



The Royal College of Psychiatrists London Division Newsletter



Editor
Stephen Ginn

March 2011 Issue 16

Editorial

“Never think of the future”, said Albert Einstein “it comes soon enough”. Predicting the future is a thankless task but for this issue four contributors have been willing to take on the challenge. A voice from the future Prof Hamish McSalter reflects on a time when ‘death became the last true resort of sanity’. Dr Derek Summerfield stays with the present day and frames the future in terms of what has come to pass thus far. Dr Trevor Turner stays with this theme: where psychiatrists have seen their future in the past is informative in guiding our current path. Dr Michael Maier’s focus is on the current difficulties with training and Dr Kevin Healy sees our role as ‘doctors of the body and of the mind’ a role set to be strengthened by scien-

tific progress. Finally with a related theme Dr Ian McClelland has taken a look at Anthony Clare’s seminal *Psychiatry in Dissent* 30 years since its was published.

Elsewhere in this issue there is topical comment with a report by Dr Abby Seltzer on the Winter academic event and an analysis by Dr Angela Hassiotis of the new government mental health outcomes strategy document. We have a report from Dr Isabel McMullen about her placement with the London Deanery and one from Dr Kostas Agath about being a medical governor. I’m also pleased to publish two prize essays from medical students and to have a contribution from Roxanne Keynejad, who has been involved with the successful King’s Psychiatry society and shares her experience with us.

Report on the arts has long been a strong suit of this newsletter, and this issue is no exception. Dr Lisa Conlan reports on a recent exhibition at the Wellcome Collection; Dr Nick Dunn recommends books for trainees; Dr Sarah Jones reviews a book from Roy Porter’s canon. We also have a feature on the treatment of psychiatric issues by graphic novels. Dr Issy Millard provides an overview of this subject and Dr Greg Neate and myself lend a few reviews. This is something I hope we can return to in the future.

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From the Chair

Dr Oyepeju Raji



Starting a new year certainly focuses the mind on what has gone well and what could be improved. Reforming the NHS is high on the Governments agenda and is going ahead at what seems like full speed. GP Consortia are forming and pilots are starting. There is some concern about how commissioning strategies will be informed. There is a rich mix of factors including the diversity of services that make up the NHS and local factors. The needs of the service user remains at the core and to avoid so called postcode lottery.

The 'Information Revolution' will enable patients to make informed choices about their care. The NHS collects an immense amount of data. Regular data collection is now part of everyday clinical practice. However, data seem to disappear and re-emerge in an unrecognisable format and the clinician cannot relate to the importance of his/her input. Interpretation of the information in relation to the service becomes obscure, as does the meaning of the data across organisations. Information needs to be accessible and useable. It is becoming more apparent that accessing and interpreting data sets is a

“Starting a new year certainly focuses the mind on what has gone well and what could be improved.”

challenge for clinicians and not only for service users. Clinicians will benefit from training to address data analysis and its application to service improvement.

Our information sharing event, the London Division Winter academic event held in Dec 2010 proved to be an informative day that stimulated a lot of debate with speakers representing many relevant roles and persuasion. The feedback was very good, however cost remains a challenge. Future academic events will be held at Standon House which will result in lower registration fee. The first London Division Mock CASC training day was held in January 2011 with the additional benefit of peer observation which candidates reported was a first for them and provided additional benefit. Thanks to all who responded to the call and gave up their time to make the day the success that it was. The plan is to make this a regular event.

On the invitation of the Service User and Carers' representative on the London Division Executive Committee, I attended the AGM of the Service User and Carers' Forum in Dec 2010. I was able to share in some of the issues of great importance across the board. Service user organisations complement and help to further the work of statutory organisations and are feeling the impact of the current economic climate. Our partnership with service users is not only as recipients of services but also in service development and training. Barnet Voice for Mental Health is a service user organisation that has been active in training psychiatrists as well as providing support for those who need it.

Colleagues south of the river have produced a position statement on recovery, 'Recovery is for all: hope, agency and opportunity in psychiatry'. The multidisciplinary perspective is a great strength of this publication for psychiatrists by psychiatrists. I would urge you to read it.

“Our information sharing event, the London Division Winter academic event held in December 2010 proved to be an informative day that stimulated a lot of debate”

On a final note, with the new Medical and Dental Education Commissioning (MDECS) there will be 5 lead providers (LEPs) in London, therefore, to remain coterminous with London Deanery boundaries, London Division will now have 5 sectors, NW, Central, NE, SE and SW each one with a Regional Advisor (RA) and a Deputy (DRA). Advertisements have gone out to the membership in the Central sector for these posts. The current structure for Regional Representatives (RRs) will be maintained.

I would love to hear about things of relevance to psychiatrists in London that would be good to share. I can be contacted at Oyepeju.raji@swlstg-tr.nhs.uk

**Dr Oyepeju Raji Consultant
Psychiatrist South West London & St.
Georges Mental Health NHS Trust**

No health without mental health

A cross-government mental health outcomes strategy for people of all ages

Commentary
by Dr Angela Hassiotis

No health without mental health: A cross-Government mental health outcomes strategy for people of all ages

This new guidance document which supersedes “New Horizons” was launched on 2nd February 2011 by Care Services Minister Paul Burstow. The document departs from previous strategies in that it recognises that all ages are susceptible to suffer from mental ill-health and explicitly attempts to bring parity in terms of importance between physical and mental health. This chimes well with the 3-year Fair Deal campaign spearheaded by the Royal College of Psychiatrists presidents Baroness Sheila Hollins and Professor Dinesh Bhugra. “No Health without Mental Health” was one of the core projects of that campaign. It argued for the following:

- Awareness of the link between physical and mental health needs to be heightened.
- Liaison Psychiatry Services are required in all general hospitals
- Engaging Patients & Carers is essential in improving services
- Re-organisation, Commissioning & Quality Standards – Liaison mental health services should be commissioned and reviewed against agreed specific service standards
- Training & Education needs to be improved for all healthcare professionals

The facts are difficult to ignore: the bill for treating mental ill-health and its costs to the economy reach a staggering £105bn. Mental ill-health is closely re-

lated to social adversity and at a time of economic austerity and unemployment there is anticipation of increase in mental disorders. Minority ethnic groups and those in disadvantaged backgrounds including long-term illness and learning disabilities are likely to be affected most.

The Government is investing around £400 million over the next four years to make a choice of psychological therapies available for those who need them in all parts of England, and is expanding provision for children and young people, older people, people with long-term physical health problems and those with severe mental illness.

Despite the euphoria that the announcement of the strategy has sparked among professionals (I for one think it is excellent) and public alike, there are already some concerns expressed by those who have had a mental disorder for a while and think that may be overlooked in the stampede of new initiatives and the sore fact that many services are under enormous strain or have not been developed for many years. Psychological therapies are an important point from which to start improvements but some population groups, say those with learning disabilities where evidence for the effectiveness of psychological interventions is weak, may continue to find it difficult to access such therapies. Furthermore, whilst the guidance encourages early intervention, it is also withdrawing fund-

ing from “sure start” projects which can be the lifeline that changes the future of young children born into chaotic and dysfunctional families. Rhian Beynon, Head of Policy and Campaigns at Family Action, commented in the Guardian newspaper that a family focus for early intervention may also be needed given that several thousand adults with mental disorders are also parents.

I, personally, found the mention of the “big society” in the preface rather disingenuous. As this is a nebulous (and dare I say “laughed at”) term anyway, it is hard to see how it would make the objectives of the strategy more palatable or meaningful.

Be that as it may, in the positives, the document uses research evidence that points towards the link between physical and mental health, the problems arising from stigmatization and the positive outcomes of early intervention before difficulties become established and at times irreversible. Although we have to manage the challenges in many “known unknowns” in the form of GP commissioning and 3-year efficiency savings, we cannot but feel hopeful that the public and voluntary sectors will use the tenets of the strategy in a way that allows people of all ages and learning ability with mental ill-health to lead fulfilling lives.

**Dr Angela Hassiotis Reader in the
Psychiatry of Learning Disabilities UCL**

Report on Winter Academic Event

by Dr Abby Seltzer

Clinician-Led commissioning: a more integrated and responsive NHS.

