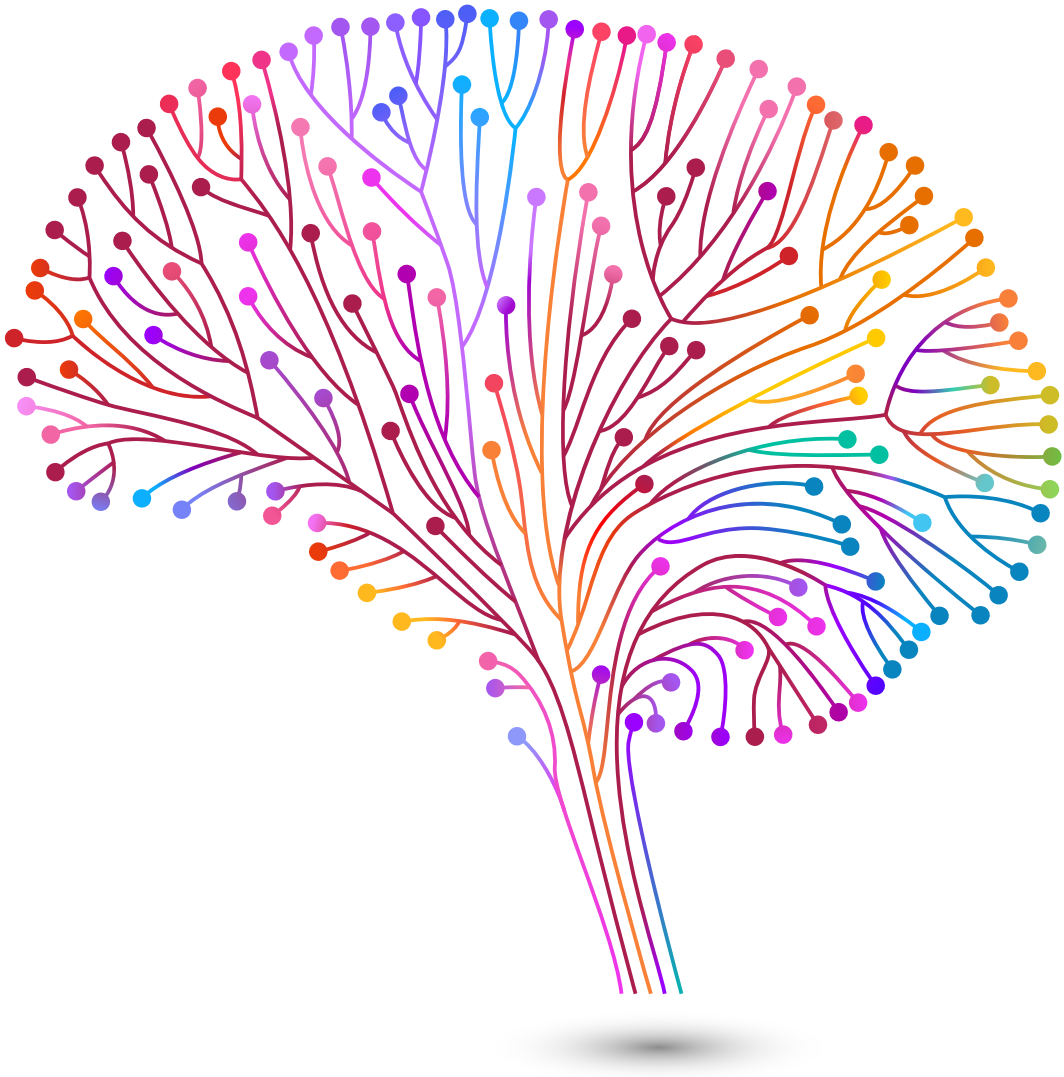
THE REGISTRAR

The Psychiatric Trainees' Committee magazine

June 2021



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The Psychiatric Trainees' Committee

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Editor's introduction

Dr Ahmed Hankir,
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Academic Clinical Fellow in general adult psychiatry at South London and Maudsley NHS Foundation Trust

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The tragic death of George Floyd in the United States last year and the **#blacklivesmatter** movement have thrust racism further into public consciousness. Unfortunately, psychiatry is not immune to racism; indeed, a recent College survey revealed that 6 in 10 Black, Asian and Minority Ethnic psychiatrists in the UK have experienced racism. Earlier this year, the College published an Equality Action Plan to help combat structural barriers faced by psychiatrists and trainees throughout their careers and in their day-to-day work. It has also committed to providing unconscious bias training to members of the psychiatric workforce to address concerns raised about racism in the profession..

