so.

Research question and results

Patriarchal parental control and emotional abuse may facilitate the development of unresolved trauma in children, more significantly in females (Dutra, 2009; Ramos *et al.*, 2020). Limited research has been carried out on the influence of parental emotional abuse. We, therefore, conducted a study to investigate if parental emotional abuse influences the perception of sexism and gender stereotyping in males and females, as well as the development of unresolved trauma. Participants (158 women and 30 men) were recruited via social media platforms to complete online questionnaires assessing experiences of parental emotional abuse, control, trauma, misogyny, and perceptions of sexism.

The results of our study show that our participants are generally more highly educated than their parents. It is expected that the higher the level of education in a population, the lower the levels of irrational and illogical thinking there are amongst them. Most participants in the study are university graduates; yet the responses reveal that many participants were confused about gender equality and female empowerment – especially in traditional contexts related to patriarchal norms. The findings of our research indicate that misogynistic culture and male gender predicted for hostile sexism, whereas emotionally abusive experiences, irrespective of gender, predicted for benevolent sexism. Our study further shows that parental emotional abuse and control in females predicted for unresolved traumatic experiences, and that female gender correlated with, and was a significant predictor of, emotional traumatic experiences (i.e., unresolved symptomatic traumas were more prevalent in females).

Conclusion and future directions

The intergenerational transmission of patriarchal parental styles continues to influence perceptions of sexism and the perpetuation

of gender inequality. This study – which is the first of its kind – on the impact that emotional abuse related to patriarchal parental styles has on victims revealed that female participants reported higher levels of loss of autonomy and unresolved trauma compared to males. Patriarchal upbringing and societal misogyny more broadly are associated with an increased likelihood of developing perceptions of hostile sexism in males compared to females. Both males and females, however, are likely to normalise benevolent sexism resulting from emotional abuse related to patriarchal nurturing.

Raising awareness of the role that emotional abuse related to patriarchal parental style plays in gender inequality and on the development of unresolved trauma may be an effective preventative public health initiative. Testimonies from survivors who harness the colossal power of storytelling can inspire a cultural revolution to banish sexism in all its different guises and can help to improve the mental health and wellbeing of victims, potential or otherwise. A future intervention study can be carried out on participants who apply patriarchal parental styles that can measure sexism and trauma symptomatology before and after exposure to a talk delivered by a survivor. Given that we are living in the digital era, the talk can be held online, scaled up and disseminated to audiences worldwide. Such an intervention can help to humanise survivors and, through identification, help facilitate emotional engagement (parents themselves have been victims of patriarchal upbringing). This may help reduce gender inequality and promote positive mental health outcomes. In summary, to promote gender equality and to reduce the development of unresolved trauma resulting from emotional abuse, the patriarchal parental cycle must be broken.

References

Barreto, M., & Ellemers, N. (2005). The burden of benevolent sexism: How it contributes to the maintenance of gender inequalities. European journal of social psychology, 35(5), 633-642. https://doi.org/10.1002/ejsp.270

Cross, E. J., & Overall, N. C. (2018). Women's attraction to benevolent sexism: Needing relationship security predicts greater attraction to men who endorse benevolent sexism. European Journal of Social Psychology, 48(3), 336-347. https://doi.org/10.1002/ejsp.2334

Dutra, L., Bureau, J. F., Holmes, B., Lyubchik, A., & Lyons-Ruth, K. (2009). Quality of early care and childhood trauma: A prospective study of developmental pathways to dissociation. The Journal of nervous and mental disease, 197(6), 383. doi:10.1097/NMD.0b013e3181a653b7

Engel, B. (2002). The emotionally abusive relationship: How to stop being abused and how to stop abusing. John Wiley & Sons.

Finzi-Dottan, R., & Karu, T. (2006). From emotional abuse in childhood to psychopathology in adulthood: A path mediated by immature defense mechanisms and self-esteem. The Journal of nervous and mental disease, 194(8), 616-621. doi: 10.1097/01.nmd.0000230654.49933.23

Glick, P., & Hilt, L. (2000). Combative children to ambivalent adults: The development of gender prejudice. Developmental social psychology of gender, 243-272.

Hadjar, A., Baier, D., Boehnke, K., & Hagan, J. (2007). Juvenile delinquency and gender revisited: The family and power-control theory reconceived. European Journal of Criminology, 4(1), 33-58.

Hammond, M. D., Milojev, P., Huang, Y., & Sibley, C. G. (2018). Benevolent Sexism and Hostile Sexism Across the Ages. Social Psychological and Personality Science, 9(7), 863–874. https://doi.org/10.1177/1948550617727588

National Society for the Prevention of Cruelty to Children [NSPCC]. (2021). Emotional abuse. Retrieved December 28, 2021, from https://www.nspcc.org.uk/what-is-child-abuse/types-of-abuse/emotional-abuse/

Ramos, B., Teixeira, F., Começanha, R., & Maia, Â. (2020). Post-Traumatic Stress Disorder and Identity Transformation After Experiences of Psychological Abuse: A Mixed-Methods Approach. Violence and Victims, 35(5), 724-740. DOI: 10.1891/VV-D-19-00041

Dr Rashid Zaman

The Registrar's Profile Series

Dr Rashid ZAMAN BSc (Hons) MBBChir (Cantab), DGM MRCGP FRCPsych is a Consultant Psychiatrist at Hertfordshire Partnership University NHS Foundation Trust & Honorary Visiting Fellow at the Department of Psychiatry, University of Cambridge, UK. Dr Zaman is also Director of the Centre for Mental Health Research in association with University of Cambridge which organises Cambridge Biennial International conference in mental health.