1st December 2010,
Mermaid Conference and Events Centre.



On a snowy day which matched the mood of many of the hardy delegates who battled to get there, the likely future of mental health services was outlined. After a warm welcome by the Chair of the Division, Dr Raji, it was down to business. Prof George Ikkos, Honorary Treasurer, talked about possible future roles for psychiatrists, emphasising that we are a species at risk if we did not adapt to survive. Dr Justin Earl, ST5 and Darzi Fellow described his experience as a Fellow, outlining the need for psychiatrists to pay more attention to developing leadership roles.

There were two impassioned pleas regarding the future of mental health services. One came from Mary Nettles, from a Service Users Forum, who described how fortunate she felt to have been able to have a care coordinator for so many years. She recognised that as someone whose mental health was by and large stable, she was a prime target for discharge, but wanted us to know that one of the reasons she has remained so well is that she has had the continued support and care of a mental health team, which has helped head off incipient crises. Dr Jacky Davis, Chair of the NHS Consultants' Association and founder

member of the Keep Our NHS Public Campaign, warned that the move to GP commissioning was opening the door to dismantling and privatising the NHS, and gave numerous examples, many of which have been highlighted in the media, of how this was likely to happen.

Richard Meier, a Policy Analyst from the RCPsych, spoke of the College's position, namely that it was broadly supportive but concerned about equality of representation and the pace of change. Dr Geraldine Strathdee, Associate Director for Mental Health, NHS London, as always inspiring, tried to rally flagging spirits by sharing her hopes and vision for better mental health services, and called for volunteers to work with her to realise this. Dr Alan Cohen, Director of Primary Care for Improving Access to Psychological Therapies

Programme shared his views of which mental health services GPs would feel comfortable commissioning, such as CBT to treat common psychiatric disorders occurring co-morbidly with common physical disorders, such as COPD, Diabetes and IHD, as studies have shown that the cost of providing physical health care is reduced when mental health needs are addressed. GPs will

also be looking to improve the physical health of those with severe mental illness. They will be aware of the needs for in-patient and home treatment services, but will feel less confident commissioning specialist therapies, day services for the severely mentally ill and forensic services. Their primary need is for specialists at the interface between primary and secondary care who will deal with complex medication interactions and managing physical illness in the mentally ill, where compliance with standard medical care is poor.

Dr Mark Spencer, Joint Clinical Director, NHS NW London, part of a pilot commissioning group, pointed out that 1/7 of all GPs were based in London. The move to commissioning, he reminded us, is happening at breakneck speed and GPs will be looking carefully at the high rates of sectioning, poor value for money and the amount of money spent on drugs and alcohol related admissions.

The take home message was hard to discern, with points of view ranging from wholehearted enthusiasm for the proposed changes to outright shrouding. The only thing that was clear is that the relative stability of the last five to ten years is over, and that five years from now, mental health services will not look like they do today. If psychiatrists are no longer central to the delivery of mental health services – a possible scenario – then they will only have themselves to blame.

Dr Abby Seltzer Consultant Psychiatrist Camden and Islington Foundation Trust

"The relative stability of the last five to ten years is over, ... five years from now, mental health services will not look like they do today."

Rebirth in Recovery

by

Dr Tony Romero

Dr Andres Fonseca



Cambian

Cambian Group in partnership with the NHS redefines services for individuals in recovery from mental disorders

Professionals often describe people with severe and enduring mental health problems in terms of disability, hindrance and challenge. There have been a number of social, political and health movements that have attempted to reverse this paradigm and assist people with mental illness integrate into mainstream society.

The recovery model (Jacobsen & Greenley, 2001) and the tidal model (Barker 2003) proposed a change in attitude towards mental disabilities. Common themes of recovery are the development of self-confidence, of a self-concept beyond the illness, of enjoyment of the world, and of a sense of well-being, hope, and optimism (Corrigan et al 1999). Fundamental to both is the additional belief that patients can be enabled to develop a set of skills to live with debilitating conditions, in the hope that they can recover skills lost during the course of their illness, or acquire skills they never possessed.

These philosophies change the focus from a passive understanding of caring for someone with a disability; where the care is provided for the person and the person is only a recipient of care, into a more active and collaborative venture; where the person who experiences the disability is enabled to regain lost function. They enable the development of new interventions and new ways to deliver care. They have influenced public policy and led to service-user based initiatives such as "Star Wards" (www.starwards.org.uk).

Despite the promise of better treatment outcomes, evidence for recovery models remains limited (Anthony et al, 2003). This is in part due to the underlying complexity of severe mental disorders and the lack of consensus on what constitutes 'recovery'. In 2004, taking these principles into account we set out the tenets of our clinical model which

we call "Active Care". We were guided by a few basic principles:

1. We would use evidence-based interventions
 - a. In areas where evidence was weak or non-existent we would defer to the consensus of opinion, informed by our advisory board
 - b. In the absence of a clear consensus we would use clinical judgement
2. We would measure progress with validated outcome measures, including "hard" outcomes
 - a. In areas where validated measures did not exist or were not fit for purpose we would create our own and take them through a process of validation
 - b. We would use these to describe needs, ascertain progress and monitor effectiveness of interventions
3. We would always work in multidisciplinary teams with all members as full and equal stakeholders. Even if individuals refused or were unable to engage with a member of the team they would remain involved.
4. We would always create the best possible environment for individuals, maximising therapy areas and personal space in our units

We opened our first locked rehabilitation unit in Langwith, Derbyshire in 2004. Today we have 15 rehabilitation facilities across the UK. Apart from the recovery facilities, the Cambian Group has learning disabilities services that range from secure care in our low secure hospital in Colchester to residential and day care. We also have specialist schools for children and adolescents suffering from pervasive developmental disorders. We work in partnership with over 70 Primary Care Trusts, over 70 Local Authorities and we currently provide care to around 1200 individuals.

Our model uses a range of outcome measures and assessments such as the

Global Assessment of Function, the Positive and Negative Symptom Scale, the Short Term Assessment of Risk and Treatability, the Model of Human Occupation Screening Tool among others. We also measure number of adverse incidents, number of hours of uneventful unescorted leave, evidence of performing daily living tasks with or without prompting and educational attainment. Our mean length of stay is 18.3 months with a mode of 12 months, and 81% of the individuals we work with move on to a less secure setting. Just under half of these go to independent accommodation. Previously these individuals have spent an average of 10 years of their lives in institutional care, never having successfully made the transition back into the community.

Our model remains dynamic, going through formal internal peer review every year; re-examining the evidence for those interventions we have incorporated and comparing it with any arising evidence for alternative interventions. Through this process we remain open to innovation following the 'plan do study act' cycle for continuous quality improvement as applied to healthcare (Varkey et al 2007).

Dr Tony Romero Group Clinical Director
Dr Andres Fonseca Medical Director

References

1. Anthony, W.; Rogers, E.S., Farkas, M. Research on evidence-based practices: Future directions in an era of recovery. *Community Mental Health Journal*, 39, 101-114, 2003.
2. Barker, P. The Tidal Model: Psychiatric colonization, recovery and the paradigm shift in mental health care. *International Journal of Mental Health Nursing*, 12, 96-102, 2003.
3. Corrigan, P.W.; Giffort, D.; Rashid, F., et al. Recovery as a psychological construct. *Community Mental Health Journal*, 35, 231-239, 1999.
4. Jacobsen, N. & Greenley, D. What Is Recovery? A Conceptual Model and Explication. *Psychiatric Services*, 52, 482-485, 2001.
5. Varkey, P; Reller, M K; Resar, R K. Basics of Quality Improvement in Health Care. *Proceedings of the Mayo Clinic*. 82(6):735-739; June 2007.



My year as the London Deanery School of Psychiatry Fellow in Management & Education

by Dr Isabel McMullen

Like many trainees, my only contact with the Deanery had been for interviews and ARCPs, and I didn't really understand what its role was. So when I saw the advert for the post of Fellow in Management & Education at the School of Psychiatry at the London Deanery, I was intrigued. The job description looked interesting, and I was keen to broaden my horizons. I applied, interviewed, and was pleasantly surprised to find myself starting as the new Fellow in August 2010, under the supervision of Dr Michael Maier, Head of School.

