

# The Royal College of Psychiatrists London Division Newsletter



Editor:  
**Andreas Papadopoulos**

## Editorial

It is funny how when people first meet, one of the questions that is commonly asked is "What do you do for a living?" I am still not sure whether this question is meant to convey a message of interest from the addressee to the recipient, or to establish whether the other person is worth talking to. Or maybe one's profession informs the others about

his or her qualities and the "kind of person" he or she is. Empathy, sensitivity and caring, together with an "intuitive" understanding of the human mind and behaviour, seem to be qualities that others often attribute to psychiatrists. And maybe it is this last quality that makes our profession seem so... fascinating!

It seems that no matter what the subject of conversation, a psychiatric opinion always carries some extra weight. From our routine daily interaction with patients to the more informal interaction with our friends and family and even random acquaintances, we are often perceived as capable of providing some evidence-based explanation about a person's actions and behaviours and being able to alter this by some specific intervention. And in our attempt to maintain our credibility and, as a consequence, our self-esteem we play our part as "good" doctors, friends etc.

We draw from neurosciences, psychopharmacology and psychoanalytic concepts and explain about the "why" and the "how to fix it". I suppose that this is what Anna Freud meant when she wrote "many doctors... are not primarily healers. They want to know, they want to figure out, they take pleasure in fixing something...". However, (by?) maintaining a fully scientific model of practice we end up missing out on empathy. With psychiatry remaining one of the most person - centred specialties in medicine, attaining to literature, visual arts, film and music can be the answer.

It is all the preconceptions about psychiatry, and the "art of psychiatry" that drove me to put this issue together. Dr Banham discusses how training in

psychiatry has been reflected in her personal life and relationships, and how her newly-acquired psychiatric techniques have not always been welcomed by her partner. In the same spirit, Mr Locker agreed to address the all important question whether career compatibility is important when it comes to dating a psychiatrist.

As medical practice has been massively influenced by evidence-based studies and research, Dr Thomasson writes about the relevance of evolution and zebrafish and voles studies in psychiatry. She suggests that our excitement about new biological discoveries should be balanced against the relevance of these findings to psychiatric practice.

Dr O'Connor on the other hand, drawing from her rich clinical and psychoanalytic experience, proposes a more psychotherapeutic practice, especially when it comes to assessing risk in our patients. It suggests that psychiatrists can be perceived as "depriving objects", withholding the best medicine from the patient, and therefore producing violent outbursts.

When it comes to the "Art of Psychiatry", Dr Brown reports on the London Psychiatry Trainee Conference that once again proved to be very popular and addressed exactly that: How arts can influence psychiatric practise. The opposite is also true. An example is "Bedlam" a theatre play by Nell Leyhson, dealing with the gruesome nature

of psychiatric practice in Bethlem Hospital in the mid-eighteenth century, which is reviewed here by Dr Prins. On the other hand, Dr Arkell has taken a more hands on approach on theatrical connotations of psychiatry, being the "in-house" psychiatrist for the Almeida theatre. In his article, he brings several examples of how theatre can influence and alter the way psychiatrists view their selves and their practice, while also tackling the common perceptions of the public. Dr Bloomfield, inspired by the play 4:48 psychosis, also discusses how theatre may allow us to acknowledge the despair of our patients in a protected and empathic way without retreating to what he calls "emotion-ectomies" as a defence mechanism.

The paintings of Monika Filipiak Peszek allow for further reflection on how visual arts can influence our practice by allowing us to be more empathic. She lends herself well to the interplay between her inner

life and her traumatic experience of sexual abuse with what she portrays on canvas.

As Dr Raji explains in her "From the Chair" column, in a Deanery as vast and diverse in terms of numbers and cultures, it is very difficult to identify subjects that will "connect rather than separate us". And in this real challenge, communication between the College, the Deanery, the Trusts and the professionals working in these is absolutely vital. Drs Dias, Saxena, Hurlow and Hussain also believe that communication is key in improving the training experience for trainees and trainers alike. Their article summarises the aims, challenges and outcomes of a trainee led survey they conducted in the SLaM NHS Foundation Trust in regards to their placements. Most important are their suggestions for improving the training experience for all those involved in it.

I am aware that this newsletter is

intended for a hugely diverse group of professionals. So if there are any suggestions, comments or responses to the articles please keep them coming in by e-mailing Ms Susan Ranger, sranger@londondiv.rcpsych.ac.uk. This is what Dr Gilgar did after he attended the "Who wants to be a Psychiatrist" academic meeting. His article published here argues the view that a psychiatric recruitment drive targeted at a younger population might produce the benefits that our field so desperately needs.

**Dr Andreas Papadopoulos**  
CT2/ACF  
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#### Editorial Team

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## From the Chair

London boasts great diversity and is blessed with a good number of centres of excellence which provide a variety of interesting training and CPD events. There is so much to choose from but a finite supply of time and funding. Mandatory events identified for training and CPD portfolios understandably take priority in job plans and these tend to be provided within Faculty/Specialty specific groupings. This poses a challenge for the London Division Academic events that happen twice a year. We are looking at how to tailor events to the needs of the diversity of psychiatrists in the Division, to identify subjects which connect rather than separate us. I hope that many registered for the Winter Academic event on 1<sup>st</sup> December with its informative and stimulating programme about the direction of travel of mental health services in London within GP commissioning.

There is still a lot to be achieved. London makes up 12.5% of the UK population and has a higher than national average spending on mental health. London has a complex variety of mental health commissioning arrangements and significant differences in care pathways. The criteria for referrals and service provision are complicated and differ from one part of London to another, providing variable experiences and outcomes. A lot of work is going on to look at how to deliver for London with its unique challenge of cultural diversity, economic extremes and higher than average prevalence of mental health problems. The Royal College is engaged in different work-streams to raise the profile of mental health. The new commissioning strategy might provide a way of streamlining services to achieve greater coherence. This is an opportunity for

those who would otherwise not be involved with steering the NHS to contribute in some way to the direction of travel. Please let me know of any local clinical leadership initiatives, so that we can share experiences across London. It would also provide useful frontline management experience for SAS doctors and Trainees.

We held a welcome event for new College members of the Division at 17 Belgrave Square in October and 23 of the 33 newly qualified members attended. The President, Chief Executive and Hon Treasurer favoured the occasion with their presence. This was greatly appreciated by the new members. The President emphasised that the College is not the building or its officers, but the whole membership and urged the new senior trainees to embrace this right from the start. The CE, Mrs Vanessa Cameron graciously treated those present to a grand tour of the College and also provided some of the historical background to the College Building. The feedback from the Trainees was good,

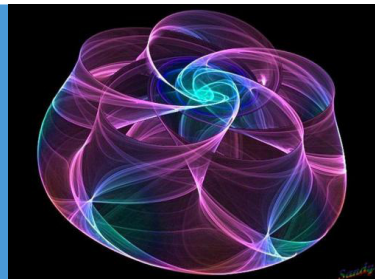
they found the College less mysterious. We are all encouraged to feel welcome to use the facilities of the College which is literally on our doorstep here in London.