Patients are equally affected. In her poignant article, *#blacklivesmatter: Racism and Psychiatry in the United States of America*, the inspirational Dr Amanda Calhoun, an activist and trainee in child and adolescent psychiatry at Yale University, unflinchingly delves deeper into racial discrimination and its impact on African-American patients. Dr Calhoun's take-home message is simple: as psychiatrists, we must challenge racism whenever and wherever we see it; in society, clinical practice and in our profession.

The pandemic has forced us to utilise online platforms to deliver undergraduate and postgraduate teaching in psychiatry. Dr Theo Boardman-Pretty and Dr Alistair Cannon co-author an informative piece about PsychED Up, a trainee-led extra-curricular psychiatric teaching programme delivered during the COVID-19 pandemic. It appears that, given how effective and accessible online teaching is, digital platforms will continue to be utilised for the delivery of psychiatric education even after the coronavirus is reined in.

The topic of suicide received increased media attention following the interview Prince Harry and Meghan Markle had with Oprah Winfrey. In a moving article about patient suicide, the prolific US-based psychiatrist Dr Moffic embraces his vulnerability and shares his powerful story about a patient who was under his care who tragically ended his life.

The Beirut blast in August 2020 was one of the largest non-nuclear explosions

in history. Compatriot Dr Ghida Nassir, a psychiatry trainee at the American University of Beirut Medical Centre, composed a scintillating article about the devastating blast and the impact that it continues to have on the mental health of the people in Lebanon and on psychiatry training.

Finally, I have also decided (after some deliberation) to include my recovery story as part of *The Registrar*'s Profile Series. My hope is that by doing so, it will provide further evidence to help us debunk the many myths about people who have mental health conditions, reduce stigma and break down the barriers to mental healthcare services for those who urgently need them, including psychiatrists of all grades. Ambitious I know but, in the immortal oratory of Professor Egon Diczfalusy: "The medical and the scientific problems of this world cannot be solved by sceptics whose horizons are narrowed by practical realities. We need women and men who dream of things that cannot be and ask, 'Why not?'"

Please do not hesitate to submit pieces for consideration for publication in future issues of *The Registrar*, we would love to hear from you.

As always, please remember to protect your hearts and to protect your minds.

Best wishes,

Ahmed

PTC officers' update

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Spring is finally upon us, bringing with it some hope of life returning to at least a modicum of pre-pandemic normality as the vaccination drive continues. We had a fantastic turnout and meaningful engagement at the 2021 Trainees' Conference in March – 'Breaking barriers to recruitment and retention'.

The College continues to engage its members with a varied list of free webinars on Thursday afternoons. You can catch all past recordings on the College website's events page.

We hope that you find the bi-monthly PTC Newsletter informative and helpful to keep you up to date with news, opportunities and resources relevant to trainees. We have also recently published a mentoring guide and other publications will also soon be available (such as the staying well leaflets, parenthood leaflets, psychotherapy survey report and a guide for international medical graduates). There have been exciting updates on the PortfolioOnline platform in response to feedback from trainees, so have a look out for these if you haven't already. We are all pleased to confirm that the CT and ST national welcome events will continue to be a regular calendar feature and hope that they will encourage trainees to get involved in College roles earlier on in their careers.

Wellbeing continues to be of utmost importance and we want to encourage you to take time for rest, recuperation and self-care when possible. With the pandemic still rampant in many other parts of the world, many International Medical Graduates and trainees who have families abroad maybe struggling due to worrying about their loved ones. Do take a moment to reach out to them, and remember there is support available via the Psychiatrists' Support Service (PSS) or NHS Practitioner Health.

We will be launching our wellbeing podcast series in the near future, and

this issue of the Registrar ends with a powerful, personal narrative of the Editor, Dr Hankir himself, who describes his recovery journey from mental illness.

This summer will see our Dean, Dr Kate Lovett, complete her term and hand over the reins to the Dean-Elect, Professor Subodh Dave, as part of Congress. We wish to thank Dr Lovett for her compassionate leadership during her tenure, her visible impact on recruitment into psychiatry and for inspiring many of us and empowering women in particular in her leadership role. We also look forward to having a similarly positive relationship with Professor Dave, working together on matters important to trainees.