So, what's it been like? It's been challenging and rewarding experience, and despite being only halfway through, I feel like I've learnt a lot. Before starting the post I knew how training in my rotation was organised and had done a fair bit of teaching students and doctors. But stepping away from my rotation has given me a chance to see the bigger picture: how training is managed across London and the "behind the scenes" work at the Deanery. It's been fascinating to learn about the structure of the Deanery and the School and contribute to the proposed changes in training.

As my job title implies, my work can be divided roughly into managerial and educational activities, although there is a great deal of overlap. The main focus has been around assessing and monitor-

ing quality of training which is of key importance given that separation of provision and commissioning of core psychiatry training in London starts in August 2011. A significant amount of quality data was already collected by the Deanery but a framework to consolidate or interpret it was lacking. Building on work by the previous fellow to map out the components of training, I have translated these components to

"It's been an interesting and rewarding experience and despite being only halfway through, I feel like I've learnt a lot"

create measurable outcomes as part of a tool to facilitate the quality assurance process. In other quality work, I've acted as the trainee representative on the Deanery visits to trusts and been part of a support package of measures to improve su-

perception following a visit.

I've attended a variety of meetings, including the School of Psychiatry Board and Executive meetings, Trainee Forum meetings, and consultations where I've been able to provide trainee representation and had the opportunity to get involved in decisions about training in London. There has been the chance to

network with other fellows at the Deanery and attend faculty development courses provided by the Deanery, as well as national conferences where I've presented work.

I have a strong interest in training and medical education, and am undertaking some qualitative research around the educational benefits of on-call work for core psychiatry trainees. I have continued with a Post-Graduate Diploma in Medical Education and retained some of my teaching commitments: teaching and examining students, training core trainees and running the Calman day programme for higher trainees. I've given talks at various careers events for medical students encouraging them to consider a career in psychiatry.

Overall the fellowship has provided me with a fantastic opportunity to experience and participate in management of medical education in London. I have been given freedom to pursue topics of personal interest while also completing projects which are of use to the School. Personally, it's been a great lesson in structuring my time and managing projects, and it's brought home to me the importance of the Deanery in the training of psychiatrists in London. Medical training in London is at a really exciting juncture, and it is a great privilege to be involved in shaping the future of training.

Dr Isabel McMullen London Deanery School of Psychiatry fellow in management and education

Forgetting Psychiatry and the Law

Tuesday 9th March
Anatomy LT, Hodgkin,
Guys
5.30pm

The Role of the University Psychiatry Society

Roxanne Keynejad shares the secrets of the KCL Psychiatry Society's success

KCL Psychiatry Society was established in 2005, "to promote psychiatry as a career to medical students, support those students who wish to pursue psychiatry as a career and raise the profile of mental health issues amongst all student health professionals". We appeal to two groups of students: those who are drawn to psychiatry but want to learn more about it beyond the scope of their brief third year rotation, and those who have never considered the career at all. Both groups are regularly faced with comments like "psychiatrists are madder than their patients", "your patients never recover" and "psychiatrists don't practise medicine". Student societies present an alternative perspective.

Our events programme was based on several minimally insightful observations about medical students:

- 1) They have strong stereotypes of psychiatry and don't associate it with exciting things like international aid work, justice or the media.
- 2) They come to free events with food/drink
- 3) They want to pass exams
- 4) Those who like psychiatry often like the arts and global health

In light of these observations, we or-

ganise a programme of speakers which showcases the diversity within the specialty, including a Dr Peter Hughes, a psychiatrist working with International Medical Corps in Haiti, Surgeon Commander Greenberg, a psychiatrist with the royal marines and Professor Michael Kopelman, an expert witness and neuropsychiatrist. All of these events attracted medical students who might

"Our events programme was based on several minimally insightful observations about medical students"

never have attended a psychiatry society event otherwise.

Thanks to generous support by the Institute of Psychiatry, KCL Psychiatry Society is able to book venues, produce posters and provide refreshments for all our events at no charge. This is a major factor in our success, since only students with some prior interest in the field will pay a membership fee.

Some of our most oversubscribed events are the four sets of revision sessions we organise for three cohorts of third year students and one group of final years, in which psychiatrists give feedback on history taking in an OSCE

format. This event again draws a completely different group of students to those a more traditional psychiatry talk would attract.

KCL Psychiatry Society's committee feels that the pre-clinical curriculum lacks opportunities for students to appreciate the clinical nature of psychiatry early on, so we gave second years the chance to spend a day shadowing a clinician at the Maudsley Hospital, which was extremely popular. We also organise a day for pre-clinical students to meet patient educators from Rethink and have a taster of the Extreme Psychiatry approach to teaching history taking, based on the view that it should be something a doctor can do anywhere, at any time. After this event, 86% of students felt more confident in psychiatry, 67% felt less afraid of psychiatry and 75% were more interested in psychiatry. Both these events introduce the specialty to students much earlier in the course than the curriculum allows and our 'Make the most of your Psychiatry rotation' booklet, given to third years, aims to help students do exactly that.

Students with an interest in psychiatry often have an arts background when graduates, and are active in the arts in their spare time. We encouraged these interests through book clubs, a talk on Shakespeare and a regular email bulletin highlighting relevant films, books and theatre in London. We also publicise free places at conferences, prizes and bursaries which give students further opportunity to explore the spe-

cialty. KCL Psychiatry Society also pairs medical students at King's with students at Hargeisa and Amoud Universities in Somaliland for peer to peer online psychiatry co-mentoring, through the website, MedicineAfrica. This partnership, Aqoon (meaning knowledge in Somali), introduces students on both sides to a completely different way of learning across cultures and enables them to consider psychiatry from a less well resourced clinical perspective.

Challenges student societies face include funding, attendance (some student bodies are more interested in attending psychiatry events than others)

and student apathy. Good ways to overcome these are to get the support of the university's head of psychiatry, to request the waiving of room booking fees (which are by far the biggest cost), to offer a programme which has broad appeal to a range of medical students and, importantly, to publicise it through every means of communication available. The more support a society receives from psychiatrists working in the area, the better. You can find your local society at: <http://www.rcpsych.ac.uk/training/studentassociates/resources/psychiatrystudentsocieties.aspx>

Psychiatry may be facing a recruitment crisis, but you wouldn't know that when attending a student PsychSoc event. As one pre-clinical student said after her day at the Maudsley:

"I realised I felt right at home. The day was brilliant, learning a lot as I watched and listened to the doctors meet patients and decide treatments, but most of all, I took away encouragement."

Roxanne Keynejad, Third Year GPEP MBBS, King's College London

London Division Essay Prize winner Charles Le Grice

"A Review of Recent Literature on Violence Post-Deployment in Armed Forces Personnel"



The mental health of soldiers returning from deployment is a highly topical issue, with one UK newspaper warning of a "ticking time bomb" (1) of mental illness amongst armed forces personnel who have deployed to Iraq or Afghanistan. Consequently when I was given the opportunity to take part in a new SSC (student selected component) offered by King's College London Medical School in Research in Psychiatry I decided to study a topic related to mental health in the military. My supervisor at the Institute of Psychiatry, Dr Deirdre MacManus, suggested that I carried out a literature review on violence post-deployment in armed forces personnel. Since anecdotal reports of increased violence by Vietnam veterans began to surface in the USA during the 1960s it has been hypothesized that past military deployment may be a risk factor for violent behaviour. A previous literature review (2) demonstrated associations between warzone experiences and post-deployment violence. However, since 2006 a number of new studies have been published, including studies measuring violence amongst military personnel who were deployed to the wars in Iraq and Afghanistan. Consequently we identified a need for

Benedek's review to be updated.

The objectives of my literature review were firstly to critically appraise the evidence for an association between military deployment and later violence, and secondly to establish what factors relating both to the individual and to their deployment experience are associated with post-deployment violence. Systematic review methodology identified 32 papers which contained new empirical

Moreover, post-deployment PTSD, depressive symptoms or alcohol abuse seem to be associated with post-deployment violence. Consequently post-deployment violence is a particular concern in specific groups of veterans: those with heavy combat exposure, those who killed another person while deployed, and those with a diagnosis of PTSD or other psychiatric illness.