There are plans to change the format of the Division academic events from 2 full day programmes to 1 full day programme and one evening debate per year. Members have indicated interest in evening events that would not require taking study leave time. Also with debates, we will have shorter programmes with themes that are of wider interest and keep costs low. Suggestions for topics are welcome. Thank you for all your comments and suggestions. Please keep them coming. I look forward to seeing more members at future events.

### Dr Oyepeju Raji

Consultant Psychiatrist  
South West London & St. Georges  
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# Psychodynamics in Risk Formulation



In the Balint group that I supervise, I mentioned an aspect of risk assessment that met with an impulsive comment from one of the junior doctors. It was towards the end of her first year in psychiatry. I had referred to the fact finding that is required in formulating a risk assessment. I expected the doctors to agree that in the history, the details of previous acts of violence, or of suicidal attempts was important. 'Nobody ever told us that!' the doctor declared. I was surprised by the comment, particularly as it came from a young woman

who was clearly very enthusiastic about her work. I doubt if this was as new to her as she was declaring. I suspect that I had said something that made sense to her for the first time.

The model I was using was psychoanalytic, and I was talking about relationships. I was noting the importance of trying to understand behaviour, as to whether there was an object relationship that could be identified in the action. It seems natural to me that a psychiatrist taking a history from a patient, after an act of violence towards

the self or other, would be interested in the meaning of the act. There is nothing in the medical model to take account unconscious phantasies in the meaning of an act. We collect and record conscious data in our history taking.

When I draw attention to the personal experience that takes the unconscious seriously, I am often met with strong emotional reactions. Anger may be the first to appear. The first time that was obvious to me was an occasion when I had arranged to see a patient because of increased

anxiety in the team about her suicidal risk. She had made many suicidal attempts over the years. In our joint interview, I said to the patient that part of my reason for seeing her with her key nurse was that we were very concerned that she would kill herself. I said that the risk was high in view of her history. This was met with an angry tirade, the intensity of which surprised me. The patient told me that I did not understand how badly abused she had been, and all that she had suffered as a child. As she continued her tirade, outlining memories of abuse, I gradually began to see what had angered her. In my wording, I had suggested that she was an active participant in her behaviour towards herself. She preferred to see herself as a passive victim and in need of something from us to stop her behaviour. That something was in the nature of tablets, or visits, or medical interventions that I would describe as the fantasized good object. If we did not give her something good, it meant that we were depriving her. From her perspective, I was accusing her unfairly. I thought that it was she who did not care enough about herself and her own safety, because of abuse and neglect.

That experience helped me to see one reaction that staff would prefer not to face. Discussions about life threatening behaviour will lead to strong emotions, if one really cares. If we avoid such discussion, we can collude in the idea that the patient cannot help it, because of illness, feeling upset or suffering badly. Thus does one avoid a therapeutic encounter that would focus on the risk to life. There is emotional detachment from the 'evidence' of destructive

and risky behaviour, leading to vulnerability towards a post-traumatic stress reaction when the violent event has been unexpected.

Without practice or training, it is difficult to discuss anti-social behaviour with a patient. How does one think about human behaviour without thinking in terms of relationships? The only way to do that is to think about behaviour in a dispassionate, scientific way that misses the main point. We do not like to have powerful emotional reactions to our patients. The scientific approach gives us protection from such emotions. However, that encourages us to miss the meaning of communication and behaviours that are directed towards us. We do like to be considered as 'good objects', giving sympathy and understanding to the victim of illness or of deprivation, not rousing up lively passions by addressing destructiveness in a focused way.

I suggest that we can be perceived as depriving objects, apparently having good or better medicines or therapies, but withholding that 'goodness' from the patient. If one is being narrowly scientific and looking only for better medicine to give, I think that it stimulates violent reactions in those who are prone to violent solutions to conflict. Suicide is an act of violence, directed towards the self, but in its expression it inevitably involves the listener. Suicidal ideation is an expression of conflict.

Reflection on our emotional reactions may not be enough when working with patients who pose risks. It may be hard to 'think' or capture the full nature of the risks. The

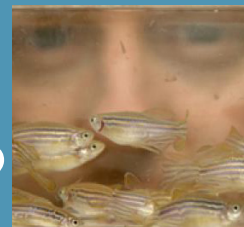
experience of working with the patient is enacted in the counter transference, or transmitted unconsciously. In our daily lives, we are accustomed to friends or family telling us things that we have not appreciated in our contacts with others. They are picking up on what we tell them, and seeing when we are being treated badly, or getting caught up with something that is risky. They tell us when our irritation is because of someone else. That is just common sense, is it not? It is now common practice for psychoanalysts to present our work regularly to colleagues. Our colleagues often see something that we have missed. I would suggest that the formulation of risk would benefit from working in the group. We can miss so much, even more so when we are working closely with them. We are liable to avoid thinking about the most destructive and emotive aspects. One risk of that is that we enact hostile feelings towards the patients without becoming conscious of them, still seeing ourselves as doing our best.

**Siobhan O'Connor,  
FRCPsych, F.Inst PA**

**Consultant Psychiatrist  
for Crisis Services in  
Southwark.**

**SLaM NHS Foundation  
Trust.**

# What is new in Evolutionary Psychiatry?



A new beginning was hailed in the book "Evolutionary Psychiatry" in 1996 when Anthony Stevens and John Price published an interesting if slightly over Jungian account of the evolutionary underpinnings of psychopathology. I read this book as a medical student and found myself wondering how related research at different levels of scientific enquiry had unfolded over the last 15 years. I uncovered a cornucopia of titles from research groups around the globe, and so it seems the concept of evolutionary psychiatry has provided a productive interface between biological and social sciences.

The first thing that strikes the budding armchair evolutionary psychiatrist is the paradox between research groups delivering a comforting message that we are closely related to other species and rightfully deserve our place in the natural universe versus Jasperians that suggest we are lonely, unique overdeveloped mutants with pathological "human only" genes that hitch a ride along with everything that makes us clever and superior, namely language, complex social behaviour and aspects of consciousness such as metacognition.

So what's new? The integrative zoologists are very excited about the Zebrafish, as early stressful experiences give rise to differential stress phenotypes later in life. Spare a thought also for the vermilion mutant *Drosophila*, whose defective NMDA neural pathways result in gradual memory decline and complete memory failure by day 28 of life. Nano post mortems reveal structural and immunohistochemical changes in the *drosophila* brain that predate the onset of memory problems. Meanwhile, the cinnabar mutant enjoys a life of relative intellectual luxury, thanks to the overexpression of neuroprotective factors. There is also talk amongst the zoologists concerning the role of vasopressin receptor gene mutations and the propensity of voles to mate for life or to erm, continually shop around.