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By Dr Ahmed Hankir, Academic Clinical Fellow in General Adult Psychiatry, South London and Maudsley NHS Foundation Trust

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Dr Rashid Zaman

The difference between realising your potential or not can often be the presence of a mentor in your life. I am incredibly fortunate and blessed to have a mentor in my life who I can emulate and look up to. Since I was a medical student, Dr Rashid Zaman has provided me with unwavering support. It is no exaggeration that I wouldn't be where I am today if it weren't for Dr Zaman's presence in my life. Indeed, Dr Zaman was one of the main reasons why I decided to choose psychiatry as my career. In this issue of *The Registrar*, I interview Dr Zaman as part of our Profile Series.

AH: Thank you for accepting our invitation to be interviewed for *The Registrar*. My first question is: Who is Dr Rashid Zaman?

RZ: That's an interesting question! Professionally speaking, I have many roles. I'm a doctor/psychiatrist/researcher/teacher. However, I wholeheartedly believe that whatever role I play, it always helps to have a human touch added to professionalism. I sincerely hope I have fulfilled my duties and that I have never forgotten my humanity throughout my career.

My current clinical work is in Hertfordshire where I am a consultant in community adult mental health and my academic work is largely based in Cambridge. I have been teaching, supervising and mentoring medical students at pre-clinical (from Emmanuel College, Cambridge University) and clinical levels in hospitals & trusts affiliated with Cambridge University, including

Addenbrooke's Hospital in Cambridge, for a number of years.

AH: Why did you choose psychiatry as a career?

RZ: My #choosepsychiatry journey was unusual! As a medical student, I was very keen on paediatrics. However, after qualifying as a doctor from Cambridge University and during my pre-registration house jobs I decided to enter the GP training scheme in Cambridge. This provided a wider experience in various medical specialties and broadened my outlook on medicine in general. I thoroughly enjoyed my training in general practice which I completed having obtained full membership of the Royal College of General Practitioners (MRCGP). The invaluable knowledge and experiences that I gained during my training in General Practice continues to be useful in my day-to-day clinical practice as a consultant psychiatrist. However, after completing the GP training scheme, I still felt a little restless and I did not feel it was the right time for me to settle down as a full-time GP around Cambridge, as comfortable as that lifestyle would have been for me.

In my search for professional fulfilment, I took on a research job in the field of psychiatry, looking into pharmacological management options in learning disability. This sparked my interest in academic and clinical psychiatry which led to basic training in psychiatry at Charing Cross Hospital in London. This was followed by higher training as a lecturer at Imperial College, University of London (St Mary's Hospital). During these years, I developed further interests in neuroscience research, particularly looking at the role of transcranial magnetic stimulation (TMS) in the treatment of mental disorders. This led to TMS work in First Episode Psychosis and Chronic Fatigue Syndrome (CFS). The research using TMS revealed the important finding that the corticospinal system remained intact in individuals with CFS. This was highly rewarding and stimulating work. After completion of my training in psychiatry, I accepted a consultant post in Bedford which came with the teaching position in the Department of Psychiatry at the University of Cambridge.

AH: What advice can you give to those who are interested in psychiatry?

RZ: If you are interested in psychiatry as a career, go into it with a positive mindset and pride. As they say, just do it! Unfortunately, negative attitudes towards psychiatry persist. However, I urge you not to be deterred by this. I have been working hard, along with many colleagues and with support from the Royal College of Psychiatrists and international collaborators, to improve the image of psychiatry and to reduce the stigma attached to the profession from within as well as from the outside. Whilst I encourage medical students and young doctors to go into psychiatry, at the same time I would like them to be aware that this speciality is not an easy option. Indeed, it helps to have certain qualities. It clearly helps to be caring and empathetic and to have emotional resilience at the same time. Good communication skills, having an active and curious mind, dealing with complex issues, being adaptable and having the ability to deal with some uncertainty is beneficial. It also helps, if one can combine knowledge from hardcore neuroscience with social sciences. I hope I am not setting the bar too high by saying that it is always good to strive to be a polymath or to be a great doctor if you want to be a great psychiatrist!

AH: Can you tell us more about the Cambridge Conference and how this has helped increase recruitment into psychiatry?

RZ: The Biennial Cambridge International Conference on Mental Health, apart from helping to bring together international researchers and clinicians in the charming Cambridge setting of Clare College, University of Cambridge, also has regular sessions titled "International Competition: Best oral presentation by medical students & foundation doctors". Many of these presentations have led to publications in Psychiatria Danubina

supplement, a PubMed journal, thus not only providing intellectual satisfaction but also helping to open doors to future academic careers. Indeed, many medical students and newly qualified doctors who have presented at Cambridge biennial conferences have gone on to choose psychiatry as a speciality. The feedback clearly suggests that they were helped by their first publications from presentations at Cambridge biennial conferences. Many have stated with pride that the presentations at the Cambridge Conference not only sparked curiosity about academic and clinical psychiatry, but also gave them the confidence and desire to pursue a career in psychiatry.