New evidence suggests that veterans

"there is evidence that particular experiences whilst deployed may be associated with subsequent violence"

data on violence or aggression post-deployment in armed forces personnel. After classifying these papers by study type, sample population, outcome measured, and methodological quality, I concluded that deployment per se does not appear to be associated with later violence. However, there is evidence that particular experiences whilst deployed may be associated with subsequent violence, for example participation in combat or killing someone.

of the war in Iraq are at risk of post-deployment violence, although their risk may be reduced compared to Vietnam veterans. However, since all studies included in the review used US soldiers as subjects, it is unclear to what extent the results of these studies can be generalized to Iraq veterans from the UK. A recent study has found that psychological outcomes among UK soldiers deployed to Iraq or Afghanistan differ from those of US soldiers (3). Consequently there is

a need for research into the effect of deployment on violent behaviour in a UK military population.

References:

(1) Daily Telegraph. War Veterans' mental illness "timebomb". 15-7-2009.

(2) Benedek DM, Grieger TA. Post-deployment violence and antisocial behavior: The Influence of Pre-Deployment Factors, Warzone Experience, and Post-traumatic Stress Disorder. Primary Psychiatry 13[3], 51-56. 2006.

(3) Fear NT, Jones M, Murphy D, Hull L,

Iversen AC, Coker B, et al. What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Lancet 2010 May 22;375(9728):1783-97.

London Division Research Prize winner

Jennifer Powell

Is there a relationship between glycaemic control and cognitive function in adults with newly diagnosed type 2 diabetes mellitus? A cross-sectional study.



Diabetes has been associated with cognitive impairment and dementia however the reasons for this are unclear. Recognising those patients who are most at risk is vital in order to ensure that the most susceptible individuals receive adequate treatment, support and monitoring. The aims of this study were to determine if

London. A comprehensive range of physical, social, laboratory and psychological measures were used in assessment, including the TICS-M questionnaire to screen for cognitive impairment. The predictive value of key variables (including level of glycaemic control as measured by HbA1c, ethnicity, age, gender, depression status, lipid lev-

white ethnic group, black (OR=3.93, 2.05 to 7.52) and Asian (OR=4.97, 1.65 to 14.95) ethnicities had higher rates of cognitive impairment after adjusting for age and gender. In the final model, pre-morbid IQ (OR=0.91, 0.85 to 0.96) and diastolic blood pressure (OR=0.92, 0.86 to 0.996) were predictors of cognitive impairment.

In conclusion, cognitive impairment was prevalent in this sample of non-elderly people with new-onset type 2 diabetes. Glycaemic control did not predict cognitive function, however in this sample the majority of participants (76.8%) had an HbA1c reading within target range and it was proposed that the toxic effects of hyperglycaemia may influence cognition only at more extreme levels. Cognitive dysfunction was associated with black and Asian ethnic groups as had been proposed, and this may be related to the relatively high rates of diabetic complications which are reported in these populations. The high level of cognitive impairment found in this sample is of concern, however due to the cross-sectional design of the study we could not conclude that diabetes was causative and it may be that pre-morbid levels of functioning were low. The main limitation of the study was the use of the TICS-m questionnaire which is primarily a screening tool and does not assess specific components of cognition, and may have been unreliable to some extent in this ethnically diverse population where in many cases English was not the first language.

“ Diabetes has been associated with cognitive impairment and dementia ... recognising those patients who are most at risk is vital in order to ensure that the most susceptible individuals receive adequate treatment”

cognitive function is below normative levels at point of diagnosis in type 2 diabetes and to assess which factors are associated with cognitive impairment. The primary hypothesis was that glycaemic control would predict cognitive function. Additionally the study aimed to examine the relationship between ethnicity and cognitive impairment. This was a cross-sectional study nested within an ongoing prospective cohort study, the South London Diabetes Study (SOUL-D) in which adults with type 2 diabetes diagnosed within 6 months were recruited from GP practices in South

els, obesity, blood pressure, pre-morbid IQ, smoking and physical activity) was then calculated using logistic regression. Of 306 participants, 78 (25.5%) screened positive for cognitive impairment. Contrary to our hypothesis, HbA1c was not associated with cognitive impairment, however other factors were. Cognitive impairment was associated with older age (median 59.0 compared to 55.5, $p=0.03$), unemployment (OR=1.75, 95% CI 1.03 to 2.94), lower pre-morbid IQ ($p=.00$), lower alcohol consumption ($p=.00$) and lower diastolic blood pressure ($p=.03$). Relative to the

Being a Medical Staff Governor: Role and Challenges

From personal experience Dr Kostas Agath contextualises the role of the Governors within a Foundation Trust and examines the challenges a Medical Staff Governor is likely to face.

I am a consultant psychiatrist. In my Trust I have been a Medical Staff Governor for almost four years and a Lead Governor for the past 18 months.

In this article, I contextualise the role of the Governors within a Foundation Trust structure before describing the challenges a Medical Staff Governor is likely to face.

The role of Governors in a Foundation Trust

A Foundation Trust (FT) is run and governed by the Board of Directors (BoD) and the Council of Members (CoM). The BoD consists of the Chair, the Chief Executive and a specified number of Directors both executive (i.e. permanently employed) and non-executive (i.e. appointed for a fixed-term). The CoM consists of a specified number of elected and appointed Governors representing

BOX 1: STATUTORY POWERS AND DUTIES OF A GOVERNOR

1. Appoint/ Remove the Chair
2. Appoint/ Remove the Non-Executive Directors
3. Decide remuneration/ allowances of the Chair & Non-Executive Directors
4. Approve the appointment of the Chief Executive
5. Appoint/ Remove the FT auditors
6. Receive the FT annual report and accounts and auditors' report on them
7. In preparing the FT forward plan, the BoD must have regard to the views of the CoM

NHS Foundation Trust Code of Governance (Published and periodically updated by Monitor) provides the key principles underpinning the role of a Governor (Box 2). Your Statutory Duties (Monitor 2009) describes further examples of good practice by the Governors following extensive consultation with stakeholders.

The considerable power of the Governors stems from their power to remove the Chair of the Board of Directors (BoD), who is also the Chair of the Council of Members (CoM).

Their remaining duties can be seen in the context of representing the interests not only of their constituencies but also of the Foundation Trust; that is the reason the Governors are described as critical friends of the FT.

Governors fulfil their role both by operating as independent representatives of their constituency and by being members of smaller governor groups, such as the Appointment Committee, Audit Group, Forward Planning group and others.

One of the most complex aspects of being a governor is ensuring that the governor not only represents the views of his/her constituents but that s/he regularly provides feedback regarding actions taken by the CoM. This is especially so in the case of large constituencies such as those of public governors, service users and carers.

Challenges for the Medical Staff Governor

A Medical Staff Governor faces challenges which relate to either his/her

“The role of the Medical Staff Governor has so far received little attention by the medical management literature. This is puzzling”

Foundation Trust Stakeholders. The CoM is chaired by the Chair of the BoD. Only the BoD is responsible for FT operational matters such as the day-to-day service provision and its quality.

The Governor of the Medical Constituency is an elected governor of the CoM of a Foundation Trust. The electorate consists of the non-training doctors employed by the foundation trust. A Governor is usually elected for a period of three years and for no more than two successive terms.

The role of every Governor is anchored in three documents. The National Health Service Act (2006) is the legislative basis of the statutory power and duties of the Governors (Box 1). The

BOX 2: KEY PRINCIPLES OF BEING A GOVERNOR

1. CoM represents the interests of FT members and partner organisations in the local health economy, in the governance of the FT
2. Governors should regularly feedback about the FT vision/performance to those who elected/appointed them
3. Governors must act in the best interest of FT and should adhere to its value and code of conduct
4. CoM should hold the BoD collectively to account for the performance of the FT

links with the Medical Constituency or to his/her professional responsibilities as a medical doctor.

The role of the Medical Staff Governor has so far received little attention by the medical management literature. This is puzzling given the current ubiquitous

process in acknowledging the role of the Governor (“a service user governor is not remunerated, why a medical governor should be?”). Pragmatically, however, and in a similar manner to a medical manager, a governor should have his/her relevant activities acknowledged in the annual job plan.