The neurochemists are equally busy with intriguing discoveries. Neurotransmitters it seems are ancient and pretty similar across species but the molecular biologists inform us that subtle inter species differences exist in promoter regions such as

5HTTLPR via differences in tandem repeats. The same goes for dopamine receptor D4. Yes, the harbour porpoise, common raccoon and polar bear all have DR4 receptors but cross species differences in tandem repeats enable diversity in receptor functions. It's not all cross species continuity though. We appear to have our very own type of noradrenaline storage vesicles in the locus coeruleus, Watch this space for further news. Perhaps some neuroimaging? Let's not forget oxytocin before we finish with chemistry, as it was recently branded a "uniquely social peptide". Humans inhale it and become more prosocial and ready to bond. I wonder if the vole group may be interested in it?..

Shifting up a few levels of level of description to human ethology we observe "ecological syndromes" in New Guinea and Indonesia, characterised by poor arithmetic ability and finger agnosia in neurologically intact individuals from remote areas. Cognitive and behavioural modelling of anti predator responses are shedding light on mechanisms involved in anxiety and PTSD. Defence strategy recalibration and neuronal plasticity are offered as putative mechanisms to explain differential susceptibility to PTSD.

Explanatory models of psychopathology are still largely centred on the enigma of a condition and its global persistence. Genes hitching a linkage ride during not so independent assortment? Potential advantages in earlier societies such as schizophrenia and creativity, anxiety and threat avoidance, de Clerambault's and mate selection? To conclude, evolution is a central concept in biology and currently provides fertile research ground for Psychiatry. The challenge is to unite different levels of description, and to strike a balance between over enthusiasm of cross species comparison versus negativism regarding the relevance of animal models.

References available on request.

**Dr Rachel Thomasson**  
CT2/ACF  
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# How the Other Half Lives!



It's a terrible cliché, but our eyes really did meet across a crowded room. We were at a business networking event and people's jobs were the main topic of conversation. Most of the people in the room were pretty easy to pigeonhole, buy this guy? He was probably not a city-type (too relaxed) and not an artist or creative type either (too well dressed). Media maybe? - he certainly had the relaxed confidence of someone who is used to speaking with people and yet I didn't think he was a journalist or TV presenter. It was obvious that lots of people wanted to be in his company.

I decided to make my way through the crowds to introduce myself and find out. When I discovered that he was a psychiatrist I was intrigued. When he accepted my invitation to dinner I was also slightly worried! Would he analyse me? And if, as I hoped, dinner turned into a relationship, would dating a psychiatrist work for me? I'm quite a private person and I keep a lot of my thoughts and feelings to myself. How would it feel to be with someone who presumably could see through that?

Actually, I think that there are a lot of misconceptions about psychiatrists but I did wonder, in a Carrie Bradshaw sort of way; "When it comes to relationships, how important is career compatibility?"

Reflecting on the experiences of some of my friends, I

remembered a vet who I knew. She was hugely attracted to this guy until she found out, on their first date, that he was a Fur and Hide Trader. His huge city salary and male-model looks notwithstanding, that was the first and only date they had. Her hopes were dashed. She thought that their respective careers would always contradict.

I have spent my career in media and so I'm always looking at books, magazines and newspapers with a critical eye and I assume that it's the same for others too. I know dentists who say that they can't help but notice people's teeth and hairdressers who mentally restyle people who they see on the bus.

When we started dating, friends would joke that I'd get analysed and that he would 'know' what I was thinking. They teased me that he would ask me about my childhood - not out of the usual curiosity that we all have about our partner's background, but to see if there is any psychiatric history in the pipeline! If he has been analysing me, he's done it without me noticing.

Of course, it's natural that our work, which occupies the majority of our waking hours, has a huge impact on our lives and the way that we view the world. Psychiatrists seem to have a passion to understand the human mind, using language to draw out meaning from people, and potentially being able to see behind masks. I think that

psychiatrists naturally deploy these skills with everyone that they meet and when it comes to relationships maybe that's a good thing! Together with their empathic understanding and highly developed interpersonal skills it makes for a relaxed, open and confiding relationship.

But as they say... it all comes with a cost! If there was a downside to dating a psychiatric trainee it would only be scheduling our leisure time together. I am trying to be as considerate and supporting as possible, maintaining a balance between "being there", listening to his stories about patients, their relatives and his colleagues, and allowing for space and time for him to achieve all the competences required for his training. However, this is not always easy when he has to be on-call, organize his research time, attend conferences, courses and events, and lately study for upcoming exams too!

Despite all this I still consider myself very fortunate! When it comes to career compatibility luckily for me psychiatry and media seem to be a great mix!

**Mr Nigel Locker**

Publishing, Press and PR consultancy

BUD UK Ltd

# Psych and the City: *insights from the first year of psychiatric training*



Last summer, my partner and I moved to London in search of fame, fortune, and specialist medical training. What better place for culture, new friends and being at the centre of innovative British medicine? Come late August, reality struck. A kind of culture shock took hold and I realised that London was great, but psychiatry was far, far more of a challenge than I had expected. Naïve? I probably was in thinking I'd somehow seen it all and wouldn't really be shocked by being on the frontline and confronted by people naked/threatening/screaming/despairing. But I was shocked, and sometimes found myself not quite knowing what to make of my new life as a trainee psychiatrist. Here I am though, a year later, and I've learnt some things...

Firstly, trainee psychiatrists are probably quite difficult to live with. Let me elaborate. Over the past year, I've come home with tales of having water poured over my head, a social worker telling me I was a "silly girl" and an interview conducted in a snowy hospital car park, trying to entice a psychotic man back to A&E. All of these revelations have been met with incredulity, a cup of tea and then a good dose of common sense ("didn't you put your coat on before you went outside?"). My partner has good-humouredly cooked me meals when I have insisted that yet again, I am revising, and his social life is also on hold until I've passed MRCPsych part 2. He may not even receive any thank-you gifts this festive season, as I've spent all my cash on revision courses. Less kindly met, have been my haphazard attempts to trial on him psychological techniques from each of the therapies I have learnt about. I was surprised to learn that he does not enjoy being motivationally interviewed in the morning, and that being asked about his thoughts and feelings as he ordered another drink, put me at risk of a repeat of the earlier 'water on head' incident. Supportive partners, friends and family are essential, but sometimes longsuffering.