I am pleased to see that the former medical students and newly qualified doctors who presented at past Cambridge conferences have included Dr Ahmed Hankir (Maudsley Academic Clinical Fellow, 2018 RCPsych Core Trainee of the Year award winner and current editor of *The Registrar*), Dr Ewa Debska , ,past Maudsley higher trainee, now consultant in Cambridge, and Dr Jonathan Rogers (Wellcome Trust Clinical PhD Fellow at UCL), to name a few. And of course, not forgetting many other past presenters now occupying highly sought-after academic and non-academic psychiatry posts, both in the UK and Europe.

AH: Why is mentoring so important?

RZ: I have been fortunate enough to mentor many medical students and trainees over the years and I have learned how important this is for both their professional and personal development. It has been an absolute pleasure and a source of pride for me to see my mentees progress and succeed. Indeed, some have obtained worldwide recognition. Mentoring empowers individuals to realise their potential. Educational and Clinical Supervisors can help to improve the self-esteem of their mentees and provide them with precious guidance and advice. Mentors themselves can reap rewards from their mentees' progress and success. It can be challenging at times, but it is hugely rewarding. Sometimes seemingly small acts e.g., micro-affirmations like 'you are doing a good job' or 'don't give up' can have a huge impact on their mentees' morale. This positivity can encourage mentees to overcome adversity and to have self-belief. And always remember, 'Don't tell me the sky is the limit when there are footprints on the moon!'

Book review

'A Cure for Darkness. The story of depression and how we treat it.'

– Dr Ahmed Hankir

Dr Ahmed Hankir, Academic Clinical Fellow in General Adult Psychiatry, South London and Maudsley NHS Foundation Trust

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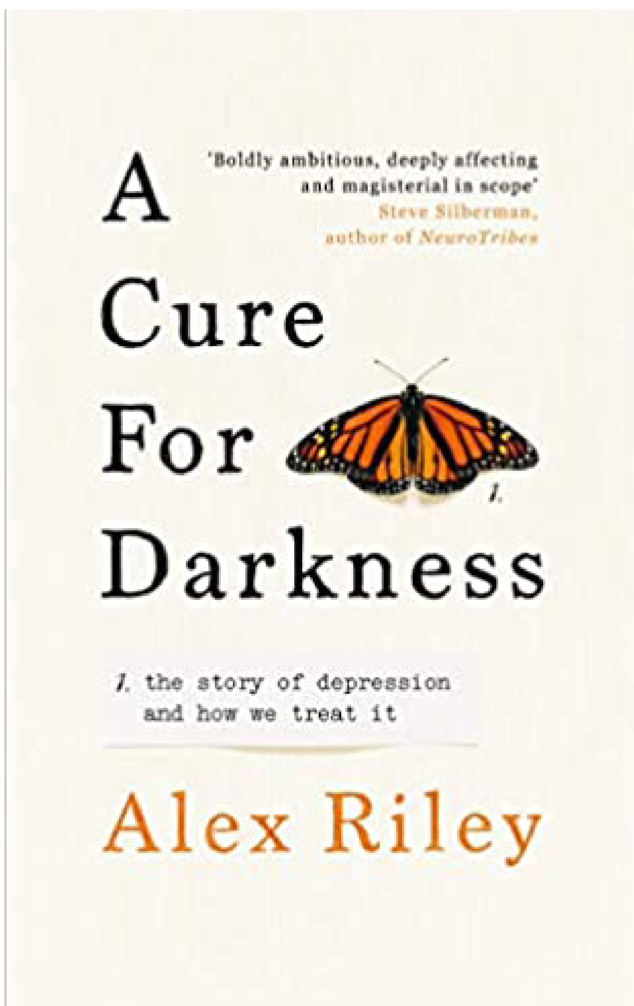
Rating: ★★★★★



Let me take you on a little journey. Not too long ago I was fortunate enough to receive an invitation to join the charismatic presenter Amol Rajan on BBC Radio 4's Start the Week. I was informed that Start the Week is *'BBC Radio 4's main conversation programme of ideas in which everything from the arts to science, history to politics is discussed.'* I'm really passionate about public engagement and education so when I found out that Start the Week has a loyal following of about 2.5 million listeners, I was very excited!

The episode that I contributed to was about understanding melancholy and I spoke about the mood-lifting power of the performing arts. Writer Horatio Clare (author of the book, *'Heavy Light: A Journey Through Madness, Mania and Healing'*) and Cambridge University academic Mary Ann Lund (author of the book, *'A User's Guide to Melancholy'*) were also invited. Horatio spoke evocatively about his experiences of psychosis and Mary eruditely discussed Robert Burton's extraordinary 400-year-old study of melancholy and its treatments.

Suffice to say we had a lot of fun and the reaction on social media was very positive. Following the release of this episode, I found myself in advanced discussions with an editor at Penguin Publishing House in relation to the possibility of writing a book about being a psychiatrist of colour with lived experience and how the performing arts contribute to my mental health resilience. It was during this discussion that I was recommended a book to read entitled *'A Cure for Darkness: The story of depression and how we treat it'* by Alex Riley.

