



The Royal College of Psychiatrists London Division Newsletter



Editor
Cyrus Abbasian

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Editorial

Welcome to the sizzling summer edition of the London Division Newsletter! We have an array of interesting articles and hopefully something for everyone.

The Division Chair, Peju Raji, updates us with the latest news and developments affecting London Division. With NHS reforms headlining again, Jim Bolton sheds light on yet more changes, this time affecting post-graduate education at the London Deanery.

Have you ever felt exacerbated with recurrent ruminations of your OCD patients not getting any better? Well guidance maybe at hand, in the form Lynn Drummond's featured article on tertiary OCD services. Then follows a succinct expose by Abdi Sanati on one of the most hotly debated ethical dilem-

mas of our time; assisted suicide. Would any amongst you be willing participants in decisions on whether someone can be allowed to end their life? This article may change your viewpoint.

Our co-editor Stephen Ginn has written two fascinating articles: a report on the government's obsession with happiness in our consumer societies and three graphic novel reviews. The graphic novel can be a powerful tool in teaching psychiatry to patients, carers and the lay public. They can also be especially influential in reducing stigma. Another good method of learning psychiatry is through novels, such as Franz Kafka's 'psychotic' fictions. Sadeq Hedayat was a Persian writer in the Kafkaesque style and his best known novel 'the Blind Owl' is reviewed in relation to references to

mind-altering drugs. Kamran Ahmed writes about the first National Medical Film Festival's attempt at reducing stigma amongst medical students. Staying on the subject of films, I have written a review on Roman Polanski's classic *Rosemary's Baby*. Finally Diane Goslor, who describes herself as an alcoholic in recovery, provides a deeply personal account of her involvement with addiction teaching at St. George's medical school: no doubt a great way to both educate and tackle stigma.

As always we are interested in your feedback and London-centric articles for future publications.

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From the Chair

Dr Oyepeju Raji

I hope that you all enjoyed the recent consecutive bank holidays and royal wedding coupled with the unseasonably warm weather. The weather has been calm in contrast to the turbulent journey of the Health and Social Care Bill. On a positive note, the implementation of the recent Cross-Government Strategy, 'No health without mental health' is making steady progress. Thirteen organisations including the RCPsych and the RCGP have come together to form the Joint Commissioning Panel for Mental Health (JCP-MH) which is co-chaired by Dr Neil Deuchar, RCPsych Commissioning Lead. This panel will address future commissioning of mental health services towards achieving parity of esteem. Surveys show that 31% of GPs felt prepared for mental health commissioning compared with 75% for diabetes and asthma. I recently met with Mr. Kieron Murphy, the

“31% of GPs felt prepared for mental health commissioning compared with 75% for diabetes and asthma”

Director of Delivery of JCP-MH based at the RCPsych to discuss what this could mean for London. I was informed that the JCP-MH is recognised within RCGP as the source of practical guidance for GP commissioning that previous commissioning bodies lacked. The JCP-MH has published Practical Mental Health Commissioning: Volume 1 Setting the Scene, the first of 3 volumes.

For the 3-year 'Fair Deal' campaign, London reported on some of the 8 specified domains. Facing the challenge of improving access to services, while maintaining quality in the current economic climate, there are glowing reports of in-patient services. Psychiatrists are linking mental and physical health through joint clinics with physical health care colleagues. Engagement with service users and carers is ongoing. In addition to providing support for mental health service users, carer organisations are involved with teaching psychiatry trainees interview skills. London remains in the forefront of research with 3 of the 5 UK Academic Health Science Centres based here. Excellence in research is being translated more effectively into improved healthcare services locally, nationally and internationally. The position statement on recovery was another achievement. Unfortunately, to avoid financial loss, I had to make the difficult decision of cancelling what would have been the Division's first evening debate on Recovery.

The mock CASC training events continue with good feedback and has now become a regular event. I am once again grateful to all those who have given their time as examiners and actors. Fu-

ture workshops are also planned. Recruitment into psychiatry initiative continues and I will be talking at a post Sixth Form event in the coming months and a higher specialty trainee will carry out a survey of attitudes to psychiatry. Upcoming events to be highlighted include the International Congress in Brighton, from 28 June to 1 July, celebrating 40

“For the 3-year 'Fair Deal' campaign, London reported on some of the eight specified domains”

years of the Royal College, and Division's academic event on 19th October, which has something for everyone.

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The London Medical & Dental Education Commissioning System

by Dr Jim Bolton

Changes are underway in the organisation and management of postgraduate medical education in London. In 2009, the London Deanery and NHS London announced a three-year programme to separate the commissioning and provision of postgraduate medical education – the London Medical and Dental Education Commissioning System (MDECS) – in line with the general ethos of purchaser-provider split. Under MDECS, it is planned that the Deanery will only have a commissioning role, rather than its present mixed commissioning and provision roles.

In 2010, organisations were asked to bid to become ‘Lead Providers’ (LPs) of education for specific specialties and geographical areas. These LPs will manage their partner organisation or ‘Local Education Providers’ (LEPs) and, in turn, will be answerable to commissioners for the delivery of education in their area. For example, a mental health trust might be the LP for a psychiatry training rotation, managing the other trusts (LEPs) that also have posts on the rotation.