Secondly, our job is fascinating - to others as well as ourselves. Around a dinner table, psychiatry will monopolise a conversation. People want to hear about the sensational events that we occasionally glimpse. Sectioning, restraint, medication and

hallucinations are somehow glamorous. But however much I want my friends and acquaintances to be aware of about mental illness, I have strangely had to learn how to evade such sensationalist topics so I don't add to the weight of stigma our patients already experience. These extreme events are actually pretty rare, and are in no way representative of the mental illnesses most people suffer. I feel it is a little recognised part of a psychiatrist's job to advocate for patients, even after hours, but doing so without sounding 'holier than thou' is tough, I'm hoping I'll have worked it out soon. My dinner party invitations are tailing off weekly.

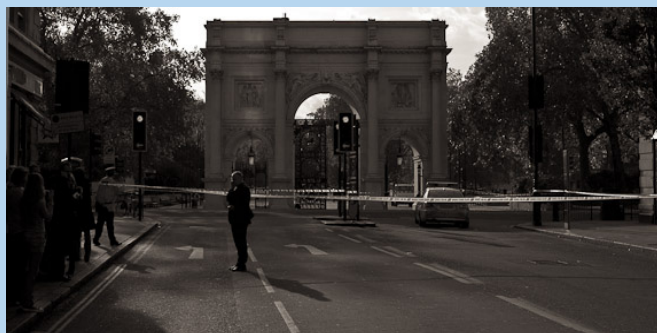
And my final revelation in CT1 was that however much we feel like whinging about our caseload/clinic/on-call/patient/patient's relative, we should not do so in front of medical students. Offering a balanced view of psychiatry as a specialty is one thing, but what we say to doctors in training is crucial to attract them into psychiatry. I recall my own first experiences of psychiatry in North Yorkshire, and my over-riding memory is of the consultant telling me that I should not choose psychiatry "under any circumstances". Thank goodness I didn't listen. Presumably, we are all doing our jobs because they are challenging and absorbing, so we should tell students about that and save the gripes for another time.

So a year on, and I'm still excited about becoming a psychiatrist and my relationship is still intact. Despite the interminable juggling of workplace-based assessments, research, an exam, on call, and 'life outside', psychiatry is still what I want to do and I feel privileged to take part in other people's lives. The patients I work with don't always feel the same about me, but at least I know I can retreat for a whinge with my colleagues, or at least to my own (living room) couch.

**Dr Lindsay Banham**  
CT2/ACF, SLaM/KCL

# London Psychiatry Trainee Conference 2010: The Art of Psychiatry

On an overcast autumnal day in central London, three hundred and fifty psychiatry trainees defied tube strikes and bomb scares to attend the third Annual London Psychiatry Trainee Conference. Joined by a host of names from literature, art, stage and screen, the trainees enjoyed a wide variety of entertaining and thought-provoking sessions on "The Art of Psychiatry".



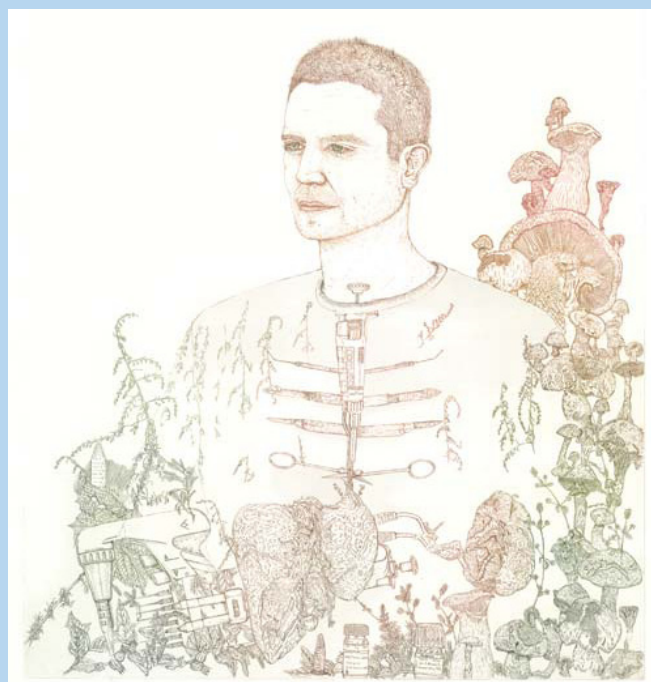
*It all started with a bomb scare... Outside the conference venue (The Cumberland Hotel, Marble Arch)*

The conference has become an annual fixture since 2008 and Dr Stephen Ginn, East London ST4 in General Adult Psychiatry, took on the challenge of organising the 2010 meeting. He chose to focus the theme on psychiatry and the arts, explaining his motivation as follows:

*"Many psychiatrists, including trainees, have a strong interest in the creative arts and this informs their practice. Both psychiatrists and creative artists are concerned with exploring human behaviour and motivation, and come to the subject of the mental disorder from different viewpoints and with different narratives. For instance the language creative artists and psychiatrists use to record or express psychopathology is totally different but equally valid. I have a strong belief that we have much to learn from one another and my motivation for making this year's London*

*trainee conference about the shared elements between psychiatry and the arts was to explore this space and to give trainees an opportunity to examine their practice from alternative viewpoints."*

Stephen and his organising committee planned a day of lectures and workshops, and in addition to inviting artists and psychiatrists from a number of disciplines, trainees were also encouraged to present their own work. The committee were overwhelmed with proposals of trainee presentations on wide-ranging topics, from studies of "Outsider Art" to psychodynamic interpretations of the baptism scene from "There Will be Blood".



*"Connor" by Gemma Anderson from "Portraits: Patients and Psychiatrists"*

On the day of the conference, the Cumberland Hotel, with a lobby filled with contemporary art, set the scene for what was to come. On display at the entrance to the conference area was an exhibition of "Portraits: Patients

and Psychiatrists". This award-winning collaboration between artist Gemma Anderson and forensic psychiatrist Dr Tim McNerny is a series of portraits of psychiatrists and their patients, exploring how patients experience mental illness and how this is formulated and treated by the doctor.

After an introduction from Dr Michael Maier, Head of the London Deanery School of Psychiatry, Professor Dinesh Bhugra gave the first keynote lecture on "Using films for teaching and cultural competence". With examples from Hollywood to Bollywood, he demonstrated how film can teach psychiatrists about mental state examination (such as Jack Nicholson's portrayal of OCD in *As Good as it Gets*) and psychotherapeutic concepts (counter-transference in *Analyze This*), as well as cultural sensitivities and prejudice.



*Professor Dinesh Bhugra giving the first keynote lecture "Using films for teaching and cultural competence"*

The enjoyment and good-humour of the delegates was evident even when the following session was delayed due to a combination of bomb scares and stranded pianos, but after an extended coffee break we were treated to a performance of "Losing It", a two-woman show tracing the emotional breakdown of Ruby Wax, through monologue and music, with songs performed by jazz singer Judith Owen whom Wax met while a psychiatric inpatient. Wax's depictions of her own struggle with bipolar disorder, as well as group therapy in the addictions-riddled world of the Priory, were both amusing and sensitive, and her work in breaking the stigma of mental illness can only be welcomed.