To be entirely honest, I was a bit sceptical at first. Alex Riley obtained his master's in zoology at the University of Sheffield and, according to his bio on the Penguin website, is an ***'award-winning science writer'***. I thought to myself, *'Surely a psychiatrist, with years (and years!) of training behind them, should be writing a book about this topic – not a science writer!?'* As it turns out, I am not the only person to show scepticism towards authors who write about psychiatry-related topics but who are not from a psychiatric background. Neuroscientist Dean Burnett in his Guardian article *'Is everything Johann Hari knows about depression wrong?'* writes, *'... If you're going to allow an extract from your book [Hari's international bestseller, 'Lost Connections: Why You're Depressed and How to Find Hope'] to be published as a standalone article for mainstream media with a title as provocative as "Is everything you know about depression wrong?", you'd best make sure you have impeccable credentials and standards to back it up...'* Indeed, Johann Hari is not a psychiatrist by training (he has been described as a writer and journalist), so perhaps Burnett is making a valid point?

My scepticism towards Alex Riley, however, was unfounded because soon after I started reading his breath-taking book (which I have described in a review as, *'The best book I have ever read about psychiatry and mental health'*), I discovered that Alex was more than capable of rising to the challenge. Indeed, I don't think I could ever produce anything like *A Cure to Darkness* and I was humbled by the depth and breadth of the research that went into this scholarly project and also by how eloquently, movingly and vivaciously Alex was able to convey his points and narrate the story.

A snippet of the synopsis of *Cure for Darkness* reads as follows:

'What is depression? Is it a persistent low mood or a complex range of symptoms? Is it a single diagnosis or a range of mental disorders requiring different treatments? A Cure for Darkness explores all of these questions and more, as the author embarks on a journey to illuminate one of the world's most prevalent disorders...'

It's fair to say that every psychiatrist must be able to answer these questions confidently. Alex certainly can,, despite not being a psychiatrist himself. Below is a review from a consultant psychiatrist which I feel summarises the book incredibly well:

'A Cure for Darkness' tells the story of how our understanding of the causes and our approach to the treatment of depression (and mental illness in general) has changed over the millennia. The book is divided into four parts. The first part 'Cutting Steps into The Mountain' is primarily focused on the work of Sigmund Freud and Emil Kraepelin, two leading figures of modern-day psychiatry. Once we're introduced to Freud and Kraepelin, Riley takes us back to antiquity and then to the Middle Ages before returning to the twentieth century. He shows how our approach to the understanding and treatment of depression throughout the centuries has followed a non-linear course; ancient wisdom and compassion gave way to a misunderstanding that led to the inhumane conditions of mental asylums, where patients were chained and bled. In the two middle parts of the book, the author discusses the development of the so-called biological treatments for depression (brain surgery, electro-convulsive therapy (ECT) and antidepressant medication) during the twentieth century. He then talks about the psychological treatments (talking therapies), as well as the challenges of talking about, let alone treating, depression in the third world. The final part, 'The Universe Within', is about current practice, as well as cutting-edge research into the causes and treatment of depression...'

Having sat the membership exams not too long ago, I was familiar with many of the historical figures that have shaped psychiatry throughout the years. However, what Alex does so well is bring these characters to life and provide the social, cultural and political contexts that

each were operating from. Given that the knowledge we are expected to learn to pass the membership exams is often fragmented (since it is often derived from a bank of questions from previous exams) I would argue that *'A Cure for Darkness'* must be required reading for ***all*** psychiatric trainees. What really appealed to me was how Alex weaved his own story of living with depression into his book, but he did not dwell on this too much. He also challenges the stigma attached to psychotropic medication and emphasises that we should adhere to a biopsychosocial model of mental illness (as opposed to a 'bio-bio-bio' model or a' psychosocial-psychosocial-psychosocial' model).

To conclude, *'A Cure for Darkness'* is a riveting read (I literally couldn't put it down!) and I feel I have a deeper and better understanding of this mood disorder and how to treat it. I would highly recommend every trainee reads it.

Twitter and psychiatry

– Dr Ahmed Hankir

Dr Ahmed Hankir, at the Petronas Twin Towers, Kuala Lumpur, Malaysia

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"Do not go gentle into that good night. Tweet! Tweet! Against the dying of the light..."

– An adaptation of a Dylan Thomas quote

Whenever I try to persuade people who are not on Twitter to open an account, I recite the above adaptation of Dylan Thomas's poem! In all seriousness, notwithstanding the odd troll here and there, Twitter is definitely a force for good in my opinion. In this article I discuss the pros and cons of tweeting and why I think having a Twitter account is a good idea.

I think Twitter can be situated in the happy medium between LinkedIn and Facebook, the former perhaps too professional the latter perhaps too personal. I joined Twitter relatively recently (my first tweet was in April 2018). Now, I find it hard to imagine a world without Twitter! Before joining Twitter, I was 'dancing in the dark'. I am passionate about public engagement and education and I delivered many face-to-face talks nationally and internationally. This was hugely rewarding, however, it eventually dawned on me that social media could help me reach an even larger audience, often with a lot less effort (as rewarding as it is giving lectures up and down the country, it can also be very challenging!)

Since joining Twitter, my connections have steadily grown and I have acquired a modest following of over 53.5k. I have had a few tweets go 'viral'. These tend to revolve around my life story and recovery journey and have resulted in interviews with mainstream media (including the BBC). This illustrates an important point: the public want to see the human face of psychiatrists.