Along with the appointment of LPs, an organisation called ‘Shared Services’ is to be set up. Shared Services will be run on behalf of all education providers to coordinate aspects of training that are more cost-effectively and efficiently run for London as a whole, such as recruit-

ment and the Annual Reviews of Competency and Progression (ARCPs).

The first stage of MDECS included the commissioning of core psychiatry training. Five lead providers have been appointed. From August 2011, all core psychiatry trainees will be on training rotations managed under MDECS. Also in May 2011, the SHA and the Deanery began the process of commissioning higher specialty training in psychiatry. It is anticipated that the smaller specialties will be managed by LPs covering wider geographical areas than for core training, either in north or south or for the whole of London. Negotiations and bidding are underway with the final decision expected in late 2011.

“An important aim of MDECS is to improve the quality of postgraduate education”

An important aim of MDECS is to improve the quality of postgraduate medical education. Although London has large training schemes and important academic centres, we do not score as

well as on measures of quality such as the GMC Trainees Survey. Under MDECS, the commissioner plans to move training resources from areas that show lower quality education to those that deliver higher quality. All training organisations will be closely monitored and the results will be used to judge quality and determine where training in London should take place. The commissioner sees training as a privilege and not a right.

Just as MDECS is being introduced, the Department of Health has published a paper outlining plans for a radical redesign of training for all health professionals in the UK. This includes the abolition of the Deaneries, with the management of education to be undertaken by Local Skills Networks. It is not clear what this will mean for MDECS. After a period of consultation, we now await the DH’s response to feedback on the proposals and look forward to yet more change...

More information on MDECS is available at: www.londondeanery.ac.uk

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The Happiness Agenda

by Dr Stephen Ginn



Image credit mlcastle via flickr

There has been growing interest amongst social scientists in recent years in the 'science of happiness'. This has also found favour with politicians, and from April – via a 'happiness index' – the National Audit Office will seek to establish the key areas that matter most to British people's wellbeing. Should this approach take hold it threatens to redefine the role of government, which has traditionally directed much of its efforts towards the aim of promoting economic growth.

Listen to enthusiasts (Lord Layard or the 'Action for happiness' movement for instance) and one could be convinced. Happiness (or 'well-being', the two words are often used synonymously) can be measured, and inferences can be drawn about what makes us happy or unhappy. Individuals and governments can then be directed towards behaviour and policies which produce the greatest happiness and the least unhappiness. As a result, overall, people are more content.

What should psychiatrists make of this happiness agenda? Even if they are not depressed, many of our patients are unhappy. If we are in the business of reducing mental suffering then we could choose to enthusiastically promote actions that increase happiness. This would be in the same way that a hepatologist might wish to endorse sensible drinking.

Happiness has a subjective nature and is a notoriously difficult thing to pin down. What makes one person happy

does not make everyone happy; indeed what makes one person happy may make another person unhappy - think of a child's glee at tormenting a sibling. These conceptual difficulties with happiness are not in themselves a reason not to try to increase happiness, but should at least inform us to proceed with caution.

Is promoting subjective well-being anything but a personal matter? A top-down approach may struggle to address the complexities at play. One notes for instance that some types of happiness are 'better' than others. Campaigners for happiness often observe that the ways in which we ostensibly seek pleasure – wanton consumption and recreational drugs to name but two – do not bring 'real' happiness. But can such a distinction actually be made?

I also have more practical concerns. Serious steps towards promoting happiness would require our politicians to change their priorities away from promoting consumerism and toward a more equitable society. These are actions they are likely to be unwilling to take. The Action for Happiness campaign does talk about 'actions to create a better society'. Many of its recommendations for behaviour are laudable, but they are also bland and do not challenge the status quo. The revolution offered is meek. As an organising principle the happiness agenda has no direction, no meaning, and no mention of duty or sacrifice.

Action for Happiness' Ten Keys to Happier Living

1. Do things for others
2. Connect with people
3. Take care of your body
4. Notice the world around you
5. Keep learning new things
6. Have goals to look forward to
7. Find ways to bounce back
8. Take a positive approach
9. Be comfortable with who you are
10. Be part of something bigger

Psychiatrists do need to be aware of how 'happiness' is rising up the agenda. With happiness as a focus we may find that our patients increasingly feel that if they are not 'happy' they are failing. One of our roles can be to promote perspective and to remind them that even generally happy lives are still liable to humiliations, disappointments and tragedies. In fact looking on the bright side, unhappiness can be useful as it can spur us on towards changing our lives.

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National Services for Obsessive-Compulsive and Body Dysmorphic Disorders

Since April 2007, the DoH has directly funded a National Service for patients with profound Obsessive-Compulsive and Body Dysmorphic Disorders (OCD/BDD) who have failed all previous treatments. This comprises services at 3 main Trusts, including South West London and St George's (SWLSTG). Strict protocols apply in order to ensure that these services are not overburdened or inequitably accessed by patients across the country. To be eligible a patient with OCD/BDD must have:-

- Scored above 30 on the Yale Brown Obsessive Compulsive Scale (YBOCS),
- Failed to respond to 2 previous trials of SRIs, at BNF recommended doses, for a minimum of 3 months each,
- Failed to respond to augmentation of SRIs as per Palanti et al. 2002
- Failed to respond to two previous trials of CBT, which include graded exposure and response-prevention; one of which should have been carried out in the environment where the symptoms usually generate.