We hope that you will enjoy this collection of articles put together by our fantastic Editor, Dr Ahmed Hankir, with contributions picked out especially for trainees. This issue highlights topical and important areas for your reading including the impact of patient suicide, racism, a trainee reflection from Lebanon and the trainee-led PsychEd programme. We hope that many of you are planning to attend the College's 2021 International Congress this month and that you will join us for a number of trainee specific events and/or meet us in the Trainees' Lounge.

You can get in touch with the PTC via ptcsupport@rcpsych.ac.uk or via Twitter: @rcpsychTrainees

We hope you enjoy the sunshine and easing of lockdown restrictions, and hope you stay safe and well.

Best wishes,

Luke, Shevonne and Rosemary

The PTC Officers

Dr Amanda Calhoun (centre)

#blacklivesmatter: Racism and psychiatry in the United States of America

– Dr Amanda J. Calhoun, MD, MPH

Dr Calhoun is a second-year psychiatry resident (trainee) at Yale University, USA. Dr Calhoun graduated from Yale University with a BA in Spanish and received her MD/MPH from Saint Louis University School of Medicine in St. Louis, Missouri, where she grew up.

Dr Calhoun's research interests include the improvement of mental and physical health outcomes in the Black American community by targeting the trauma of racism, especially in children and adolescents. She aims to increase representation of Black populations, both in the USA and abroad, in academic research and has first-authored a plethora of publications.

Dr Calhoun considers herself an activist and has given a myriad of presentations and protest speeches exposing racism in the medical system. She firmly believes that all doctors should be activists and promotes the integration of social justice teaching with medical education.

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"The opposite of racist isn't 'not racist'. It is antiracist. One either allows racial inequities to persevere, as a racist, or confronts racial inequities, as an anti-racist. There is no in-between safe space of 'not racist'. The claim of not racist neutrality is a mask for racism."

– Ibrahim X. Kendi,
How to be an Antiracist (2019)

I do not feel safe discussing the impact of racism in children, but I hope that will change. I hope that the footage of the murder of George Floyd, the modern Emmett Till, has shown society that racism is far from dead. I am relieved that my medical colleagues, from students to deans, have mobilised to participate in academia-supported protests. But I have to ask, as a lifelong activist and Black person in America: where have you been? And will you stay?

Racism is not new, and the medical system is not exempt from it. We, as Black doctors, have been telling the world that racism is killing Black patients, both literally and figuratively, since 1837. Dr Jason McCune Smith was the first African American allowed to obtain a medical degree, which he received in Scotland, as it was still illegal to do so in the United States. Although he returned to practise in the United States, he was never allowed membership to the American Medical Association. Nevertheless, Dr Smith was a brilliant intellectual who challenged the medical system in its ideas about biological differences based on race. A recent survey of white medical students revealed that these ideas still persist, with over half believing that Black patients have less sensitive nerve endings compared to their white counterparts.[1] I learned this information, on my own time, because the existence of racist ideas is not discussed during my medical education, but I firmly believe it should be.

As a child psychiatry resident, I am always aware of my race. Not just because I am often the only Black person in a predominantly white field, but because I am often the only child psychiatrist explicitly naming the effects of anti-Blackness and racism on children. I find it frustrating when I bring up issues surrounding race, issues that my Black child patient confided in me after the attending left the room, only to have my concerns brushed aside and my notes deleted. I find it enraging, when a Child psychiatry fellow tells my patient she is paranoid, after she wonders whether nurses are undertreating her pain and neglecting her due to race. Yet, studies have shown that minority patients receive less communication and attention.[2] Yet, it is documented that Black patients, including children, are undertreated for their pain, compared to their white counterparts.[1,3] Yet, the American Academy of Paediatrics released a policy statement naming racism as a social determinant of health and driver of health inequities for children.[4] Racism touches every specialty and every Black child. If your patients have not told you this, it is because they do not trust you. And why should they? Why should I?

I want to break down the wall between Black children and families, who are constantly reminded of their race, and child psychiatrists who have the luxury of being colour-blind. I want child psychiatrists to start naming racism, not implicit bias, and asking their patients how racism affects their mental health. If our patients trust us enough to share their experiences, we should listen, even if it means changing our own behaviour or confronting a

colleague. I want Black trainees, like me, to stop being silenced when we bring up our concerns about unfair treatment of child patients due to race. I want education about the racist legacy of psychiatry and the medical system to be interwoven throughout child psychiatric education.