Medical governors also must be available out-of-hours. As colleagues are likely to bring sensitive issues to his/her attention a telephone conversation out-of-hours is perceived as being more confidential than an email. In my personal experience, the out-of-hours accessibility of the Governor has been used more than holding an open-access medical governor surgery in trust-wide events.

The systematic communication with his/her constituents offers a different challenge for the Medical Governor. S/he has a well defined constituency that can be identified through the Human Resources Department and email lists of Consultant or other non-training grade doctors can be easily obtained through the Medical Director’s office.

However, timely communication with

medical constituency despite the need for rapidly cascading information or consultation. It is with that goal in mind that a medical governor should foster strong links with the medical representatives of the Local Negotiating Committee as well as the chair of any existing Medical Staff Committee.

Medical Governors should be mindful of the limited exposure medical trainees get to the functions of the Foundation Trust. Medical trainees do not belong to the medical constituency of a Foundation Trust but they can become members of the Foundation Trust through membership of the Public constituency (that represents the general public in the locality). It is therefore important for medical governors to link up with the local medical training committee and trainee groups.

Finally, in the current climate there is a distinct possibility that there could be tensions between the medical governor, as a member of the CoM, and the medical director, as a member of the BoD. The potential conflict is complicated by the professional accountability of the Medical Governor to the Medical Director. Resolution of potential conflicts should always aim at promoting benefit for the FT; however transparent reporting of such conflicts to the medical staff constituency is a relatively uncharted territory.

Conclusion

A medical governor needs to walk on a tightrope if s/he is to facilitate the leadership inherent in the role, without compromising his/her integrity, the interest of his/her constituency, the interest of the Foundation Trust and the fulfilment of his/her multiple professional roles.

But the medical governor role is here to stay and, will further develop as more medical professionals become involved in it.

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The author is a Medical Governor and Lead Governor of the CNWL NHS Foundation Trust. His views do not necessary reflect the views of his Trust.

“A medical governor needs to walk on a tightrope if s/he is to facilitate the leadership inherent in the role, without compromising his/her integrity, the interest of his/her constituency, the interest of the Foundation Trust and the fulfilment of his/her multiple professional roles”

focus on ‘medical leadership’ and the latest White Paper (‘Equity and Excellence: Liberating the NHS’). The White Paper not only endorses Foundation Trusts but also promotes the contribution of the NHS staff to the future of their organizations.

It is worth pointing out that fulfilling the role of a medical governor is time-consuming and it is not as yet clear whether and how it should be addressed in the Governor’s annual job planning. There are ethical arguments against employing the job planning

his/her constituency about major issues such as the FT annual planning cycle can be strenuous. It lasts for less than two months and covers both operational and strategic information that not only is commercially sensitive but it could substantially change during the planning cycle. Therefore any exchange of information and feedback can be superseded very quickly. Nevertheless, in this era where improving efficiency may require extensive service restructuring, I believe that the Governor should have a low threshold in reporting back to the



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bjornmeansbear at flickr.com

What’s the future for psychiatry? Five thinkers share their verdicts Plus *Psychiatry in Dissent* - 30 years on

Salient Phase Imaging (SPI) changed everything – for those that could afford it. By 2040, its use was routine in most gated communities. Despite the claims of the IoP, the imaging itself wasn’t the crucial break-

challenge. The fact that the ‘Big Five’ of psychology could be precisely and uniquely mapped onto real-time flow between microscopic brain regions was a discovery so important that even now, twenty years after Wing-Chung’s seminal paper, the psychiatric community has yet to fully grasp its significance.

The precise localisation of belief, mood and motivation in a cerebral substrate came as a mixed blessing to those charged with drafting psychiatric taxonomies. The retention of the archaic term “schizophrenia” for DSM VI, in 2013, made a drastic rethink about classification seem more urgent than ever. DSM VI-R sadly made little progress, ignoring Andreasen’s warning that psychiatry had ‘sacrificed validity for reliability’. Many argued that

the APA’s decision to ignore the Chinese research was motivated less by science than politics. When it was finally published in 2020, critics argued that DSM-VII, with its definitions of ‘trauma’ and ‘stress’ as the core criterion for all mental

illness, effectively defined the entire of human nature as a form of mental disorder. Death became the last true resort of sanity.

The challenge today, of course, lies in using our new model of the mind to create reliable

treatments. Whilst SPI has undoubtedly helped neuropsychologists to tailor individual therapies to the unique ‘mental thumbprint’ of every brain, more anatomically based treatments, includ-

“Psychiatry – the last fifty years”.

Dr Hamish McSalter

“Salient Phase Imaging (SPI) changed everything – for those that could afford it. By 2040, its use was routine in most gated communities.”

through; after all, conventional fSPET was being used to track cerebral activity at the level of the individual neuron as early as 2017. The real breakthrough came when the Beijing group – skilfully exploiting the IoP’s hiatus after the evacuation of London – combined high-resolution global activity scanning (H-GAS) with real time emotive-cognitive

Feature

ing the much-maligned trials of experimental ablation in the early '30s, have yet to live up to the promise they held only a decade ago. Whether they will prove quite as fruitless as the trillions of Yuan wasted on genomic research – which simply failed to grasp the sheer complexity of post-Darwinism – remains to be seen. Nonetheless, the presence of SPI scanners in most therapy suites today is a testament to the potential of this discovery. Once the size of a house, these devices now occupy the space of a family turbocar. If progress in quantum computing continues at its present rate then portable devices may be com-

monplace in twenty years from now. The real challenge will then lie in producing a device robust enough for use outside the gates, where the links between environment, trauma and disorder seem more evident, and as little understood, as ever.

This was taken from a valedictory address by Dr Hamish McSalter (age 98) Director of Neuropsychosemiotics, Institute of Neurotherapy, Gulmargang, India 1100178 in March 2051.

Future City Illinois
Photo courtesy of ILMO JOE at flickr.com



Dr Derek Summerfield

Before we wonder where psychiatry is going, let us remember where we have come from. Most broadly, this is the Western cultural trend towards the psychologisation and psychiatrisation of everyday experience, and thus the emergence of a distinct domain of experts authorised to pronounce, treat and prognose. Psychiatry seems to endorse the view of the average citizen as ever less robust and more vulnerable, a cultural trend that will do no one any good in the longer run. Psychiatric academe and professional leaders like the Royal College of Psychiatry uncritically back preposterous population prevalences for mental disorder as high as one in four, and uncritically support the extension of psychological therapies promoted by Layard- whose most extraordinary statement (in the BMJ) is that “in Britain mental illness has now taken over as unemployment as our greatest social problem”. This is what I would call ominous kitsch.

In March last year, the Royal College of

Psychiatry published a challenge for the Government that would be elected in the forthcoming general election. This was what they called a four step manifesto presenting a clear plan of action. These were:

1. "Stop harmful cuts to mental health services", adding that cuts already taking place were “threatening people’s mental health”.
2. "Increase mental health research

***“In my view the psychiatric mainstream industry, grounded in biomedical interpretations of the world (psychiatric diagnoses pretending to be real diseases) is risking future hubris, and probably deserves it.*”**

funding", adding that mental health research received only one quarter of the funding that went to cancer.

3. "Invest in early intervention", asserting that “taking action at an early age saves lives and money”.

4. "Put mental health at the heart of public health", asserting that "poor mental health is associated with...smok-

ing, alcohol misuse and obesity"

For what my opinion is worth, I consider all four statements dodgy. I wonder what colleagues think: do you see these as straightforwardly true? I would argue that psychiatry and the mental health industry in general have come to take up far too much cultural and societal space, yet struggle to show that the benefits brought are more than merely non-specific, and are relentlessly self-aggrandising in the way prevalence figures, supposed unmet need, the need for more funding than ever etc. are talked up. In my view the psychiatric mainstream industry, grounded in biomedical interpretations of the world (psychiatric diagnoses pretending to be real diseases) is risking future hubris, and probably deserves it.