At SWLSTG we are also able to offer intensive home-based therapy throughout UK, as well as outpatient and medication advice, and inpatient treatment for the most severely disabled patients. To be eligible for admission patients must have specific reasons why less intensive treatment is unsuitable, for example:-

- Danger to self either due to extreme self-neglect (e.g. failure to drink sufficiently without nursing input) or sui-

dality

- Danger to others due to OCD (e.g. impulsive acts)
- Compulsions so severe that cannot be managed without 24 hour care (e.g. regular incontinence)
- Complicating additional diagnosis making close observation throughout treatment essential (e.g. anorexia nervosa)

YBOCS, which is observer rated and Beck Depression Inventory (BDI), which is self-rated, are completed by all patients. The last 100 OCD inpatients treated at SWLSTG were: 55 males and 45 females, with average age of 35 years (range 18-66; sd12), and suffered from OCD for an average of 17 years (range 1-50 years; sd 11). 85% were single and only 18% had ever been in stable cohabiting relationships. 83% were long-term

unemployed. However, despite the chronicity and severity of symptoms and previous failure to respond to treatments, these patients did well.

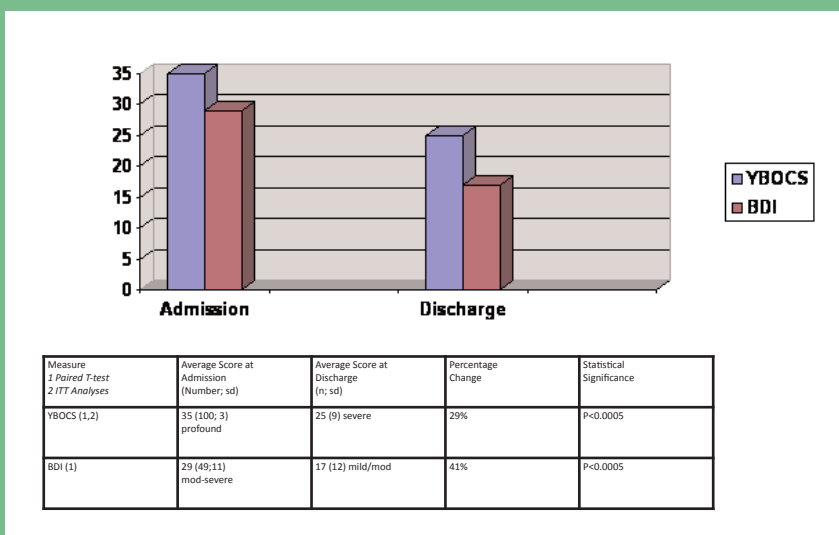
The most severely disabled patients with OCD and BDD can be treated at a specialist unit, without the need for local funding to be arranged. The units which comprise the National Service will redirect patients, work collaboratively and cross-refer suitable patients to each other. Overall clinical outcomes are good following specialist treatment.

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<http://www.swlstg-tr.nhs.uk/our-services/ocd-bdd-service-bcpu-national>



Assisted suicide: is it morally justified?

A brief overview

by Dr Abdi Sanati

In recent years the issue of assisted suicide has been discussed more frequently in public and professional discourses. Different YouGov polls in the last 10 years have demonstrated 80-87% public support for legalising assisted suicide. The opinion of the medical profession has been, by and large, against this. In this short article I aim to raise the most relevant questions needed to address this debate. There is some confusion about the definitions of the terms euthanasia (active or passive, voluntary or involuntary) and physician-assisted suicide, which are used interchangeably. This confusion, it seems to me, is one major obstacle in having a constructive debate on the subject. Professor Tony Hope in his concise, but nonetheless informative, book on medical ethics has given an excellent clarification of these definitions. (Hope, T. 2004)

In the UK the debate has been revolving mainly around physician-assisted suicide; in fact a collection of questions begging clarification. Does suicide per se, unequivocally indicate an unsound mind? Do people have a right to suicide? Is life always preferable to death? Should suicide be assisted by physicians? In debating this one should always be aware of the distinction between the principle and practice. While physician-assisted suicide can be

acceptable in principle, there might be valid practical reasons to oppose it.

The assertion that suicide is a *prima facie* evidence for a disease of mind has been contested by different academic groups in philosophy and psychiatry. It is sufficient to say if this assertion were true the question of physician-assisted

suicide would most likely be rendered redundant. This debate includes questions like: While mental illness plays a known cause of suicide does the reverse also follow, or is it medicalizing misery? Can suicide be rational and aren't people entitled to act irrationally? Patients can refuse life saving treatment for reasons that could sound irrational to doctors.

The preferability of life to death takes us to the realm of val-

ues. While generally life is valued more than death (the argument from sanctity of life), it is difficult to speak of it as absolute. The only rightful arbiter of these values for the patient would be patients themselves. Some of the main argu-

ments against come from the practical aspects with the most forceful one being the slippery slope arguments; so far the most convincing argument against physician-assisted suicide. There are valid criticisms of the latter (by likes of Tony Hope and Mary Warnock). In real life situations Laws tend to assume a course of their own and are used in a variety of different situations, some unrelated to its original purpose (like the use of the Anti-Terror Law in early disposal of trash cans).