*Ruby Wax and Judith Owen perform "Losing It"*

The conference was then divided into ten parallel sessions. A team of dramatists and directors discussed theatre and television depictions of psychiatry, and artists explored the role of art in expressing and understanding mental illness. In a workshop on psychiatry and graphic novels, Darryl Cunningham and Philippa Perry gave examples of how graphic novels can provide an accessible but educational medium for discussing mental health issues and battling its associated stigma. Poet Dr Sarah Wardle read from her own work and discussed the benefits to doctors of reading poetry. Author Will Self drew a substantial crowd, despite competing with the delayed lunch, and gave a thought-provoking reading of his latest novel "Walking to Hollywood", which included surreal stories that raised questions about our daily assumptions. The roles of psychiatry in film and literature were explored, and in discussing psychiatry and music Dr Andrew Johns gave a fascinating talk which included a psychopathy checklist on Wagner's Siegfried.

Three sessions were led by trainees who discussed their own studies of creative arts and psychiatry as well as experiences working abroad, and opportunities for creativity in teaching psychiatry were demonstrated by the Extreme Psychiatry team.



*Will Self discusses Psychiatry and Literature*

The afternoon keynote lecture was given by psychoanalyst and author Darian Leader. He spoke about the psychodynamic treatment of psychotic patients using the example of German judge Daniel Schreber, whose memoirs of his own mental illness were later interpreted by Jacques Lacan. Leader went on to join Nell Leyshon, the first female playwright at Shakespeare's Globe with "Bedlam", Sarah Wardle, Gemma Anderson and Dr Tim McInerney to take part in the final plenary session discussing "What can creative artists and psychiatrists teach each other". Leyshon was accompanied by three poets from Vita Nova, a theatre company providing writing workshops to recovering addicts, who read self-penned poems about their own experiences of mental illness to a captivated audience.



*Delegates and members of the plenary panel Dr Tim McInerney, Gemma Anderson, Nell Leyshon and poets from Vita Nova enjoying "Losing It" earlier in the day*

The conference ended with a poster prize presentation, won by Dr Paul Wallang (ST6 Forensic Psychiatry, East London) whose poster on "Wittgenstein's Legacy and Narrative Networks" was perfectly in keeping with the theme. All in all the day was a huge success enjoyed by delegates and speakers alike, as was clearly evident later on in the hotel bar!

With thanks to the London Deanery and the 2010 London Psychiatry Trainee Conference Organising Committee:

Dr Stephen Ginn (ST4 General Adult Psychiatry, East London)- conference lead

Dr Jane Jones (ST4 CAMHS, Tavistock Clinic)

Dr Penelope Brown (ACF Forensic Psychiatry, SLAM)

Dr Myooran Canagartnam (Fellow in Medical Education and ST6 CAMHS, Tavistock Clinic)

Dr Olimpia Pop (ST6 General Adult Psychiatry, South West London and St Georges)

Dr Issy Millard (CT2 SLAM)

Photographs by Dr Wojtek Wojcik (ACF in General Adult Psychiatry, SLAM)

Dr Penelope Brown  
ACF in Forensic Psychiatry  
SLAM NHS Foundation Trust/  
Institute of Psychiatry

# Improving Training: a trainee-led survey



Core Training is the first step in a career pathway in psychiatry. Experiences in training placements will shape our future attitudes and practice.

Every trainee is familiar with anxieties about moving to new placements. Anecdotal and personal experience tells us there are considerable differences between placements.

The National Training Surveys organised by the GMC, PMETB (before the GMC merger) and COPMeD, run annually and rate trusts in several educational domains, highlighting areas of notable practice and areas of concern. However, the national surveys do not tell us the strengths and weaknesses of individual placements. Although we had an overview, there was an urgent need for more detailed information.

A major Trust-wide survey was commissioned by the Trust's Director of Postgraduate Medical Education. To encourage honest and therefore useful responses the survey was entirely led and conducted by trainees in the South London and Maudsley NHS Foundation Trust (SLaM). Trainees were also responsible for the dissemination of the information.

The overall aim of the survey was to obtain detailed and useful information on training placements mapped to the domains in the 2008/2009 National Training Survey. We aimed to find examples of good practice and identify problems to help improve placements and the training scheme as whole.

Core Trainee experiences of placements in SLaM were assessed using an anonymous online survey. The targets for the survey were current Core Psychiatric Trainees (Years 1–3) on the rotation. The survey was advertised in person to

trainees at their MRCPsych teaching course and via email.

The survey asked trainees five key questions which were selected and adapted from the National Training Surveys as areas where more information was needed. Trainees retrospectively completed a questionnaire for each of their Core Training placements. In addition to the five questions derived from the National Training Survey, trainees were asked whether they had experienced any undermining behaviour and were given three open response questions.

We obtained a 62% response rate (77 out of 124 trainees) which provided over 200 responses on 102 different placements. Trainees identified the major strengths of the training scheme as being the wide variety of placements in specialist posts and the quality of Educational Supervision. The majority of trainees identified their supervision time as the one part of their training they would protect. Overall areas of concern included supervisions being used primarily to discuss clinical work and placements with a heavy workload which limited opportunities to gain competencies and complete work place based assessments. There were also a small number of placements in which trainees felt unsupported and identified the need for a senior support as the one thing they would change.

The data does have limitations. The information is subject to response and recall bias. The relatively low response rate means the opinions of a number of trainees were not heard. We also faced a number of challenges. The information we collected was highly sensitive particularly given questions about

undermining behaviour. Given the limited number of placements a trainee completes there was a risk trainees might be identifiable from their responses. We needed to ensure that trainees felt safe enough to provide honest, accurate and hence useful responses.

The approach we adopted was that the survey was led by trainees who were fully responsible for collection and reporting of the information. We published a report which rewarded high scoring placements by naming them and gave an overview of data. The few cases where undermining behaviour was identified by more than one trainee were managed by channelling the information to the Director of Postgraduate Education for further investigation. The more detailed information in the survey was the starting point for an in-depth interview-based review of training placements in the Trust.

Our key recommendations are that the Trust should set up a fixed, anonymous system for trainees to deliver feedback after every placement. We also need to develop a structured means of delivering feedback to trainers and to provide support to improve placements. We recommend the trainee-led approach as crucial to ensuring trainees feel confident to provide open feedback on problems they faced, both for future work in SLaM and for other Trusts to consider adopting.