Health disparities between Black and white children should not be taught without acknowledgement that such disparities exist, in part, due to 400 years of racism. Treating paediatric sickle cell disease should be taught in conjunction with evidence documenting the longstanding differential treatment experienced by Black paediatric sickle cell patients. Medical vignettes should be varied, instead of disproportionately depicting Black children as poor and uneducated. Substance use disorders in adolescence should be explained, along with the acknowledgment that even though white people deal more drugs, Black people are more likely to be arrested and incarcerated for it.[5] Racial disparities do not exist because one race is superior or harder working, yet that is the narrative implied. Disparities exist because of a system that intentionally places walls that Black children and families must climb, barriers that non-Black people will never see unless they enquire and learn.

I ask for your help in my role as an activist trainee. Help me amplify the voices of Black patients and Black trainees. Help us bring anti-racism into child psychiatry in the US, UK and beyond. And long after the Black Lives Matter Tweets stop trending, help us keep child psychiatry anti-racist.

References:

[1] Hoffman KM, Trawalter S, Axt JR et al (2016) Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites. *PNAS*, **113(16)**: 4296–301.

[2] Johnson RL, Roter D, Powe NR, et al (2004) Patient race/ethnicity and quality of patient-physician communication during medical visits. *Am J Public Health*, **94(12)**: 2084–90.

[3] Goyal MK, Kuppermann N, Cleary SD, et al (2015) Racial disparities in pain management of children with appendicitis in emergency departments. *JAMA Pediatr.*, **169(11)**: 996–1002. 4.

[4] Trent M, Dooley DG, Dougé J, et al (2019)The impact of racism on child and adolescent health. *Pediatrics*, **144(2)**: e20191765.

[5] Rothwell J (2014) How the war on drugs damages black social mobility. *Brookings. Retrieved from: https://www.brookings.edu/blog/social-mobility-memos/2014/09/30/how-the-war-ondrugs-damages-black-social-mobility/. Accessed on 25 July 2020.*

The PsychEd Up Faculty

PsychEd Up: A trainee-led psychiatric teaching programme delivered during the pandemic

– Dr Theo Boardman-Pretty and Dr Alistair Cannon

Dr Theo Boardman-Pretty and Dr Alistair Cannon are core trainees in psychiatry at South London and Maudsley NHS Trust and co-leads at PsychED Up.

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This academic year, Alistair and I took over the leadership of PsychEd Up, an extra-curricular programme for third-year medical students at King's College London. Over terms of seven weeks, we present important psychiatric topics in a large group seminar, then split into groups of seven students to practise and then dissect roleplays. Our aims are to build the students' confidence and communication skills, including how to give feedback on their peers' performance, as well as exploring the hidden curriculum. Each small group is run by a peer facilitator (a a student who took the course in the previous year), with clinical input from a core trainee. A team of volunteer actors provide simulated patient encounters.

As CT1s, last year we both taught on the course, meeting our students and team members in the modern seminar rooms at King's. We were able to examine

the subtle details of the students' communication with the simulated patients in the room. But as the second term was drawing to a close in March 2020, we had to make the decision to postpone the final session, later arranging this to take place over Zoom.

Most of our faculty had reservations about how well we could critique the finer points of the students' communication skills without seeing each other in the room. But the extra focus on facial expressions gave a fresh lens through which to pick up on aspects of non-verbal communication. The session ran smoothly, resulting in all students telling us they would sign up to a fully online course.

After that proof of concept, we pressed ahead and continued the 2020/21 programme via Microsoft Teams, and the students became used to learning online. To account for some early technical issues, we had back-up actors who were also able to observe and mentor their colleagues. We also spent some time checking everyone's connections and setups to allay their concerns. Both terms went largely to plan, and our amazing faculty has adapted admirably to the new setting.

The programme's wider activities have continued too. A team came together to continue content development, making the existing scenarios believable online and creating brand new ones to keep the programme fresh. Our evaluation efforts have persevered; hopefully we haven't overburdened our participants with the questionnaires. We have got several posters lined up for presentation throughout this academic year, and we are pleased with the personal development of our contributors.

Over both terms this year, there was a significant increase in the students' confidence in talking to people with mental health problems, and in their subjective preparedness for OSCEs. As in previous years, students emphatically said they would recommend the course to friends.