It is imperative that the right questions are asked and valid arguments are used. While I personally think it is not the physician's role to participate in assisting suicide, I believe it is dangerous for society to impose its values on individuals.

I have tried to highlight some of the questions but in this short article there was no way that I could do the topic justice. For references and list of relevant terminally please contact me.

Finally I would like to thank Dr. Stephanie Young for her input.

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"While I personally think it is not the physician's role to participate in assisting suicide, I believe it is dangerous for society to impose its values on individuals."



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International links: supporting the MMED Psychiatry programme in Zambia

By Dr Angela Hassiotis
and
Dr Kostas Agath

The Republic of Zambia is a sub-Saharan African country that was under British rule until 1964. It is a low income country with a significant HIV problem (approximately 15% of the population are currently infected) and high maternal and infant mortality.

Mental health is as yet an underde-

veloped area, although recognised as one of the “big five” subjects in medical education. To this end, the Zambian Ministry of Health, along with volunteer colleagues from the UK and support from the Tropical Health and Education Trust (THET), have developed a MMED course in psychiatry to train home-grown psychiatrists. The programme, which has recruited three trainees, has just run the first of a four year cycle.

Our involvement began in response to a request by Dr. Blackwood (General Adult Psychiatrist and coordinator of the MMED curriculum) for specialists to support the programme. The remit was

teaching various subjects of the curriculum and contribution to service development in the area of substance misuse and children with special needs. Given our clinical and academic expertise and

“We did not come across a single case of low morale amongst the doctors we met”

a curiosity about the social and political situation in the African continent, we agreed to a short-term visit. Many emails were exchanged over several months involving THET - who sponsored our trip - Dr. Blackwood and his Zambian counterparts, supplemented by face to face discussions during Dr. Blackwood’s visits to the UK. THET staff were helpful in managing the practicalities of the trip and we had a fascinating time there, including a visit to Victoria Falls!

The mental health needs in Zambia can be overwhelming and the resources within the state health system were scarce: there was no clinical guidelines

or patient care pathways; no mental health policy (or rather one had been in draft form for some time with no end in sight); services can be fragmented and multidisciplinary working arrangements were not sufficiently cultivated.

The MMED programmes in psychiatry may be a way forward in building clinical and research capacity in a neglected health domain; in fact a similar programme is beginning in Malawi. Curricula must also have space for personal development and well-being, not just educational achievements, and how they are delivered is a challenge since many of the skills and competencies in the UK Gold Guide were not readily available.

We have concerns about the role of trainers going there only in the short-term and how to sustain the programme in the longer term. Also it appears that creating a research agenda in mental health maybe trumped by the vast amount of money and labour going into communicable diseases.

Nevertheless, during our visit we were able to contribute to the local curriculum, both in content and in format. For example we introduced concepts such as: inclusion of medical leadership and psychotherapy experience in the curriculum, clinical supervision of individ-

ual doctors and having grand rounds. We also suggested research projects to trainees, advised on service configurations that may help underpin medical training and participated in workshops shaping the national alcohol policy.

In the process we also learnt many things. We were impressed by the dedication of the local doctors, irrespective of whether trainees, trainers or medical managers. We witnessed “master-classes of HIV clinical management” on a daily basis and did not come across a single case of low morale amongst the doctors we met. How does that compare with the situation in your locality?

Our experience endorses the concept of interdependence in global health (Crisp, 2010). This interdependence, however, needs to be cultivated through ongoing input from training and educational initiatives. Such endeavours are not without challenges in organisational terms as they become a bridge between different socio-political structures. Many of us will not have worked in low or middle income countries before, so induction prior to starting out may be necessary in the future. Furthermore, maintaining a balance between consultation, ownership of the initiative and focus is paramount if the objectives are

to be achieved.

Acknowledgments: We would like to thank the trainees, nursing staff and colleagues who spoke with us, and the service users and carers who agreed for us to be present during consultations.

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Film review by Dr Cyrus Abbasian

‘Rosemary’s Baby’ - Roman Polanski’s insight into Prenatal Psychosis

Roman Polanski is the critically acclaimed director of films including *China Town* and *The Pianist*. His film *Rosemary’s Baby* is set in 1960s New York City. The newly married Rosemary rents an apartment with her husband Guy, which had allegedly been previously occupied by Satanists and witches! The next door neighbour’s flat was part of theirs before separation by partitions. Rosemary, originally from Nebraska, was raised in a Catholic home and attended convent school.

Prior to becoming pregnant Rosemary starts becoming suspicious towards her neighbours and Guy’s elderly friends. Guy’s revitalised career after his main rival going blind also troubles her. He then announces the ideal ‘baby night’ and gives her some ‘chalky-tasting’ chocolate mousse. Rosemary passes out and in a bizarre nightmare is tied up and raped by a monstrous creature. When awake she is scratched and Guy apologises for having had intercourse with her whilst asleep.