Dr Marisa Dias, Dr Sarah Saxena, Dr Jo Hurlow and Dr Muj Husain

Core Trainee Doctors, SLaM  
NHS Foundation Trust

# RECRUITMENT TO PSYCHIATRY: A FOUNDATION DOCTOR'S PERSPECTIVE

I was fortunate enough to attend the London Spring Academic Meeting, "Who Wants To Be A Psychiatrist?" back in May.

<http://www.rcpsych.ac.uk/rollofhonour/divisions/london/previouslondonevents.aspx>

It was a compelling meeting. It drew attention to the ongoing difficulties of recruiting junior doctors to psychiatry. Included amongst the speakers was Professor Robert Howard, Dean of the Royal College of Psychiatrists, who outlined the problems surrounding recruitment and the plan to improve the quality of recruits. Professor Howard is highly attuned to the situation; citing psychiatry's declining popularity, its over-reliance on overseas graduates and an unacceptable variation in quality as major challenges. He spoke of the need to further engage with medical students and to increase the number of foundation training posts that include a rotation in psychiatry.

There were excellent, inspiring talks from Professor Ania Korszun of Barts and the London, Professor Simon Wessley from Kings College London and Dr Chris Manning, a retired GP with a vast background in the mental health field. Additionally, a fellow foundation trainee, Dr Kate Stein, offered us her hitherto experiences of psychiatry and how it features, or sometimes does not feature, within the wider medical disciplines. One of the prevailing themes was that the unfavourable views of psychiatry amongst other medical specialities damages the willingness of medical students to consider a career in psychiatry. It is not seen as 'scientific' enough. Students start out at medical school with an open mind about becoming a psychiatrist but by the end of the course their receptiveness has eroded due to the cynicism of senior doctors. The hope is that the younger generation of doctors, through exposure to anti-stigma campaigns and advancing science, will not adopt such standpoints.

Attending as a foundation doctor with an aspiration to specialise in psychiatry, I found the meeting fascinating. I was buoyed by the enthusiasm in the speeches, the probing discussions and passionate concerns for the future of psychiatric recruitment. I got the sense that the priority was not enhancing the legacy or standing of psychiatry as such, but

providing people suffering from mental illness with the best care, because that is what they deserve.

Medical students and foundation doctors were present in the room, most of whom had an interest in psychiatry as a career already. The point was raised that psychology as a degree is indeed a popular choice for school leavers applying for university. Psychology students however, quite often find the jobs market highly competitive following graduation. This led to a suggestion that by talking to sixth-form students about psychiatry as a career may prompt some considering a career in psychology to think about doing a medical degree instead. However, I wonder if we overlooked the fact that the vast majority of medical schools still require chemistry A-Level for an eligible application. Many sixth-formers interested in psychology may not have chosen chemistry as an A-Level and so perhaps it might be more beneficial to target students before they make their A-Level choices i.e. at GCSE stage. Chemistry is recognised as one of the 'respectable' subjects, valued for its examination of a student's ability to apply logic and memorise pure facts – key attributes for the intellectual rigors of medicine.

I was also lucky enough to attend the Student Associates' Conference at the International Congress of the Royal College of Psychiatrists in Edinburgh in June. Again, there was an inspirational speech on 'Why psychiatry is a great career' by Dr Ross Overshott, a Consultant Psychiatrist in Oldham. It was brilliant, but similarly to the event in May, there was a sense of 'preaching to the converted'. There is no doubt that there is great interest out there in psychology amongst young people, and that surely many potential psychology graduates are capable of attainment in core science topics. Perhaps not overnight, but in years to come, a psychiatric recruitment drive targeted at a younger population might produce the workforce benefits that the field needs and merits.

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# Bedlam at Shakespeare's Globe, by Nell Leyshon



*"Love is merely a madness, and, I tell you, deserves as well a dark house and a whip as madmen do." This is one of Shakespeare's famous quotes which reflects upon the perception Shakespeare's Londoners must have had about psychiatry around 1800. I can imagine that the playwright Nell Leyshon used similar quotes as an inspiration to write the play 'Bedlam' for the Shakespeare's Globe Theatre. She is the first female playwright to be staged in the Globe Theatre.*

When I first found out about the upcoming 'Bedlam' play I knew I would like to review it, having been a trainee that worked at the Bethlem Royal Hospital in Beckenham and also being fascinated by the history of psychiatry in general. I had really high expectations to begin with. Some of them were met while others were unfortunately not.

The play is set in mid 18th century at 'Bedlam', a word meaning uproar and confusion, derived from the name of Bethlem Hospital. Around this time the hospital, or better, the asylum was still housed at Moorfields. A venue as the Globe Theatre understandably added to the atmosphere and time setting of the play. The goals of the asylums were mainly to protect society from the patients

compared to the nowadays intention to treat and care. Dr. Carew is the medical director as well as the only physician at the asylum and his son is his medical trainee. The asylum staff was portrayed as corrupt and far from empathic towards the patients.

Personally I was quite fascinated by the 'ward rounds' acted out on stage. The physician used one of his own patients to take notes and called out the new admissions by shouting at them. After quickly observing them, he decided upon a treatment plan from only a few options available: either applying leeches on the patient's body or prescribing them with laxatives!

We have all probably heard the appalling stories about the 18th century elite visiting the asylums as a Sunday afternoon 'treat'. This is also portrayed in the play. Local elite, consisting of a poet and his friends, pay the nursing staff to be allowed the amusement of poking the patients and observing their responses.

Gin or alcoholism seems to be one of the main 'themes' throughout the play. As it is well-known from history and literature, gin was a 'cheap' and strong distraction of daily life. All the social classes, patient or staff, young or old appeared to be under the influence of this

magic potion. Nell Leyshon wisely created a humoristic 'Gin lady'. She isn't shy of distributing her Gin between the staff and patients. She is also acting as a human link between the asylum and the outside world, showing them and us 'how daily life really works' in the mid 18th century London.

In the sober decor which looked more like a prison than an asylum you would assume that there was hardly any inspiration to sing and dance. However this play was full of singing and dancing which made it quite cheerful and upbeat but also at times resembling more a West end musical than a play about the "mentally insane".

The cruel times of Bedlam psychiatric practice seemed to change as Dr. Maynard an 'inspector' arrives to discuss and observe the medical practice in the asylum. Half way through the play he is the character that bursts out in a monologue about mental illness and the link between body and mind, also citing an appeal against stigma. A fascinating appeal which perhaps should've deserved a bigger part of the play, as although a lot of progress has been made since then stigma about mental illness still exists.

One of the themes seemed to be 'the sane going insane and the

insane being cured after all'. Dr. Carew's mental state gradually deteriorates under the influence of alcohol and the signs and symptoms of neurosyphilis. In a tragedian redistribution of justice, he ends up admitted into his own asylum, among his own patients and under his wife's eyes.