Dr Derek Summerfield Consultant Psychiatrist South London and Maudsley NHS Trust



their increasingly large asylums and yearned for 'assertive' powers. It emerged in the early 1900's that syphilis was the cause of general paralysis of the insane (GPI), which affected some 10% of asylum inmates, and the hoped - for future was the elimination of the underlying infections that created mental illness. At the same time the emergence of endocrinology (sex glands, thyroid function, adrenaline) generated hoped of rebalancing hormones. Unfortunately taking out all potential sources of 'focal infection' (i.e. teeth, tonsils, appendices, colons) didn't work and injecting monkey glands, inducing deep sleep and Insulin coma therapy didn't work either.

Of course the great overarching hope was, from Freud onwards, that psychoanalysis would somehow dig down to all those complexes, those monsters from the id, expose them and extract them and create a new world order of sanitised happiness. Analysis in schools, homes or work places, prisons and asylums (of course) was the great mission of psychiatry. Unfortunately this evangelical bid for global effectiveness, that somehow psychiatry could not only "cure" illness but also solve family difficulties, criminality, social conflict, has generated disillusion, mockery and blame, for example via Homicide Enquiries, sucking us into the black holes of risk management, C.P.A. and Hollywood caricature.

So, in predicting the future the history of the future is quite predictive and quite helpful. Maybe we can even choose our future if we stay with doing things we can do and that we are good at. For example making sure we are really

good doctors, who know about taking histories and clarifying diagnosis, who know their psychopharmacology and who know how to talk to people and deliver thoughtful therapies, and who choose not to work for the apparatchiks of mindless and social control managerialism.

Dr Trevor Turner Consultant Psychiatrist East London NHS Trust

"Psychiatry, its future and the history of its future" by Dr Trevor Turner

Trying to predict 20 years on what Psychiatrists will do, where they will work and, even, what they will look like is essentially scary for someone who started out in Medicine in 1970. But, using that standard, risk management, tool of modern indoor psychiatry (a.k.a Forensic Psychiatry) that future violence is best predicted by past violence, what has happened in the last 40 years?

The answer is 'quite a lot'. In the UK we've closed nearly a 120 asylums, (so now we're short of hospital beds) but we have opened many more mini-institutions (e.g. MSU's). We have lots of shiny new 'teams' (early intervention; assertive outreach; etc) to help with community - based care. We have a range of anti-psychotic and antidepressant medications (at least that's what they're called) which probably treat symptoms rather than illnesses and we do have a more articulate patient/user population. And there are many more women psychiatrists. All of which would seem to predict better tailored drugs, better tailored psychiatrists and better dressed though variably informed patient advocates.

But there is a real decision to be made.

Do we want a more utopian or more dystopian future? If 'risk management' and the demands of the Home Office (rather than the Department of Health) are allowed to hold sway then, just like the iron curtain that blocked off Eastern Europe for 50 years, we will become the automatons of a structural (i.e. buildings) and organisational (i.e. social control) institutionalization. Our effective therapies like CBT will revert to BBT (bullying behaviour therapy?) or even ABT (asylum behaviour therapy), rather than advancing to DBT (dialectical), or even EBT (eclectic?), FBT (forward-thinking?) and so forth.

This future isn't a lot different from the history of the future. The 19th century psychiatrists begged for 'early interventions', so as to get people into the moral therapy that they felt they were delivering (walks, amusements, prayers) in

"There is a real decision to be made. Do we want a more utopian or dystopian future?"

The future but without the wait
Photo courtesy of jacksnell at flickr.com



Dr Michael Maier

Having promised, before the election, not to make further changes to the NHS the coalition government has put into motion the most significant revolution since 1948. Untested and attracting significant resistance it has been suggested that it may be just a little too experimental a reform.

Staff in the NHS are also under pressure. No pay increases, no uplift in salary and a full frontal attack on clinical excellence awards. Consultants are being demonised in subtle ways with information appearing in newspapers stating that consultants are on quarter million pound salaries. The NHS is fully in the government's sights.

So why may this be significant? Because of two issues relevant for the future of medical training. These being the separation of medical training into a commissioner/provider split and the recommendations of the Temple report.

In London we have now separated core training for psychiatry, medicine and surgery and are in the process of planning the separation of higher training in psychiatry into a commissioner/provider split. The new structure will allow us to hold the lead providers to account for the quality of training and be clear about the sanctions when the quality falls short of what is required.

I personally don't think that we will be able to improve training significantly until we have a consultant delivered service, 24 hours a day. Trainees will be able to work in a fully supervised environment and not be purely accountable to service requirements. Furthermore, it

is only when money comes with a trainee, where ever the trainee needs to go, that we will see organisations really take the quality of training seriously. Currently, training posts reside within trusts and this often leads to a state of inertia in the organisation. If the trust had to attract the trainee together with their funding they would have to be more active in selling their product.

In his report Temple states that the

"It is up to all of us to ensure that we are advocates of maintaining quality and to be vocal when we see it under threat."

sickest patients in the country are looked after by the most inexperienced doctors. This is a scandal. The NHS in 1948 perhaps could get away with providing this type of care, but no new medical organisation would be allowed, or even succeed in a competitive market with this business model. So we will inevitably need a further increase in consultant numbers.

Over the last few years application numbers to psychiatry have fallen significantly. This year for core recruitment London has a ratio of 1 to 1 applicants to places. London has done better than

other regions and this leads to accusations that London is syphoning trainees off from other places. As a result there is constant pressure for London to reduce the number of training places, as it appears to be disadvantaging the rest of the country. This attempt at musical chairs is clearly not the solution to the more fundamental problem of why foundation doctors are not choosing psychiatry as a specialty. Obviously the changes in visa regulations have over the last few years dissuaded non-EU doctors from abroad coming to the UK. In addition the expansion in GP training has also reduced the numbers looking at psychiatry, as it is the same type of trainee that is attracted to the two specialties. I have asked our excellent Darzi fellows in London to look at this problem and offer some ideas for a solution. I have also opened discussion with GP training to see if we can share training in the two specialties and perhaps share some common competencies that may be transportable across the specialties.

Times are tough for the NHS and for psychiatry. As trainers we are in the business of producing the next generation of doctors. The quality of the doctor determines the quality of patient care. For this reason what we do is fundamental to ensuring the highest level of safety and quality of care for our patients. Training is not an add-on, it is core NHS work. It is up to all of us to ensure that we are advocates of maintaining that quality and to be vocal when we see it under threat.

Dr Michael Maier Consultant Psychiatrist West London Mental Health NHS Trust



As seen in 1962. An 'AutoTutor' from '1975: And the Changes To Come' by Arnold B. Barach

A view of psychiatry over the next twenty years by Dr Kevin Healy

I surmise that some currently active factors will remain relevant to how we will deliver services over the next twenty years. They will include our ever active attempts to position ourselves as professionals who are central to sensible decision making and resource allocation through our skills in assessment, diagnosis, treatment and biopsychosocial management of patients with mental health difficulties. We will continue to strive to be influential and to offer coherence, consistency, containment and leadership qualities within multidisciplinary teams and in the development of care pathways and managed clinical networks. We will seek to deliver clinical services in primary care and near to a patient's home. We will use the continuing influential voices of patients and of their families in maintaining flexibility in the delivery of otherwise prescriptive manualised evidence based interventions. We will use IT to its maximum

advantage and do what we can on the telephone, on Skype and online.

In our contacts with patients the psychiatrist's role as a doctor of the mind and a doctor of the body will be more

“ the psychiatrist's role as a doctor of the mind and a doctor of the body will be more clearly defined by the continuing explosion of scientific knowledge”

clearly defined by the continuing explosion of scientific knowledge on the development and functioning of the brain. We will be enthused by new and exciting findings on epigenetics and attachment that will advance our understanding of trauma, of autonomic reactivity, and of sensorimotor bodily functioning. Combinations of differing approaches will create a more whole

'body and mind' experience and will enhance the effectiveness of therapeutic interventions. We will learn new skills about sharing relevant information with patients and about helping patients decide on the options for intervention that best suit their needs.

We will continue to be thoughtful, mindful and good value in crisis situations. We will encourage colleagues, by example, to find a healthy balance between their own professional and personal lives and in this way sustain the work they do with others. We will need from time to time in our professional careers to undertake additional trainings to expand our knowledge, our skills and our competencies as the evidence base for what we do evolves. As you can see, I am describing a pattern of pragmatic continual evolution in which we as professionals seek to have some ongoing personal and organisational influence.