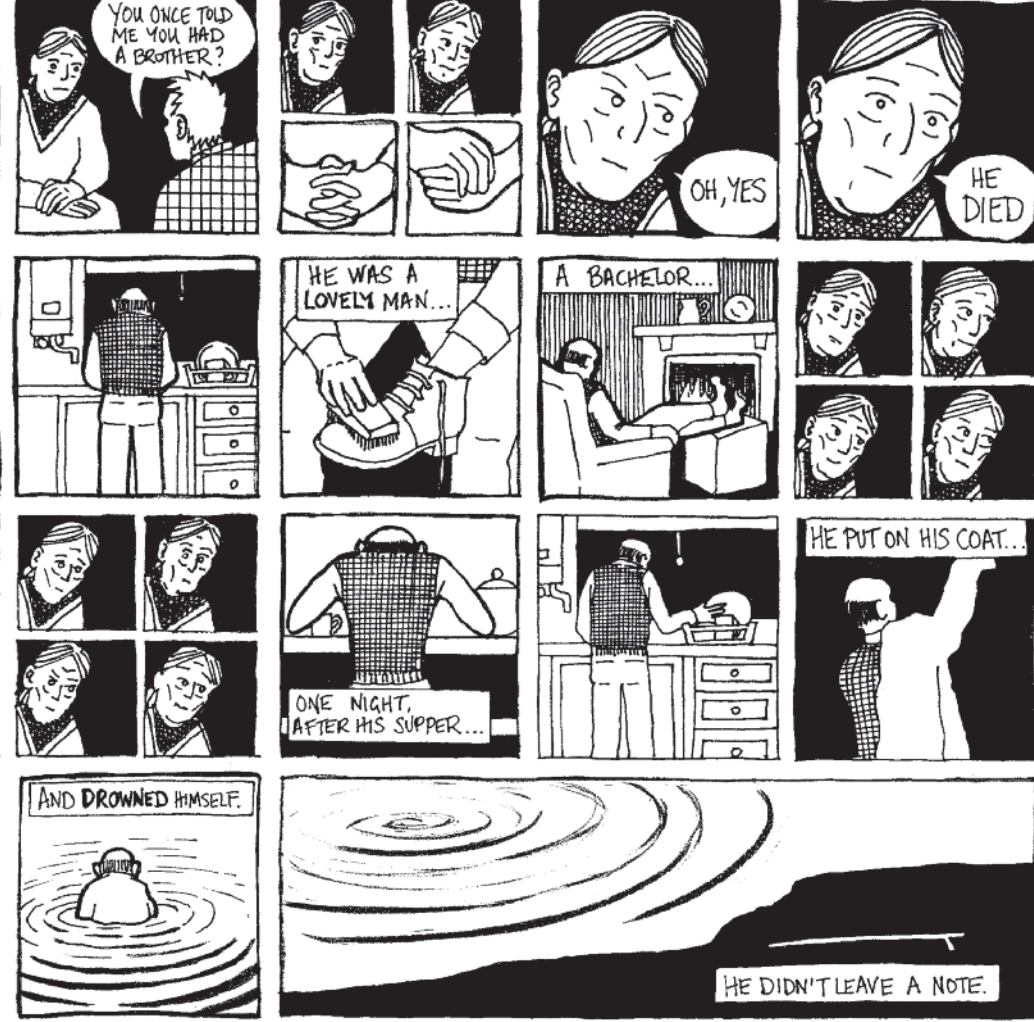
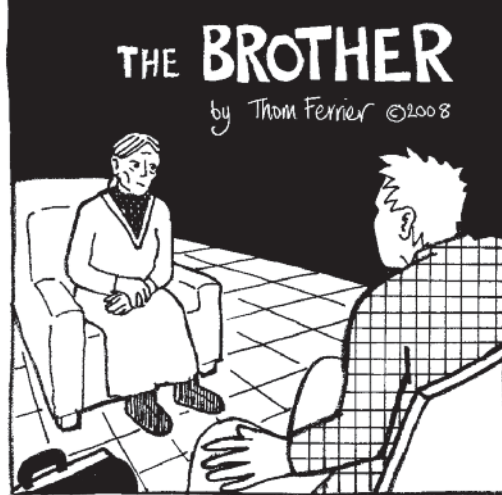
When pregnant Rosemary starts seeing Dr. Sapirstein, an Obstetrician, ac-

cepting his advice of taking ‘vitamin drinks’ prepared by the neighbours. As pregnancy progresses she feels mounting anxiety. A friend visits but then falls into a coma and dies, but not before giving her a book called ‘All of Them Witches’. She suspects that her husband’s friends are Satan worshipers and visits Dr. Sapirstein telling him she will no longer visit. His secretary’s remark, that he sometimes smells of ‘tannis root’ – commonly called ‘Devil’s Pepper’ – convinces her that her Obstetrician is also a witch and part of the plot against her.

Prior to delivering she continues to discover more strange things concerning witchcraft involving Guy, including infanticide. Rosemary sees another doctor revealing her suspicions. He pretends to take her seriously, but then administers sedatives. She is horrified upon waking to find Guy and Dr. Sapirstein have arrived to take her home; asking her to be quiet otherwise may be locked up in a psychiatric institution. During Rosemary’s struggles she goes into labour and is injected with a

drug. Upon waking she is told that her baby has died.

Days later her breast milk continues to be collected by neighbours and she starts hearing a baby crying. She grabs a knife and through the cupboard partition dividing adjacent apartments finds her way into the next door neighbours’ flat. All the witches have gathered there and in a cot she sees her child for the first time; becoming horrified of his strange eyes. She finally learns of the full plot, which was her impregnation with Devil’s spawn. After the initial shock she seems to warm to the idea of being a mother. The movie ends with her rocking the cradle.