This experience has proved that the programme works both online and through traditional face-to-face methods. We hope that the next step in the project is to help other teams of enthusiastic individuals replicate the benefits for students at other institutions, perhaps fostering greater interest in the specialty. If you would like to talk about how you might implement something similar locally, in either format, please do get in touch. We would love to talk about ideas for improving communication skills, delivering psychiatric simulation, or exploring the hidden curriculum.

Does it take a patient suicide to make you a 'real' psychiatrist?

– Dr H. Steven Moffic, M.D.

Dr Moffic is a retired tenured Professor of Psychiatry at the Medical College of Wisconsin, USA. Not only a recipient of the Administrative Psychiatry Award from the American Psychiatric Association (APA) and the American Association of Psychiatrist Administrators (AAPA), he has also received the one-time Hero of Public Psychiatry Award from the APA's Assembly.

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There is a saying that pops up every now and then in our profession, most often in reaction to a patient suicide: "One is not a real psychiatrist until a patient dies by suicide". Pretty macabre of a saying, don't you think? I mean, what psychiatrist wants a patient to die by suicide to make them a 'real' psychiatrist? Another way of putting it is that there are two kinds of psychiatrists: those who have had a patient die by suicide and those who have not.

This saying probably derives from the relatively rare event of patient suicide of most psychiatrists. In contrast to other medical specialties, much fewer of our patents die during treatment from any cause. Yet, partially because of that rarity, and partially because we often have a more intense relationship with our patients, the effects are profound.

A patient suicide can feel like losing a child or a parent. Because of the impact of a patient suicide and the typical guilt of whether the care we provided could have been better, we tend to try harder for suicide never to happen again, which, at best, leads to enhanced conscientiousness.

I became a 'real' psychiatrist even before I finished my residency training. In 1973, for one of my first outpatients, I was assigned an older, married, white male. He presented with what appeared to be a severe episode of major depressive disorder. I started him on an antidepressant and was planning on adding psychotherapy depending on his response to treatment. On his second visit, he appeared better; he reported that his mood lifted and that his sleep improved. But, before his third visit two weeks later, his wife called and said that he died by suicide after drowning himself in Lake Michigan. I was devastated and afraid to tell my supervisor, fellow residents and faculty. Was I not cut out to be a psychiatrist? Would I be kicked out of residency? Would I be sued?

All my fears were misguided as the faculty was incredibly supportive. The Chief of Outpatient Psychiatry said that I probably should not have been triaged such a risky patient so early on in my training. I should have been warned that apparent improvement in a depressed patient for no good psychiatric reason might mean they felt relieved by the decision to get rid of their psychological pain by suicide.

This patient suicide influenced my decision to specialise in serious mental illnesses such as post-traumatic stress disorder, major depressive disorder, bipolar affective disorder, and schizophrenia. Fortunately, I did not have any more suicides. But the first and only suicide in my career continued to affect me, consciously and unconsciously. I was even accused of having rescue fantasies. Was that true? If true, was that a good or a bad thing? Was that the 'side effect' of suicide?

After I retired from clinical care, I was invited to be on a panel to discuss the tragic event of an adolescent girl in our community who ended her life and how we could try to prevent future suicides. I thought that I would open my presentation by talking about my own patient. I got up to speak but started to cry inconsolably. Finally, I heard a quiet and dignified voice from a man next to me who said to relax and catch my breath. I did so and was able to proceed. Afterwards, I went to thank him, and he turned out to be the father of the deceased teenager. Imagine – me, the clinician, being helped by the father who lost his adolescent daughter to suicide. That experience made me realise that despite all the care and concern that I received after my patient suicide almost 50 years ago, that I had not completed my grieving. Did my story mean that I was not a 'real' psychiatrist until after I retired and cried? Hardly. I was not even practising then. Nor will you be prevented from being a 'real' and empathic psychiatrist if you never have a patient die by suicide.

My take-home message would be that given the uncertainty, always take the route of safety in assessing suicide. If anything, that is what I learned after my patient ended his own life half a century ago. My advice would be to learn how to evaluate suicide risk as best as you can. And, if ever you need an example for how to do so, just access the interview of Meghan and Harry by that master interviewer Oprah Winfrey on March 7 2021. In fact, that interview is so good that it could be used instructively for patients, the public, colleagues, and continuing medical education. I would also urge you to seek pastoral support from your supervisors and local services.