The commitment of the actors to the play and the characters definitely deserves your attention from start to finish. Their interaction with the audience, ensured that

everyone was involved in the play, making it a more personal experience. However, the characters were static with hardly any development and that, despite the cast's enthusiasm and acting skills the play less interesting from a psychiatric point of view. Leaving the play I could not help thinking what service users would think about the play.

Perhaps the best line from the play was one of Dr. Carew

reflecting upon his profession and own mental state. Therefore I'd like to conclude with the following quote:

" Excuses me, I'd like to stress I am a 'Mad-doctor' not a 'mad' doctor!"

**Dr Anne-Marije Prins**  
CT2 in Psychiatry  
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## A Front of House Psychiatrist: Almeida Theatre



The Almeida is a 325 seat theatre in the heart of Islington. It produces a diverse range of British and international drama with some of the world's best artists, and has developed a reputation as a local theatre with world profile.

I have been a sort of 'in house' psychiatrist for the Almeida theatre for the last 4 years. I was initially asked to advise the cast about T. S. Eliot's wife Vivienne Haigh-Wood's illness for Michael Hastings' brilliantly researched play 'Tom and Viv'.

It's not clear to me whether I subsequently was more on the lookout for depictions of mental health in theatre than before or whether the fashion for psychology and psychiatry in TV has spilled over onto the stage and lead to a real increase in appearances of psychiatry and psychology. In any case there have been frequent opportunities to develop a series of collaborations between the Royal College of Psychiatrists and the Almeida. These have been primarily as post show panel discussions expertly chaired by Professor Dinesh Bhugra. The panels include mental health professionals,

but we often benefit from members of the cast and the director joining in.

The focus of the discussions has been on theatrical representations of psychiatry, psychotherapy and psychology. Theatre allows us to explore both how we see ourselves as professionals and also how we are perceived by a wider audience.

The first panel discussion was after Matthew Lloyd's production of Tom Kempinski's 'Duet for One' starring Juliet Stevenson and Henry Goodman (5/3/2009). The play tells the story of the relationship between a celebrated musician struck down with MS and her psychiatrist. It was hugely successful and transferred to the west end. Dr Peter Byrne and Dr Cleo Van Velsen joined Professor Bhugra and the director on the panel. The drama of the play relied on breaches of professional boundaries and a rather smoke and mirrors depiction of the therapeutic relationship. Of course, an accurate depiction of a therapeutic encounter rarely makes for high drama, so there must be artistic licence. The play was written in the 1980s and since then one could argue that the

professional role of psychiatrist has changed to emphasise transparency and collaboration. (Perhaps in part due to patients' easier access to information on the web.) Despite this professional shift the panel discussion revealed how public perception of this relationship may not have caught up. I use the script for teaching purposes to generate debate on how NOT to interact with patients. For instance Dr Feldmann does not warn his patient Stephanie of any potential side effects from the antidepressant in case she is too suggestible; unthinkable nowadays.

Thea Sharrock's production of Nicholas Wright's play 'Mrs Klein' depicted the damaged and competitive relationship between Melanie Klein and her daughter Melitta Schmideberg. It intertwined the drama of a fraught mother-daughter relationship with themes from Klein the great psychoanalyst's work. Our panel included Margaret Rustin and Professor Juliet Mitchell who offered insights into the life of Klein. Both playwright and director were on the panel, but the highlight of the panel discussion was when the lead actor Clare Higgins joined the discussion to offer insights into how it felt actually to BE Klein! (11/11/2009).

'Through a Glass Darkly' was adapted for stage by Jenny Worton from the Ingmar Bergman film. It depicts the psychotic breakdown of a young woman Karin on a remote Scandinavian island in the fifties. For Bergman the accuracy of the depiction of mental illness was less of a priority than it was for in this adaptation for the stage. I assisted Jenny in ensuring that there was a degree of clinical authenticity to the depiction of psychosis. While the play's artistic mission went beyond a truthful description of Karin's illness it provided rich teaching material for Almeida Projects. This is a creative learning project for young people. It offers outreach workshops to schools and community groups in Islington and beyond. This play was a starting point to generate educational resources about mental illness. For instance, generating a discussion about what support a young woman with first onset psychosis in 2010 Islington might expect from a modern early intervention team.

'House of Games' is another adaptation this time from a David Mamet film. Interestingly

Richard Bean's theatrical version changes the protagonist from a psychiatrist into a psychologist. She has made money writing a successful book and perhaps tired of working with patients she is drawn into the shady underworld of con artists and gambling by her patient, who is a con artist posing as a compulsive gambler. Acting, being in itself a deception, means that performing the role of a con artist involves complex layers of pretence for the cast. Here again the drama relies on crossing therapeutic boundaries and the professional is conned by the patient. Dr Cleo Van Velsen kindly chaired a post show panel with Dr Etta Bowden Jones offering insight into the world of compulsive gambling. Cleo and Dr Tim McInerney both working in forensic psychotherapy and psychiatry commented on the art of the con and working with deception in the therapeutic relationship.

Our next planned panel discussion is for David Eldridge's 'The Knot of the Heart.' This is a play about a young successful woman struggling with addiction. Dr Owen Bowden-Jones has already offered the cast his expertise and will join Dr Cleo Van Velsen on the panel chaired by Professor Bhugra. The panel will be after the performance on 06/4/2011. If you would like to buy tickets for this panel discussion please contact the box office on 020 7359 4404. Tickets are £10 and include a glass of wine. Tickets to the performance range from £8 to £29.50.

For more details on the play, please see the Almeida's website: [http://www.almeida.co.uk/production\\_details/production\\_details.aspx?code=105](http://www.almeida.co.uk/production_details/production_details.aspx?code=105)

Also if you'd care to sponsor my 2011 London marathon in support of The Mental Health Foundation and Almeida Projects please proceed to <http://uk.virginmoneygiving.com/jamiearkell>

**Dr James Arkell**  
Consultant Psychiatrist  
CNWL Foundation Trust

# Contemporary British Theatre and Subjectivity in Psychiatry



A Narrative Medicine workshop was held at South Kensington & Chelsea Mental Health Centre to explore the subjective experiences of mental distress using a selection of readings from Sarah Kane's play *4:48 Psychosis*. It was felt that a more in-depth exploration of the text would be beneficial so it was arranged for the play to be read in full and then discussed. The reading was well attended by junior and senior colleagues. What follows is an abridged synopsis of the evening's introduction, the play and the themes that emerged out of the discussion afterward, led by Dr Anne Patterson (College Tutor). I would like to acknowledge Drs Patterson and Chris Hilton (ST4) for their help in organizing the evening.

## Sarah Kane & In-Yer-Face Theatre

Kane is accepted as having been a cutting-edge playwright of the *In-Yer-Face* movement of British theatre. These plays strove to make audiences experience the extreme emotions being portrayed, employing shock and projective identification. They were often bleak and dystopic, in antithesis to the "Things Can Only Get Better" propaganda of the 1990s.