Read more Thom Ferrier at <http://www.disrepute.info/>

Graphic novel reviews by Dr Stephen Ginn

'Couch Fiction' by Philippa Perry

Couch fiction – a graphic tale of psychotherapy is an illustrated tale of fictional psychotherapy sessions between James, a successful barrister, and Patricia, a psychotherapist.

Despite his wealth, James has a penchant for petty thieving and troubled relationships in his present and past. As the therapy sessions develop both his emotions and motivations and the nature and peculiarities of the therapeutic relationship that develops with Patricia are explored. Perry presents the therapeutic process as helpful and special, but also addresses the imperfections of

the process. For different levels of interest or expertise in psychotherapy Perry has provides two texts in parallel. The graphic strip contains the narrative where we read the characters thoughts and speech, whilst footnotes underneath are more didactic and unpack the therapeutic techniques at play.

For the uninitiated especially there is much to discover from this book about the process of psychotherapy. However the dialogue is rather wooden, and the illustration is not particularly accomplished or interesting. I also found the dual approach to narrative unsatisfactory, as it's jarring to read both simulta-

neously but neither is fully satisfactory on their own. The ability to innovatively combine words and pictures is one of the strengths of graphic novels so the decision to opt for a dual approach is perhaps a missed opportunity.

Finally, although she is at pains to present realistic characters, Perry does yield to the temptation to give her story a resolution, whilst never conceding that one of the great frustrations of psychotherapy is that full resolution of the difficulties of the subject of therapy is rarely achieved in the neat way she presents.

'Epileptic' by David B

Epileptic is a memoir of childhood and disease, and also tackles the dreams and fantasies of emerging maturity. When Pierre's brother, Jean-Christophe, develops epilepsy age 11, his family is profoundly affected. In a search for a cure his parents seek the

advice of all manner of alternative therapists, mediums and communities; but alas any improvement is often short lived. Pierre seeks solace in drawing elaborate battle scenes and as an adult becomes the acclaimed cartoonist David B. In contrast the adult Jean-Christophe becomes demoralised and distant, his

life dominated by the side effects of his medication and his still constant seizures. Central to the book, the relationship between Pierre and Jean-Christophe remains complicated.

***I had a black dog and Living with a black dog* by Matthew Johnstone**

Less a graphic novel than a picture book on an adult theme, 'I Had a Black Dog' is Matthew Johnson's visual articulation of what it is like to suffer depression. Borrowing Churchill's sobriquet for his dark moods, throughout the book's pages Johnson illustrates a man bedevilled by an ever-present black dog: it's his reflection in the mirror; it lies between him and his partner at night; it sits on

his food. Johnson's illustrations have a dark wit, but also a serenity as he charts his subject's journey from despair toward insight and respite via professional help.

A sequel of sorts, 'Living with a Black Dog' continues the theme, focusing on the challenges faced by partners and carers of people affected by depression. Amongst the subjects covered are how to recognize depression, good and bad things to say, and how carers and patients alike can access help.

'I Had a Black Dog' and its companion project homogeneity onto what is in fact a very heterogeneous patient body and mostly shun any discussion of the complex ways in which people arrive and are maintained in this state of mind. This reductionist quibble aside, their accessible approach and common sense advice make them a good place to start any discussion on this common disorder.

The Doped Owl! Opium in Sadeq Hedayat's Writings. By Dr Cyrus Abbasian



Sadeq Hedayat (1903-1951) is the best known twentieth century writer of Persian short stories, famous for his 'psycho-fiction', especially the surreal Kafkaesque novella *The Blind Owl* (1937). Written in the first person, this nightmarish story has been interpreted as psychotic and compared to Franz Kafka's *The Metamorphosis*. Hedayat was in fact the Persian translator of the latter novel and just like Kafka seemed preoccupied with life's misfortunes and death. He eventually committed suicide in Paris.

In his writings are numerous references to mind-altering drugs. In *Buried Alive* (1930) he describes in some de-

tail overdosing on a cocktail of drugs, including opium. He was known to be fond of this narcotic in real life, which gives a feeling of "drifting away, although motionless with cold and numb feet."

"The joy of Opium," he writes, "is like seeing light from behind crystals, breaking up into various colours." "In this state, absurd thoughts enchant and passing thoughts are cunningly glorifying. If we reflect on landscape it's inflated and the passing of time isn't felt." He also writes of subsequent withdrawals symptoms: "when the effect is worn off an eternal sadness envelops." "I become cold, shaking relentlessly for more than half-hour, teeth clicking. Then I develop a burning flu, sweating profusely, with chest tightness and shallow breaths."

Opium has been mentioned no less than 17 times in *The Blind Owl*(i), the novella that begins with the mesmerizing sentence: "In life there are inaccessible gangrenous wounds which, like leprosy, devour and diminish the psyche in solitude."(ii) Wine is also written no less than 34 times which the narrator uses, with opium, as a "shelter for forgetfulness." Leading on from the opening sentence he writes about opium as follows: "These pains cannot be divulged to anyone... hu-

manity hasn't found any solutions or medicines for, but only forgetfulness with wine and artificial sleep with opium and illicit drugs – but sadly the effects of these are temporary and instead of relief, after a while, increase the pain's intensity."