Dr Kevin Healy
Chair Medical Psychotherapy
Faculty Executive

Psychiatry in Dissent

- 30 years on

by Dr Ian
McClelland



Psychiatry In Dissent was written by Dr Anthony Clare in the 1970s but remains a well known examination of our profession. It's not difficult to see how it has endured. It is fantastically readable, and I am sure it was an insightful, accurate and sensible analysis of British Psychiatry and treatment of mental illness at time of its publication. But, If the book was written today would there be anything significantly different to say? Over 30 years on from the second edition (1980), are we in a stronger position to help treat the mentally ill?

While reading PiD I made a mental list of any obvious psychiatric advances since its publication. The list wasn't very long. Undoubtedly the introduction of the atypical antipsychotics has given the Psychiatrist a number of further options. Equally the SSRIs have been a useful advance. However, I would speculate that in 1980 Clare would have hoped by today much more would have been understood about mental illness, both from a causative and preventative perspective. He would have expected treatments would have become more specifically tailored to diagnosis, that mental illness was no longer so stigmatized, and that psychiatry was considered a higher status speciality to train in. Sadly, I don't think we are quite there yet.

The book is still invaluable as a resource for answering psychiatry's critics. Clare gently, yet brilliantly, dissects some of the arguments of Thomas Szasz and R.D. Laing. Today, anti-psychiatric views that are commonly known emanate from Scientologists such as Tom Cruise and John Travolta. Both are anti-psychopharmacology and anti-ECT. No doubt Clare would challenge their views in a coherent and respectful manner.

PiD is very general adult psychiatry specific, were it written today there might be more emphasis on the sub-

specialities. Advances in drug and alcohol treatment, dementia medications, and personality disorder research, amongst others, would be mentioned. Our diagnostic process remains largely the same as in the 1970s. The mental illness diagnosis remains predominately a clinical judgement and this will probably remain the same for some time to come. Modern Psychiatrists are taught in the Bio-Psycho-Social framework which is essentially how Clare suggests a good Psychiatrist should work. The Gene x Environment interaction is the best explanation we have to conceptualise the casual factors, and this hasn't changed for some time. There is now more focus on the operational v categorical debate, and the fuzzy line between disease entities might deserve a chapter today. Newer debates about the medicalization of problems, eg, Seasonal Affective Disorder and Oppositional Defiance Disorder are controversial even within the discipline, let alone from outside critics. Within CAMHS, the emergence of ADHD, and the drug treatments that treat it, has come to largely dominate the daily work of the CAMHS Consultant.

Aside from drugs, have there been any other significant developments in treatment? Well, new behavioural therapies with three letter acronyms - CAT, DBT, and CBT - help people get back on their feet after bouts of the 'neurotic' illnesses and this array of 'talking therapies', would now need to be explored. PET and MRI scans have given us a greater insight into the psychopathology of illness, as has research into neurotransmitters and neural networks. I suspect chapters on imaging and genetics (including neurotransmitters) would replace chapters on psychosurgery, and ECT. ECT remains both controversial and extremely effective and this still deserves to be mentioned probably in a chapter with other treatments. The volume of research into mental illness over

the last 30 years has been vast. So a chapter on research, in effect legitimizing the 'pure science' behind illness could be justified.

A chapter on the expansion of the MDT might also be in a modern PiD. Clare barely refers to psychologists, but they are increasingly involved with all teams treating the mentally ill. And with recent changes of the Mental Health Act, many non-psychiatrists have the option to train as Responsible Clinicians. Equally despite PiD having a chapter on the contemporary state of psychiatry, very little is mentioned about nurses working with the mentally ill. Today making psychiatric nursing an attractive career for bright, dedicated people is a real dilemma. Low morale is also a problem and the reasons behind this might be explored in an updated text.

The Mental Health Act has been updated a couple of times since 1980 but the essentials remain the same. Professionals are still able to restrict the liberty of those that are assessed as being mentally unwell and a risk to themselves, or others. There has been no shift back to asylums. The vast majority of people are treated in "the busy outpatient clinic" as Clare refers to it, but when hospital is required, admissions are usually short and take place in Mental Health Trust Hospitals, slightly removed from the local DGH. Stigma towards the treated (and the treating), remains, largely the same.

Overall PiD stands up to be a clear and inspiring book. It could be updated for today without significantly changing the flow of the book, and I would recommend it to any doctor unsure whether to train in our richly rewarding field.

Dr Ian McClelland
ST4 Child and Adolescent Psychiatry
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Graphic novels and psychiatry

Dr Issy Millard looks at how this maturing art form is well suited to explore psychiatric themes and Drs Greg Neate and Stephen Ginn review a personal selection

At long last, Comics seem to be being taken seriously and the struggle for 'funny books' to escape their geeky ghetto is over. A new school of academic criticism - "Comics Studies" - has emerged and literary critics give the best graphic novels as much attention and recognition as they do the latest releases from celebrated novelists.

The last twenty years have seen a renaissance, driven by advances in technique, new understanding of the medium, and the realization that comics can be used to tell any kind of story. In-

"It can be argued that comics might be the best medium for telling certain kinds of story"

deed, it can be argued that comics might be the best medium for telling certain kinds of story!

The American cartoonist Scott McCloud, in his influential work of criticism *Understanding Comics* offers an explanation for why this may be the case. He compares the experience of watching a movie, reading a book, and reading a comic.

When you see a film, McCloud says,

you are entering a world where the creator has complete control. Every image and sound that is projected has been selected for you, producing an overwhelming and totally immersive sensory experience. When you read a book, by contrast, you are given words to interpret in your mind's eye. How you choose to see those words is entirely up to you; the crucial part is the imagining.

McCloud sees comics lying half-way between the other two forms. A cartoonist, through the choice of frame, character, design, and line has the same control as a movie-maker. He can present a world and the narrative exactly as he wants you to see it. At the same time, explains McCloud, there is a crucial piece of magic going on as your eye passes over the page. In the gaps between frames, the story is no longer dictated. Instead, you are imagining the connections that move the story forward. You are building the narrative in your head.

It is this combination of authorial control and the reader's imaginative engagement that makes comics special. It is why we will believe that Superman flies, or that a dog like Snoopy can talk. It also reveals why we don't believe it when we see the same thing happening on screen. The literalizing of a previously imagined wonder can only be disappointing.

It is not just stories about men in tights that benefit from this effect. Recent

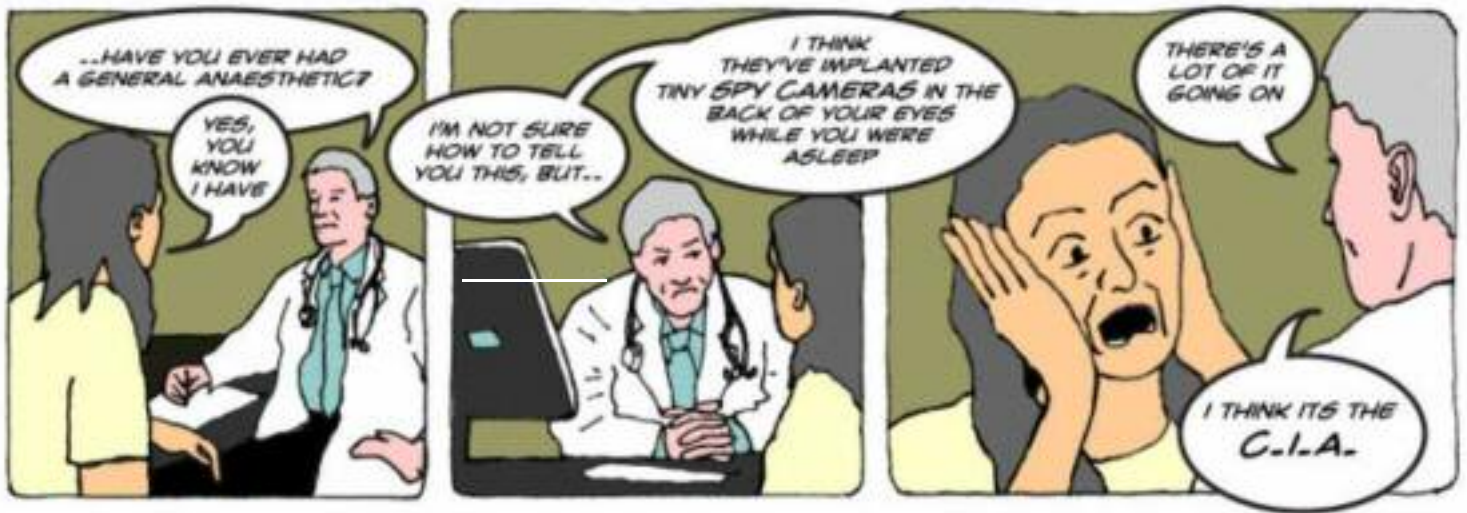
graphic novels like *Epileptic* (David B), *From Hell* (Allan Moore), and *The Photographer* (Guibert) have convincingly explored psychiatric themes. These stories are wildly different in intent and style but have a common desire to explore subjective experience. They also share techniques: the books frequently show jarring contrasts between reality as it is, and how it is perceived by their subjects; they slip suddenly into vivid depictions of dreams and fantasies; or they use tricks of rhythm and form to subtly unsettle, and surprise the reader, mimicking their subjects own experience