There is support available on the College website for psychiatrists who have experienced a patient dying by suicide

Finding your blessing in disguise: The experience of a psychiatry resident in Lebanon

– Dr Ghida Kassir

Dr Ghida Kassir is a psychiatry resident at the American University of Beirut Medical Centre, Lebanon. In her free time, she enjoys going on hikes and exploring nature by foot. She also loves travelling, experiencing different cultures and making memories all over the world!

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"If I could go back in time, I wouldn't do a single thing differently..."

The people of Lebanon have been through a lot. When a brutal 15-year civil war ended three decades ago, little did the Lebanese know that this was far from being the end of all their troubles. Chronically struggling and failing to kickstart a healthy journey towards recovery due to several economic and security crises, Lebanon has been on a steady path towards disaster for many years, with an exponential increase in the rate of adverse events over the past couple of years. As expected, this has had a huge toll on the mental health of the Lebanese, with a 17% prevalence of psychiatric disorders and a staggering treatment gap of more than 80% [1].

Despite these numbers, I have always had an optimistic vision for Lebanon: a

Lebanon with proper access to mental health care, with abundant mental health resources, and with no stigma towards mental illness. I wanted to play a role in realising that vision: training in psychiatry in my home country had always been my calling, and it was to be the first step in my contribution towards a mentally healthier Lebanon.

However, as this dream grew and approached becoming reality, and as I came closer to achieving part of my goal, the challenges seemed to relentlessly

grow in parallel. For nearly a year and a half now, Lebanon has been witnessing political unrest and facing economic and financial turmoil. Banks have applied severe restrictions on people's withdrawals, the Lebanese pound, the country's national currency, has sharply depreciated by almost 80%, and a foreign currency exchange black market has emerged, all contributing inexorably to outrageous inflation and the collapse of the citizenry's purchasing abilities of their basic needs. In addition, a severe COVID-19 crisis hit the country, causing an increase in the daily death toll and hospitalisation rates and mandating a nation-wide mass quarantine and a quasi-total lockdown, adding strain to the country's already struggling healthcare system and leading to further economic collapse. Tragically, to add to these woes, a colossal explosion shocked the capital, Beirut, on 4 August 2020, leading to hundreds of deaths and thousands of injuries, causing around $15bn of property damage and an estimated 300,000 people to become homeless, and leaving the country completely paralysed [(2)]. The Lebanese helplessly watched as any sense of normality in their daily lives, which they had endeavoured to establish over many years, quickly and unapologetically vanished in front of their eyes.

Following this unsettling time, people's need for mental health services has expectedly and dramatically increased. The number of patients presenting to the emergency departments has drastically risen, the psychiatry outpatient department clinics – public and private –were fully booked, and the number of new patients on the psychiatry liaison services increased by the day.

However, despite the urgent and pressing need for delivering timely, high-quality mental health care during these times of turmoil, the health sector was struggling to stay resilient in the face of the gargantuan challenges which had emerged. With the COVID-19 pandemic and the financial crisis and restrictions, essential medications – including psychiatric medications – went missing from the market, forcing an abrupt cessation in some patients' previous treatments and a narrowing of available options for alternative treatment regimens. Other imported medications, still temporarily available at select larger pharmacies in the capital, witnessed skyrocketing increases in prices, restricting patients' abilities to secure them. This has left our hands tied as mental health providers, forcing us to carefully navigate with limited options available and to settle for what is readily accessible, rather than what is ideally recommended. Additionally, due to the pandemic, most hospital floors, including psychiatry units, were urgently transformed into COVID-19 units, further reducing the hospitals' capacity to accommodate acutely mentally ill patients, which was already low. This has also narrowed our options with patients who require urgent hospitalisation, forcing us to think one step ahead and to implement not-so-traditional treatment plans, while prioritising the patients' health and safety at the same time. To top it all, the financial crisis and the pandemic have had a more direct impact on our training as psychiatry residents: they have limited our ability to travel for electives for additional exposure abroad, to participate in international conferences and, sometimes, to even afford taking international exams that are needed for additional future training, which unfortunately limits our chances of further personal development.