In Persian literature the opium poppy has symbolised love and Hedayat describes the beloved as "a fictional opium-inspired scene." *The Blind Owl*'s protagonist, in fact, increases his opium and wine intake in order to forget her beloved: "similar to how I was used to opium, I was used to her!" In another paragraph he writes: "I went and prepared my fire-pan, and when fire took hold placed it in front of the paintings – took a few draws from the pipe and in ecstasy stared at its images, wanting to gather all my thoughts." "Only opium smoke could achieve this and provide peace of mind" he concludes, "I smoked all my opium until this 'stranger' removed all problematic curtains covering my eyes... Then it was like a weight had lifted from my chest..."

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(i) *Iraj Bashiri's English Translation.*

(ii) *the Author has used his own English translations, from the original Persian, elsewhere in this article.*

Medfest: the national medical film festival by Dr Kamran Ahmed



One of the major obstacles to recruitment in psychiatry, which can affect medical students, is its image, both in the eyes of the public and other medical specialties. How might we challenge these preconceptions? Many psychiatrists have a creative streak which should be embraced and encouraged. There are strong artistic elements to psychiatry; the patient assessment interview invoking some of the same skills employed by journalists, photographers and writers. Speaking as a film buff and (very) amateur filmmaker, I find striking similarities between films and psychiatry. Both are concerned with observing people, exploring personal relationships, and in-

“There are strong artistic elements to psychiatry; invoking some of the same skills employed by journalists, photographers and writers.”

credible often gripping tragic stories. More broadly, however, the worlds of medicine and film have a long and complicated relationship. Films such as ‘One Flew Over the Cuckoo’s Nest’ and ‘My Left Foot’ have produced profound cinematic moments, yet have also portrayed healthcare professionals and patients controversially.

Given these connections and my interest in film, I thought up the idea of organising a national medical film festival ‘MedFest 2011’ consisting of a series of free events aimed at medical students. Since organised by psychiatrists, I hoped that students at these universities would see our specialty in a different, more positive light. Instead of falling prey to some unfounded allegations, they may start to view psychiatry as the specialty for creative doctors who have a genuine interest in people.

The festival team included members from the College Psychiatric Trainee Committee and was run with the assistance of Psychsocs at nine universities across the U.K. Between us we developed and printed posters, created a website, acquired funding, secured panellists for each event (including comedians, authors, film-makers, actors and eminent doctors) and planned an evaluation to establish its effect on attitudes towards psychiatry.

The programme consisted of a presentation on festival’s theme, the image of doctors, followed by a series of short

film screenings exploring this topic. The first film was a historical gem from the Wellcome Archive, ‘Britain’s Health Services: The family doctor.’ Then the BAFTA-winning short ‘Shadowscan’, about junior doctors working under pressure, was subsequently screened, followed with an animated short film on the image of psychiatrists ‘Beards & Bow-ties’ written and directed by myself. At the events we debated the relationship between medicine and cinema and the depiction of doctors on screen, including how this affects public opinion of the profession. The discussion frequently turned to psychiatry and why medical students were reluctant to pursue a career there.

All in all, the festival was a success and we hope to continue it in the future. I hope that it made some small difference to student perceptions of psychiatry. Also I hope that psychiatric trainees and consultants will continue to support Medfest in the future. In addition to your presence as role models, your assistance will help us continue the festival’s success, which might bring us closer to dispelling myths that plague our specialty.

Please visit www.medfest.co.uk for more details

Kamran Ahmed
Founder & Lead, Medfest
Vice-chair, RCPsych Psychiatric Trainee Committee



Recovering reality

by Diane Goslar

Can you imagine what it's like to be abstinent and yet live in a society dominated by alcohol? I'm not sure how many people understand how truly difficult that is.

My immediate reaction when, as a service user, I was asked to help with teaching addictions to medical students was: "yes, I will" followed silently by, "I wonder how personally difficult this will be?" and "How will

it be received?" Why was I committing myself to something that would, at times, be very painful; as I would have to re-live painful experiences, remembering things I have been trying to forget. Not so easy. Well, part of the answer is that old adage 'giving something back' – being grateful for all the help and support that I have been given. Also being asked about alcohol addiction and on-going recovery gives it im-

portance – that it's worth talking about and people may be interested... Everyone needs encouragement and I'm no exception.

These talks take place at St. George's Medical School and are part of the penultimate year's course. The psychiatrist lectures on addiction and I dovetail into this by discussing my own experiences – symptoms, behaviour, actions, treatment etc. – as an alcohol addict. Admittedly I have to "turn off" when talking here otherwise it would be too emotional. I discuss the past abuse, initial GP referral to a

London NHS Alcohol Treatment Centre, subsequent failed attempts at controlled drinking, five years of descent into fully-fledged alcoholism, finally returning to the same Centre desperate for help when I realised that my only hope was abstinence. The students seem especially fascinated by detox – how it's done, what you see when hallucinating, and how you cope afterwards. I always stress that recovery is

not a finite process. For me it's something on-going and difficult; with some days harder than others.

After disclosing my experiences, the floor is given over for questioning. I remember initially being worried that no one would have any questions. Thankfully there are usually more than the time allows! Some of them pull no punches, such as "you were drunk the whole time before, so what do you do with your time now?" or "do you now think of alcohol as the devil?" I wish I did consider alcohol 'evil' as it would make things easier...