Kane was born in 1971 in Essex to Evangelical parents and is reported to have rejected her Christianity. It is publicly known that Kane had been an in-patient, however her diagnosis will deliberately not be discussed. Her public career began in 1995 with her first play, *Blasted*, and ended with her suicide by hanging, before the post-humous production of *4:48 Psychosis*.

The playwright David Greig writes in the introduction to Kane's *Complete Plays*, "It would be a pity... if in attending to the mythology of the author we were to miss the explosive theatricality, the lyricism, the

emotional power and the black humour contained within (Kane's) plays". I question whether by deliberately not attending to this "mythology" we are participating in a denial of the brutally distressing violent fantasies actually acted out on stage through her work.

*Blasted* opens in "a very expensive hotel room in Leeds" with two characters, Ian and Cate. Ian's first line is, "I've shat in better places than this". The discourse becomes increasingly vulgar and it is revealed that Ian has raped Cate. There is then a knock at the door, a soldier enters and brings a violence that shatters or *blasts* the internal and external worlds of the piece. The play undergoes a fragmented, violent and regressive breakdown, losing temporal and spatial continuity, becoming a horrible yet powerful primary process montage depicting urination, defecation, rape, cannibalism, helplessness and isolation. It is in this way that extreme emotions are thrust at the audience. At the time *Blasted* created a furore with the Daily Mail describing it as a "disgusting feast of filth" - the press reaction is said to have precipitated a depression for Kane.

All of her plays build on the anti-naturalism established in *Blasted*. Her other plays are a re-working of Seneca's play *Phaedra*, where *Phaedra* commits suicide after falling in love with her step-son; *Cleansed* - where love is sadomasochistic; and *Crave*, which Kane described as her "most despairing play" about "losing faith in love".

## 4:48 Psychosis

The themes of Kane's earlier works reverberate in *4:48 Psychosis*. It is written without stage direction and it is unknown who is speaking.

Consequently, it has been performed as a monologue and an ensemble piece. The title is explained as the “darkest hour” of early morning waking “at 4:48” and the plot follows a psychotic breakdown including admission to hospital. At times there is a clear “gallows humour”.

We are told:

*“I am sad*

*... the future is hopeless...*

*I am bored...*

*I am guilty*

*I would like to kill myself...*

*I can't eat*

*I can't sleep*

*I cannot make love...”*

We are presented with an existential paradox “I have become so depressed by the fact of my mortality that I have decided to commit suicide”.

The play is punctuated by a voice giving serial 7s and “no ifs or buts”. There appear to be conversations between psychiatrist(s) and patient. At one point a voice replies “Okay, let’s do the drugs, let’s do the chemical lobotomy, let’s shut down the higher functions of my brain and perhaps I’ll be a bit more capable of living”. On a ward-round, “a room of expressionless faces staring blankly at my pain”. The *objective* voice of a psychiatrist contrasts with the despair of the patient which pleads, “You are my doctor, my saviour, my omnipotent judge... the surgeon of my soul”.

When asked, “why did you cut your arm?” we are told “...Because it feels fucking amazing”. An unconnected voice says “victim – perpetrator – bystander” and we are left wondering who is the victim? Perpetrator? Bystander? - In the case of deliberate self-injury we can find ourselves locating this triad within the patient.

One of the clearest themes that arose from the discussion was the feeling that 4:48 appeared *real* and sincere to Psychiatrists and there appeared to be a number of previous clinical cases that were sadly reminiscent. It was interesting to note the experience that some patients with severe borderline personality disorder, appeared to enter transient psychotic states in a way not fully encapsulated by present diagnostic guidelines.

Another theme was that perhaps our own clinical *objectivity* is a defense against the unbearable despair of some of the problems we are presented with. We therefore routinely perform “emotion-ectomies” on our cognitions. This in itself is inherent throughout medical specialities, the patient that physicians are going allow to die becomes the patient that is “not for 2s”, just as a hell where the walls of reality break down becomes “F32.3”.

In a similar vein to the tragic self-portraits of Brian Charnley, 4:48 Psychosis provides a wealth of clinical information to the trainee psychiatrist. It perhaps represents an *in vitro* tool to explore some of the psychodynamic themes emerging from the treatment of the suicidal patient, which can help in understanding potentially unbearable emotions.

Sarah Kane’s Complete Plays is published by Methuen Drama.

**Dr Michael Bloomfield**

Clinical Research Fellow & Honorary CT2

South Kensington & Chelsea Mental Health Centre

# Monika Peszek's Artwork



A collection of Monika Filipiak Peszek's artwork is on permanent display at the Awakenings Center and Gallery in Chicago, Illinois, in the United States. The Awakenings Foundation is a private operating foundation established by Jean W. Cozier, a writer and sexual abuse survivor, in June of 2010. Its mission is to support the work of artists who are rape and sexual abuse survivors, and to share their stories with the public, to build awareness of the struggles faced by rape and sexual abuse survivors as they attempt to heal themselves in a society that doesn't like to listen to them.

Jean first purchased Monika's artwork in 2004, but they didn't meet in person until five years later. Monika's artwork was featured at the 2009 "Arts of Survival" exhibition at Northeastern Illinois University.

## "Hang In There"

Acrylic on canvas, 24 x 48

There were periods in my life when I was in a really dark and painful place. I did not want to see or talk to anybody. People can say the most inappropriate things, often with the best possible intentions:

*Why can't you just get over it?*

*It happened so long ago ... let it go.*

*Stop living in the past and think about your future!*

## "The Invader"

Acrylic on canvas, 30 x 40

The abuser invades your territory and becomes a part of you forever. You are never just yourself – you become a land under occupation, ruled and programmed with fear and filled with feelings of worthlessness. He's always present in the background, influencing every decision you make. The abuser kills the person you could have been.



## **"Ripped Apart"**

Acrylic on canvas, 30 x 40

For the longest time, I felt ripped apart, hollow, empty, and skinless. With these feelings came a need to feel whole and put together. I knew the only way to do it was to go back and revisit the abuse and the feelings it brought up in me. I expected it to be painful, like literally sewing myself back together. And it was. But without it, I wouldn't be where I am now.



## **"NO!"**

Acrylic on canvas, 18 x 36

I want to scream the word "NO!" and I do. I scream it over and over, but nobody wants to hear it. And so it keeps happening, over and over again.

For more information about the work of the Awakenings Foundation, contact Jean Cozier at [jcozier@sbcglobal.net](mailto:jcozier@sbcglobal.net) or visit the Awakenings Foundation Web site at <http://www.awakeningsfoundation.net>

(The website will go live in 2011) Originally published in Hektoen International Journal, Vol. 2, issue 3. link: [www.hektoeninternational.org](http://www.hektoeninternational.org)

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