The overwhelming majority of people who I have interacted with on Twitter have been respectful and I have been humbled by the support that I have received from the online community of mental health advocates. I tweet in my capacity as 'The Wounded Healer' and most of the content I share is about my lived experience of a mental health condition and the lessons that I have learned. I would even say that my lived experience is a 'superpower' in the sense that, by embracing my vulnerability, I have been able to establish authentic connections with people all over the world. Once, for example, I was invited to give a talk at University College London and I saw a person sat by herself in the audience. I

noticed she was older than the students who were attending and I initiated a conversation with her. It turned out that she was from New Zealand and was only in London on holiday. She said that she and her son follow me on Twitter and that I was a source of inspiration for them both as her son often struggled with his mental health. She said that I gave them hope that he would recover and realise his potential. I would be lying if I said that I was not deeply moved and emotional after she shared this information with me. This example, I feel, illustrates the power of Twitter. And this isn't the only great thing to have happened. I was invited to lecture in Los Angeles and Kuala Lumpur (all expenses paid) due to my activities on Twitter. So, this social media platform has been terrific for me on both personal and professional levels.

I think it is incumbent upon psychiatrists of all grades to engage with the public and Twitter empowers us to do just that. It is no secret that the image of psychiatry needs major improvement. A survey on the general public revealed that 47% of respondents would not feel comfortable sitting next to a psychiatrist in a party! This, when many of the psychiatrists I know are the life and soul of parties!

We can help improve relations between the profession and the public by harnessing the power of Twitter. We can share the results of the latest psychiatric research on Twitter but we can also humanise the profession further by sharing aspects of ourselves – if we feel comfortable with this of course. We can talk about our hobbies, what makes us smile (and what makes us cry). We can campaign for parity of esteem between physical health and mental health and we can challenge mental health stigma.

Of course, the boundaries must be clearly defined and we must never, ever share any information about our patients. We must abide by the highest ethical standards set by the Royal College of Psychiatrists and the General Medical Council. There have been some negative experiences. By sharing we can make ourselves vulnerable. I think a degree of vulnerability can

The Petronas Twin Towers at night

be helpful and healthy but we must be careful not to share too much and we must know when to draw the line. I would never give clinical advice via Twitter and whenever I am asked to do so I signpost people to appropriate services (e.g.., if they are in a crisis situation to call 999 or to go to their local A&E).

Since joining Twitter I have never looked back! There are many psychiatrists on Twitter, including our College Presidents (past and present). Twitter provides a fantastic platform for us to engage with the public and to improve the image of our profession. It is no exaggeration to say that Twitter has been life-changing for me and I would highly recommend you consider opening an account!

The dilemma of digital education

- Dr Ismail Memon

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Over the last two years, a pandemic has raged throughout the world and has had profound effects on all aspects of our lives, both personal and professional. Consequently, much, if not most, teaching and training in healthcare has shifted onto online platforms. Moreover, the provision of NHS care also became digitised. Many believe that online education has been helpful and I, too, would agree with this to an extent. It can save people, patients and professionals, the time and resources necessary for travelling from one place to another to attend an appointment for a medical or psychotherapy review. Indeed, it is particularly helpful for those patients who can't drive, and who must take public transportation to attend their consultations. You are only a click away and, voila! You are with a mental healthcare professional within a matter of seconds. You don't necessarily need a laptop or a computer, you can simply join a meeting through a link sent on their mobile phone. It gives you the flexibility to work remotely from any part of the world which is a wonderful thing for frequently travelling professionals. It's economic as you don't need larger offices, and if half of the staff can work from home, you can manage in a smaller office easily and safely.

Here in Wales, we have been utilising the Attend Anywhere Web Platform for online consultations which has been a great experience in many ways. However, it was not a problem-free affair as technological issues were not uncommon. Though online teaching and appointments have many benefits, I would like to discuss some of the limitations and challenges. I will start with my personal experience. I am a Registrar (ST4) in General Adult Psychiatry in Cardiff and Vale University Health Board. During this pandemic, all our educational activities were held online which included weekly multidisciplinary team meetings, weekly post graduate teaching sessions, our training related lectures organised by Health Education and Improvement Wales and our registrar training sessions. Even clinical appointments with patients were held online.