I've now been involved in five teaching sessions and feelings and reactions tend to be different on each occasion. The feedback received has been positive. I do hope that students learn something extra from having a patient present to talk to. It isn't unusual for some of them to give thanks personally. Who knows, it may also reduce stigma and some students may even decide to become addiction specialists. All in all, a worthwhile exercise...

Diane Goslar
Expert Patient

"Admittedly I have to 'turn off' when talking here otherwise it would be too emotional"

**We are pleased to invite you to our Autumn Academic Meeting
19 October 2011 at Standon House, 21 Mansell Street, London**

The aims of the meeting are:

1. Overview of key research developments relevant to clinical practice,

- Prof. Eileen Joyce will discuss how cognitive changes in schizophrenia can be used to improve outcomes in schizophrenia.
- Prof. Allan Young will focus on depression and how best to optimise treatments in unipolar or bipolar depression.
- Prof. Declan Murphy will present data on the development of brain scanning diagnostic tests for autism spectrum disorders.

2. Skills Development,

- Dr. Mark Salter and Dr. Peter Macrae will lead parallel workshops focusing on assessment and management of risk in different clinical settings.

3. Policy Updates,

- Dr. Kieron Murphy will discuss ways in which commissioning for mental health services is expected to change.

Consultants, Locum Consultants, SAS, ST4-ST6 £60.00
ST1-ST3 and Retired Members, £ 40.00

Registration forms and programmes:

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

or contact Susan Halliwell, London Division Manager

tel: 0207 977 6650 email: shalliwell@londondiv.rcpsych.ac.uk

LONDON DIVISION VACANCIES

The London Division has Regional Representative vacancies in the following areas:

North West London

General & Community
Eating Disorders

South West London

Old Age(from October 2011)
Eating Disorders

South East London

General & Community (from October 2011)
Eating Disorders

Any one who is interested in taking up one of these posts should send their CV along with a statement containing a short profile of the attributes and experiences they feel they could bring to the post, and also reflect on the time commitment required in meeting of deadlines assuring your capacity to act in the advisory role to:

Susan Halliwell
London Division Manager
6th floor, Standon House
21 Mansell Street
London E1 8AA

LONDON DIVISION MEDICAL STUDENT ESSAY PRIZE

The Annual Medical Student Essay Prize has been set up by the London Division for all medical undergraduates in the London area.

The essay can be on any topic related to Psychiatry. Applicants might like to consider a literature review, an essay written as a debate on a topical issue in psychiatry, a description of a significant experience in psychiatry whilst at medical school, etc. The topic should be agreed with a Psychiatric tutor or the Head of the Department of Psychiatry.

Prize: £250

Frequency: Annually

Eligible: Medical undergraduates who are currently in a Medical School in London.

Where presented: Divisional Academic Meeting.

Regulations:

1. Eligible students are invited to submit an original essay of up to 10,000 words which should include all references, acknowledgements and appendices on an aspect of their choice.
2. The essay should be supported by a review of relevant literature and should be the candidates own work.
3. The topic should ideally be agreed with a Psychiatric tutor or the Head of the Department of Psychiatry.
4. The London Division Executive Committee will appoint a minimum of three examiners to judge the entries.
5. Submissions should be made electronically to Susan Halliwell.
6. Only one submission per candidate will be accepted.

Closing Date: **17:00 hrs Friday 5 August 2011**

Submissions to: Susan Halliwell
London Division Manager
The Royal College of Psychiatrists
6th Floor, Standon House
21 Mansell Street
London, E1 8AA

Tel: 0207 977 6650
shalliwell@londondiv.rcpsych.ac.uk

LONDON DIVISION MEDICAL STUDENT RESEARCH PRIZE

The London Division has established an annual prize for the best research project conducted by an undergraduate in the London Division. This should describe a research project in psychiatry where the student has made a significant contribution. The topic should be agreed with a Psychiatric tutor or with the Head of the Department of Psychiatry.

Prize: £250

Frequency: Annually

Eligible: Medical undergraduates who are currently in a Medical School in London.

Where presented: Divisional Academic Meeting.

Regulations:

1. The manuscript should be no longer than 10,000 words which should include all references, acknowledgements and appendices and be written in the format normally associated with research articles published in the academic press.
2. The manuscript should also include an abstract of no more than 200 words written in jargon-free language that can be understood by a lay person.
3. The topic should be agreed with a Psychiatric tutor or with the Head of the Department of Psychiatry.
4. The London Division Committee will appoint a minimum of three examiners to judge the entries.
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Executive Committee Members

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| Dr Kostas Agath | 2011 (E) | Financial Officer |
| Dr Saeed Alam | 2011 (C) | Affiliate Representative |
| Dr Mark Andrews | 2009 (C) | Deputy Regional Advisor |
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| Mr Raymond Brookes-Collins | 2009 (C) | Carers Representative |
| Dr Andrew Cohen | 2010 (C) | Child & Adolescent Faculty |
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Contact

Susan Ranger (Division Manager and Newsletter Co-ordinator)

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email: sranger@londondiv.rcpsych.ac.uk

Please feel free to send us your articles

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

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