Indeed, training in psychiatry in a developing country like Lebanon is a

challenge by itself, and the challenges keep growing every day. And while these challenges might sound oppressive, I believe training with limited resources in Lebanon has allowed me to see things from a different perspective; while applying what I have read in books in the past few years would have been ideal, I have alternatively learned to think out of the box and to seek non-conventional methods at times. I genuinely believe that the past few years of training have equipped me to thrive in difficult times, and most importantly, have taught me to find my blessings in disguise. If training in psychiatry in Lebanon has taught me anything, it is the importance of stepping out of one's comfort zone, especially at times of crises, and adapting to what the people and the country need. For instance, psychological support was, and still is, urgently needed for people who were heavily scarred following the August blast, and this has encouraged us to go the extra mile; we partook in a series of webinars focusing on trauma-focused therapy and even volunteered in a trauma assessment and support clinic[3].

This has not only helped us develop our skills, but has allowed us to connect with the people on a deeper level and has prompted empathic connections when the country as a whole, was, and still is, struggling.

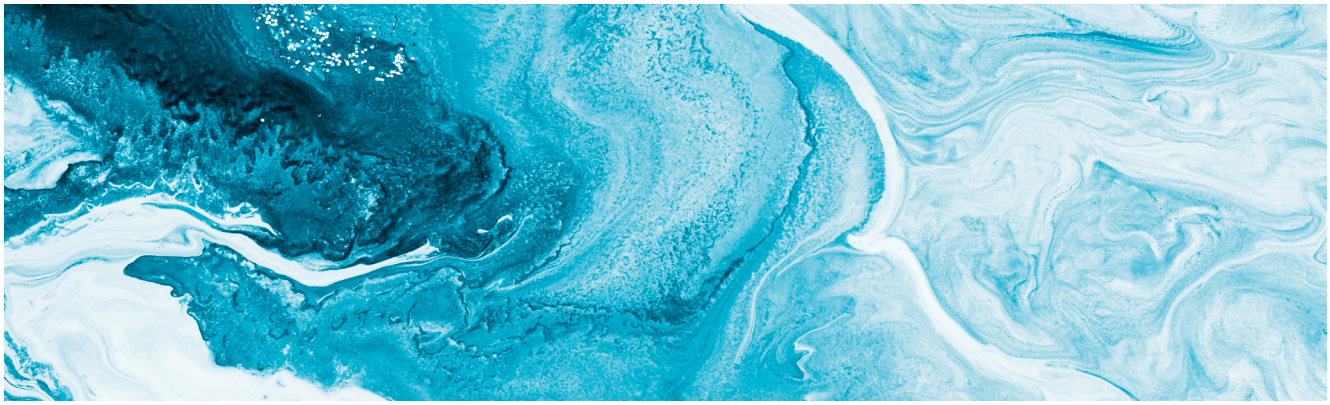
So, if I could go back in time, I would not do a single thing differently. I would make the same career choice all over again, despite the hardships that have emerged along the way. While the mental health system in Lebanon is still in its infancy, psychiatry residents, like me, who have trained during Lebanon's triple crises, have an actual chance of turning the tables and providing this country with what has always been lacking: unhindered access to high-quality mental health care. The people of Lebanon have been through a lot, but we shall hopefully be the agents of change that shall carry on the journey which our mentors have already begun – the journey to a mentally healthier Lebanon.

References:

[1] Arafat SMY, Shoib S, Kar SK, El Hayek S (2020) Psychiatry in Lebanon. *Lancet Psychiatry*, **7(11)**:932. doi:10.1016/S2215-0366(20)30415-6

[2] Abouzeid M, Habib RR, Jabbour S, Mokdad AH and Nuwayhid I (2020) Lebanon's humanitarian crisis escalates after the Beirut blast. *Lancet*, **396(10260)**:1380–82. doi:10.1016/S0140-6736(20)31908-5

[3] El-Khoury J, Medawar B (2021) Beirut, Lebanon. *Lancet Psychiatry*, **8(2)**:104. doi:10.1016/S2215-0366(20)30561-7



The Registrar's profile series:

Dr Ahmed Hankir

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I wholeheartedly believe that we can harness the colossal power of storytelling to debunk the many myths about people who have mental health conditions that abound. So, I have embraced this opportunity to share my recovery story.

On 10 July 2000, I left my family behind me in Lebanon. The situation back then over there was not good at all. The nation was ravaged and battered by a brutal conflict which had far-reaching consequences. So, there I was in Beirut International Airport bidding my parents farewell. All of us were distraught but I had no other choice.

I arrived in England and I naively believed that I would just waltz into university. However, the reality was that my qualifications from Lebanon were not recognised. So, I ended up working as a janitor cleaning floors and as a stock advisor stacking shelves in Marks & Spencer from when you cannot see in the morning until you cannot see at night. I was working 70 hours a week on a minimum wage to earn the money to put a roof over my head and food into my stomach.