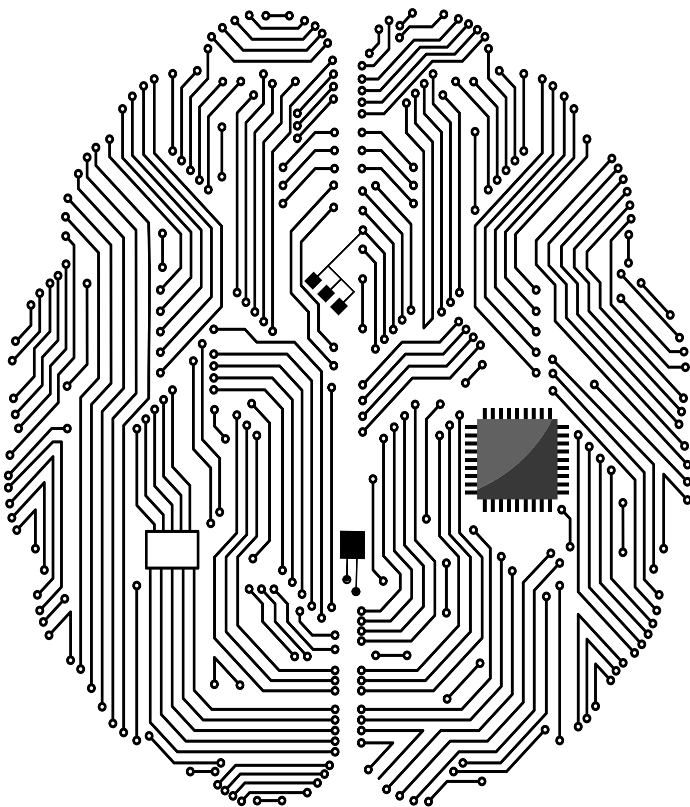
Dr Ismail Memon

One of the more common technical issues we faced was not being able to hear each other clearly due to poor connectivity. Moreover, online teaching did not feel as effective as face-to-face teaching. For example, we were unable to interact socially with other learners on online educational platforms, which I believe is a very important aspect of our learning. Moreover, the body language of the speaker is not easily captured during online teaching. This is unfortunate because, as Bandura said in

his social theory of learning, "observation and modelling play a primary role in this process".

Having schools closed and educational activities held online over the last two years created multiple challenges. For example, not everyone was in possession of a computer or laptop (usually due to not having the resources) so those who didn't have the equipment felt excluded in their educational activities. It generated strong feelings of being deprived and disadvantaged.

The overall impression amongst our colleagues was that the technical issues we encountered made online learning and provision of care challenging. However, every challenge represents an opportunity, and I am optimistic the provision of online teaching and care will improve.



The Long Read

Interview with...

College Dean Professor Subodh Dave and PTC Chair Dr Rosemary Gordon

– Dr Deepa Bagepalli Krishnan

Dr Deepa Bagepalli Krishnan

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Values guide our conduct and how we interact with others in both our personal and professional lives. The College, PTC and *The Registrar* values overlap considerably. We felt it was both timely and necessary to articulate what those values are, why they are so important and why every trainee should know about them. Who better to speak with than our very own College Dean Prof Subodh Dave and PTC Chair Dr Rosemary Gordon about these values and their vision for the future of psychiatric care and training? So, Dr Deepa Bagepalli Krishnan interviewed Prof Dave and Dr Gordon the transcript of which, I'm sure, will inspire you all...

Deepa: Thank you Subodh and Rosemary for accepting this invitation to be interviewed for *The Registrar*. This is an excellent opportunity for us as trainees to understand the values that underpin the College and the PTC and to discuss other College and PTC related matters especially those pertaining to training. The theme for this year's World Mental Health Day was 'Mental health in an unequal world'. The COVID-19 pandemic has highlighted this issue. What are your thoughts on how we can place more emphasis on this within training and what can we do to encourage trainees and other members of the workforce in thinking about inequalities in mental health?

Subodh: Thanks Deepa. Inequality is discussed not just in medicine but across society broadly. It is important to remember that inequalities have always existed, and there is a lot of data to support this, which we have known about for a good long while. I think if we don't speak up for our patients, who will? So, I think speaking up consistently and in a way that is impactful is an important skill for me and I would say this needs to be a part of training for all of us in the psychiatric workforce. We need to start thinking about the broader issue of what causes inequality and what perpetuates inequalities.

Professor Subodh Dave

We know Michael Marmot's work around how socioeconomic deprivation and childhood adversities play a big role. We probably talk about developmental history, but do we do this consistently? As an adult psychiatrist, I know that I could have thought more about how we manage the impact of all these factors on our patients' lives, I am not sure the systems are in place for that to happen in training. So, I think understanding the science behind these adverse experiences and understanding how we stop that cycle is absolutely key. This is a very fundamental shift, and this is not about tweaking the curriculum. In medicine, we are taught to assess, diagnose, and treat and the focus is on the doctor-patient relationship. So, the whole idea of their role in managing the care of the patients within the community gets lost. So, good medical or psychiatric practice should also be thinking about doctor community relationship and case-based discussion should also have an element of caseload-based discussion. So ,that's the fundamental shift in thinking about our role as not just interventionist but also as preventionist and I think if we start thinking like that, that then starts shifting the focus of training.

Rosemary: We need to think about inequalities in different categories. I think the inequality our patients experience is related to their mental illness, and this is exacerbated by stigma. There has been a lot of campaigning over the years and that is something we need to keep up. But also, to appreciate that mental illness does affect patients in every part of their lives. Even psychiatrists often minimise that stigma and inadvertently overlook the reduction in life expectancy and the social determinants of mental illness. I also think we need to look at inequality within training and inequality within medicine. I think so long as we have those inequalities within our workforce, it's very hard for us to do the best for our patients. I think we start by working from within. The College is doing a fantastic job in trying to start work towards that, including having presidential leads for inequality.

Deepa: Thank you Subodh and Rosemary for your insightful responses. There needs to be more emphasis on thinking about social determinants in mental health and thinking about a diverse and inclusive workforce which links into one of the core values of the College – Respect. So, thank you for highlighting those important issues. The COVID-19 pandemic has impacted training and workforce wellbeing amongst many other things. What is the role of the College and PTC in supporting trainees' wellbeing?

Rosemary: Wellbeing has very much been part of the PTC priority for the last couple of years, starting with Supported and Valued, which one of our previous Chairs Dr Alex Till oversaw some years ago. We all know that the last couple of years have been incredibly difficult for everybody, but I think particularly for trainees. There have been changes in exams, changes in the curriculum and there has been a lot of uncertainty, and I am incredibly proud of all the trainees. RCPsych has done a fantastic job but I know that it doesn't come without its challenges, and that lots of people have struggled. What we need to be sure about is that we are not making things worse. It's Maslow's hierarchy of needs,

isn't it? You need the basics before you can get to the extra stuff. You know the PTC have got wellbeing podcasts and if you haven't listened to them, please do. Dr Matheiken organised them, and they are terrific. There is support through the RCPsych Psychiatric Support Service. We hope that trainees can go to their PTC representatives and talk about what is going on for them and be signposted to PSS or other places for support.

Subodh: Thanks Rosemary. I guess I worry about there being a wellbeing fatigue and I think people switching off when wellbeing is discussed. In the initial part of the pandemic, we saw people making bread and putting up pictures of bread and doing all sorts of things. But then it just got tougher and tougher. So, I do feel that there has been a real impact of the pandemic, and I think it's easy to perhaps desensitise ourselves to that, but at some point, it will hit us all, if it's not already done so. I think from the College's point of view, making reasonable adjustments is vital and I think we have been doing that. I am proud of the way the exams were digitalised in record time. I know there were problems and I apologise to all the trainees who experienced problems, and this is a genuine apology from me and from the College because I know it's such a stressful time. We understand that the exam is such a high stakes matter and if everything is not okay, it affects trainees in a major way. I hope that people will see the bigger picture and the need for us to have done it. I am proud of the College team and everybody else who helped deliver this. We have commissioned an assessment strategy review to look at that because I know that the exams form a big part of training.

We have seen lots of wellbeing surveys, some done by us and other agencies. Exam stress comes up as a major factor for trainees. So, I think getting this right is important, and so the assessment strategy is going to look at the question of whether we stay digital or go back to face-to-face exams. So that is one thing, but then also more broadly, thinking about how we can use assessment as a lever to improve

Dr Rosemary Gordon

patient care making sure we avoid assessment overload.

I know *The Registrar* is mainly for trainees but sharing this with trainers is a good idea. I think that we need a culture whereby trainers feeling invested in their trainees' success in the exam and their career progression.

We touched upon stigma earlier, but there is also discrimination, and I am aware that perhaps it is not easy to disclose this in training. I am not trying to paint a picture of a world that is utopian. That's not true, but having said that, there is real cultural support throughout the College and PSS is a good example of that. We know from a membership survey that only about 11% of our members access the service or know about the service. I want every trainee to know that this is available free of cost and that it's confidential. There are support units available through local deaneries. Using this support early is important.

We are all involved in so many different activities and I know you both have worked so hard in

so many different areas and what drives people is that higher purpose. I'm not sure that as organisations and I don't just mean the College, but I mean our employers, deaneries, all of the organisations, we do well enough in terms of aligning people's personal objectives with the organisational objectives and I think we should start doing that a bit more. So, making training firstly, meaningful, and purposeful is quite an important objective for me. And I think that's the challenge for all of us as trainers and trainees. How do you find that space where you can express what is personally meaningful to you and how can we support you in doing that? I propose to achieve this objective through some concrete plans.

When there is an element of fun to the learning process, better outcomes are achieved and the learning is often deeper. So how do we do that? One of the things we are doing is launching a National Psychiatry Quiz competition, which will be held from the next year and the finals will be a glittering affair, I promise. I hope that all the trainees, trainers and SAS doctors will join in and make it a success. It would be a fun way of learning about psychiatry but also showcasing to the world that it's a broad science with neuroscience, humanities, and arts and everything else in between. So that's one thing, and linked to that I think is really building our identity and being proud of our identity as psychiatrists. For me, that identity is very important, and I know it is true for almost all of us. I think we need to showcase that, and we need to talk about it. We need to be demonstrating that in our practice and research. So how do we do that? I think that is where bringing psychosocial formulations as a core part of practice is important.

The third thing I really want to see is an increase in the number of out of programme (OOP) experiences, particularly in research but even more broadly. It is about trying to marry that individual trainee's passion to something that serves the higher purpose. How do we make that happen? That's a challenge for us and I really want to work closely with the PTC to try and see how we can make that happen and address the geographic inequality in availability of such opportunities to the trainees. The broader idea here is to make training personally meaningful and purposeful, and all these examples are step changes, but hopefully will help us achieve that.

Deepa: Thank you Subodh and Rosemary. I think the key message for trainees is to reach out early to access support through PSS and other support systems in place. Staff wellbeing is linked with retention of the workforce, and we have seen that the Choose Psychiatry campaign has been hugely successful. We have had a positive recruitment into psychiatry training in the recent years, but retention is still an issue, especially when it comes to certain areas and certain subspecialties. What ideas or plans do you have to improve recruitment and retention further?

Subodh: Kate Lovett, my predecessor and the entire team have done a great job through the Choose Psychiatry campaign. I think we have done well with recruitment, so I'm really pleased about that. But as you say, we can't rest on our laurels. It's going to be an ongoing challenge and the demand is increasing, and so we have made a call for 7,000 more medical students, and the Medical Schools Council has made a call for 5,000 more medical students. But we know it takes a long time to train as psychiatrists. So, I think having that in the pipeline will help, but it won't necessarily solve all problems now.

Retention is also very important, once we get people in psychiatry, we want them to not just choose psychiatry, but we want them to love psychiatry and stay in psychiatry. That's where the training experience comes in and all the things that we talked about earlier in terms of making that training personally meaningful and flexible. I think retention is vital. There are a couple of things I want to say about it. One is that I have commissioned a strategy document on this. We have multiple strands of work that are already going on in the College.