How did I feel? Well, legally speaking, I was not even an adult. My mind was still maturing, my brain was still developing, my heart was still growing. I saw other people my age living with their parents and preparing for their A-levels. I felt melancholic, but I was fully aware that I had been given a decent shot at life; education in the UK is a birth right and that is not the reality for most people in this world. I would admonish myself if I squandered this golden opportunity. I just had to stay focused and work really, really hard.

The following year I enrolled into a sixth form college and I continued to work full-time hours to survive. I will never, ever forget what the head of the sixth form at the time said to me when she asked what I wanted to do with my life. I informed her that it was my dream to become a doctor. She then laughed in my face and, although she did not have to say it, she made me feel like I was this dirty little immigrant with delusions of grandeur. She then scoffed: "Choose another course. You will never get into medical school."

Her words hurt me. Her words hurt me a lot. However, I did not allow her to diminish my resolve. I continued to work hard, I dug deep and despite the constant threat that being in full-time employment posed, I secured straight A grades and matriculated into Manchester medical school. Life was going great up until July

Dr Ahmed Hankir winning the Psychiatric Trainee of the Year Award at the RCPsych Awards in 2018

2006 when I was a third-year medical student and I woke up one morning to discover that my hometown in Lebanon had been bombed and that hundreds of people had been killed overnight. My nightmare turned into a reality; my world turned upside down. I feared that my family were among the dead. I saw harrowing and horrific images of dead bodies strewn on the streets of Lebanon. I felt powerless. I was overwhelmed and I developed a severe episode of psychological distress. C.S. Myers in the *Lancet* said that, "Everyone has a breaking point, weak or strong, cowardly or courageous, war frightened everyone witless". And, in the words of *The Joker*, "Insanity is much like gravity; all it takes is a little push..."

Debilitating though the symptoms of psychological distress are, the stigma is far, far worse. I was marginalised, ostracised and dehumanised by people who I thought were my closest companions at the time. I was forced to interrupt my studies, I was rendered impoverished and hopeless and I was sinking deeper and deeper into the darkness. In my despair, I contemplated suicide. However, I resisted the urge to act upon those thoughts because suicide is forbidden in Islam. This deterred me from ending my life, so my faith was a protective factor.

I eventually sought informal support from my Imam in my local mosque and

he urged me to seek help from an NHS psychiatrist. Indeed, it was a psychiatrist, not a surgeon, who saved my life and who rescued me from the depths of my own despair. I gradually recovered, resumed medical school with renewed determination and resilience. There was a fire burning in my belly and thunder in my heart to realise my potential and to make important and meaningful contributions to our world.

Against all the odds, I qualified from medical school. However, I had been rejected, ridiculed and humiliated for so long that I was inspired to work above and beyond the call of duty. All of the sacrifices, suffering, pain and heartache paid off. In 2013, I received the Royal College of Psychiatrists' Foundation Doctor of the Year Award. It was one of the proudest moments of my life.

I was aware that many students do not receive teaching on the devastating effects of mental health-related stigma. So, I was inspired by my fellow survivors to pioneer the Wounded Healer which traces my recovery journey and which has been described as an innovative method of teaching that blends the power of the performing arts and storytelling with psychiatry. The argument we make is this: how can you educate an audience if you cannot engage them? So, I literally re-enact scenes from famous films and I recite poetry to entertain, enthral and engage my audiences and, once engaged, I educate them with the facts and evidence derived from empirical research.

I have been fortunate to deliver the Wounded Healer to over 75,000 people in 19 countries in five continents worldwide. I received the 2018 Royal College of Psychiatrists' Core Psychiatric Trainee of the Year Award in recognition of excellence in psychiatry. I was also shortlisted for the 2015 and 2017 RCPsych Psychiatric Communicator of the Year Awards. It is important to note that I did not receive the highest honours in psychiatry despite my experiences living with mental health problems, I received the highest honours because of my experiences living with mental health problems.

We invite you to join our cultural revolution to empower and dignify people with mental health conditions.

I will close with these take-home messages:

- **It is okay not to be okay**
- **There is no shame in living with mental health problems**
- **Effective treatment is available**
- **Seeking help is a sign of strength, not a sign of weakness**
- **Recovery is a reality for the many, not the few.**