We commissioned a report from UCL which has given us great insights into the factors that influence retention. I am glad to say that we have just got a green signal from HEE for a run-through programme along the lines of successful piloting in CAMHS to expand that to old age and intellectual disabilities but subject to GMC approval. I am positive that we will get there. There are other things that we need to look at, wellbeing is clearly an important one. I think we know that the state of medical education report from the GMC suggested that IMGs at the age of 45 are more likely to quit psychiatry and go abroad or quit medicine and go abroad. We need to investigate the reasons for that and the reasons why there are 10% vacancies and why people are choosing locum jobs. I think it is likely to be multifactorial, but I feel that we need to be thinking about all those factors and then trying to see how we can make an impact. I am hoping that sometime in the spring we will be able to present a document that brings all these things together (the various initiatives that we have around wellbeing, supported and valued, working with IMGs, addressing differential attainment and strategies to improve retention).

Overall, my key message is that if we can promote the strength of psychiatry as an academic science and the identity of psychiatrists, I think these will be big factors influencing retention. I think the more we can demonstrate a direct link between what we do in training and how it influences our patient outcomes, the more I feel that people will want to remain in psychiatry. As a final concrete piece of action, I have launched the Deans grand rounds. We have got eight sessions next year where a Faculty and Division will co-host the grand rounds. As a Dean, I really want to narrow the translation gap from research to practice. So, we will start with a question, look at the evidence and practice and discuss how we bridge that gap. We have four elements in the grand round. The first is lived experience, so we have an individual or community organisation that considers how psychiatric treatments have aided specific patients. So how has that affected them individually? And then the second element is the evidence. The third element is the contextual data, and that is where I think we'll be able to really highlight the translation gap between research and practise. The fourth element, which I'm sure will be close to your heart, Deepa, is the key element: quality improvement. We want to end asking "So what? – What does it mean for my practice? What does it mean for my organisation? What does it mean for the divisional practice? What does it mean for the faculty practice?" I hope that leads to a short project that demonstrates how we can bring about a change and narrow that gap between evidence and practice. So that is one practical example of how we do that and my challenge to all of us here and to all the trainees reading this will be to look out for and identify those gaps in practice and feedback.

Rosemary: When I think about recruitment and retention, if you had asked this question three years ago, I would have given you this simple answer. I would say there is a lack of consultants, we need more training posts and lots of trainees do think that. I totally understand why they think that. In my role on the PTC, I sit on the recruitment committee. I think things are not quite as simple as that. There's lots of discussions. It's not the College's role to create posts, but to argue for them to put forward proposals for why we need them. I think that is something the College works especially hard on, and I think they have done a fantastic job over the last few years through the Choose Psychiatry campaign. We have 100% recruitment to core training posts for the first time, which is all fantastic. Thinking about recruitment and retention, we must think about the entire span of a psychiatrist career, we need to start early in schools through work experience in psychiatry. A lot of our PTC representatives talk at the medical school careers events because lots and lots of people go to medical school wanting to be a cardiologist or a neurologist, why not a psychiatrist? You know, we need to get in there early. We need to be involved now through PsychSocs in universities. The PTC has a really close relationship with all the PsychSocs and we do have a medical school

representative on the PTC and the College has a fantastic conference for medical students. And then we need to think about training. I am going to talk about the other end of the spectrum, people who are in consultant posts or the senior SAS posts. One of the issues in training is that lots of people look at what the seniors are doing, and they are not entirely sure that is what they want to do. We know that the workforce is underfilled, we know that the job is getting more and more difficult, waiting lists are getting longer. So, I think we should look at that part of the workforce. I think we need to understand that research in UCL shows that trainees are increasingly opting for time out of training and that is ok. We need to remember that they have a life, they have families and all things which are incredibly important to make a well-rounded psychiatrist, but we need to plan our workforce around achieving that flexibility in the program. I think it is a great profession and I do look forward to being a consultant. So much has changed in the last two years, work plans have changed, and I am working from home today and have been last week because I have had this horrible cold. That is something that just wouldn't have been a possible four or five years ago. I think embracing that change, will make a massive difference to workforce going forwards. At the PTC we are also involved in recruitment and retention, and we started National CT and ST welcome events. Further details are on the College website, so have a look at them. We have also got recruitment events. I think conversations and collaborations need to happen between agencies, College, HEE and wider statutory educational bodies and the government.

I know there is other fun stuff in your education, as Subodh said earlier, with opportunities to network. So, things like the trainees' conference which is a fantastic opportunity to network with people. You know there are so many options within psychiatry, I think we need to showcase those experiences so that people can find their niche. But I am overall very hopeful for the future of psychiatry, I think we are improving the recruitment, starting out with retention, and knowing the trainees have a very positive future.

Subodh: I just want to say one quick thing and that's really about the collegiate feeling. I think that's important. So, all the welcome events you know, and I think everything we do, we really want trainees to feel that College is a family and that should be the overall purpose of the College.

Deepa: Thank you Subodh and Rosemary for those interesting insights and sharing some exciting plans around the improving training. We discussed and heard some brilliant plans on engaging and supporting trainees and how to make training more personalised, flexible, and meaningful and you have both clearly outlined the College and PTC values. Thank you so much again!