This kind of playfulness with time, reality and perception, is something that is only really possible in graphic narrative. When combined with comics' proven strength at portraying the fantastic, it explains why the medium offers such an exciting, and underexplored platform for exploring mental health issues.

What is so exhilarating is that the form is still very new. The rules are still being written. To offer an analogy: comics now stand where cinema stood at the dawn of the talkie.

Dr Issy Millard CT2 South London and the Maudsley NHS Foundation Trust

Facing reviews by Dr Greg Neate Locum Consultant Psychiatrist Sussex Partnership (recently of St Georges) and Stephen Ginn ST4 East London



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

Hate No. 24 by Peter Bagge

With its enduring depiction of Seattle's 'grunge' culture, the 1990s serial comic *Hate* benefitted by association with its location during its first 15 issues. However, when the suburban, slacker everyman, Buddy, returned to live with his family in New Jersey for the next 15 issues, *Hate's* slapstick and tragic dynamics expanded to include three generations struggling to live the American dream and with each

other.

Psychiatry features most directly in issue 24 when Buddy insists his emotionally unstable girlfriend, Lisa, sees 'a shrink' after her latest 'irrational' outburst. More of *Hate's* stock-in-trade counter accusations follow; 'You're the one that's crazy, not me!', before Lisa attends a male Freudian analyst and then a female, cognitive therapist. Both are professional but tied to their 'agendas' and ultimately unable to overcome her

lack of purpose. As Buddy and Lisa drive home after a final revealing joint session, Lisa impulsively suggests they have sex. An exasperated Buddy succumbs and their 'love' continues, though this time the reader is spared one of *Hate's* graphic displays of tension obliterating intercourse. **GN**

Issues 1-15 of *Hate* are collected in *Buddy Does Seattle* (2005) and 16-30 in *Buddy Does Jersey* (2007) both published by Fantagraphics Books.

Gregory I-IV by Marc Hempel

While comic book characters commonly have 'funny' shaped heads, Gregory is unique for depicting a mentally disordered, straightjacketed boy whose vocabulary is limited to grunts and shouting aloud his name repetitively. Still despite the unlikely setting for humour of his isolation cell, that doesn't

stop Gregory's adventures or those of his visiting friend; Herman Vermin, a vain, grandiose, imaginary (or is he?) rat.

The playful use of perspectives, including through Gregory's eyes, enables readers to experience his tragic and hilarious humanity. Dramatic compression and expansion of the comic strip panels, the four walls of Gregory's world, reveals him to be both oppressed and

contained by his environment. Similarly, despite his 'helpless' state, Gregory has a profound effect on those he encounters in this sympathetic portrayal of the tensions and tedium within a psychiatric institution. **GN**

Gregory was published as four books *Gregory I - IV* by Piranha Press and later reprinted in two volumes by DC comics as *A Gregory Treasury Vol. 1 & 2* (2004).

'The Alcoholic' by Jonathan Ames/Dean Haspiel

Jonathan A., the protagonist in this semi-autobiographical book, is a writer and an alcoholic with a 'propensity for getting into trouble'. As we first meet him he's drunkenly running from the police having been apprehended in flagrante with a dwarven pensioner. Predominantly in flashback, A. charts the beginning of his problems

to high school 22 years earlier, the first time he experience the dangerous sensation that alcohol made him cool.

A.'s heavy drinking continues through college and worsens with the death of his parents, but a spell in rehab allows him to remain abstinent and to establish himself as a crime writer. But sobriety does not improve the other subject of this book: A.'s troubled relationships. The failure of the friendship with a

treasured teenage male friend wounds him and a relationship with an aging aunt is his only of any stability. Eventually he falls in catastrophic love with a younger woman, and the swansong of this romance returns him to drink.

'The Alcoholic' is artfully drawn as well as being pacey and grimly compelling. Although predominantly concerned with loss and melancholy, it is not without humour. **SG**

Further reading:

Psychiatry:

Psychiatric Tales - Darryl Cunningham
Years of the Elephant - Willy Linthout
Couch Fiction - Philipa Perry

Biography/flashpoints:

Maus - Art Spiegelman
Persepolis - Marjane Satrapi
Palestine/Gaza - Joe Sacco
Pyongyang - Guy Delisle

Superhero:

The Watchmen - Allan Moore/Dave Gibbons
The Dark Night Returns - Frank Miller
V for Vendetta - Allan Moore

Saturday 9 April 2011
Concert in aid of Barnet Voice for Mental Health
Venue: St Paul's Church, Bedford Street, Covent Garden, London, WC2 9ED

Ana Antigony Ikkos-Serrano - soprano
Luba Tunnicliffe - violin
Neil Cloake - piano

Guest appearance Lia Ikkos-Serrano - mezzo-soprano

Suggested minimum contribution £5.

Barnet Voice for Mental Health is an independent voluntary organisation whose aim is to provide a voice for users of mental health services to influence the development and delivery of mental health services. They enable users and ex-users of mental health services to offer individual and group support to other people experiencing mental health problems and promote a positive view of people who experience mental distress. Barnet Voice for Mental Health offer training in user awareness to mental health professionals and aims to increase understanding in the community about mental health issues.

For further information, contact 020 8371 9678
or look at their website: <http://bvmh.co.uk/>





'High Society'

by Dr Lisa Conlan

A review of the recent Wellcome Collection exhibition

Every society is a high society' is the tagline of this topical and playful exhibition. 'High Society' challenges the status quo that we live in an era of unprecedented levels of drug addiction and that it is a very modern disease. In fact, as this exhibition sets out to demonstrate, addiction is nothing new and psychoactive experimentation, rather than a minority activity, is something of a universal experience. Using historical relics, paintings and commissioned installations, 'High Society' charts humanity's long and intimate relationship with mind-altering substances, licit and illicit, be it caffeine, alcohol, kava root, opium, cocaine eye drops.

The first part takes a brief but broadly historical look at drug use and trade through the ages, focusing on the important role opium trade played in the 19th century in the development of the British Empire. As tea increased in price and the British ran out of silver to exchange for it, the East India Trading Company sanctioned the mass manufacture of opium in India to trade for it; actively establishing, promoting and fostering opium addiction in China.

A good part of the exhibition is given to an anthropological overview of drugs, from ritual kava ceremonies in Polynesia to Native American peyote. Colourful US Prohibition-era posters hint at the current debate on legalisation but sadly, this theme is explored no further. There are featured original manuscripts including Samuel Taylor Coleridge's 'Kubla Khan' and Thomas de Quincey's 'Confessions of an English Opium-Eater'. Paintings and photographs are used to good effect, in particular, Keith Coven-

try's haunting photographs of gaunt crack addicts. Fun installation pieces recreated the dizzying experience of being high, my favourite being Rodney Graham's comical acid-fuelled bicycle ride to a Pink Floyd soundtrack. Some interesting film and video excerpts were featured, including Jonathan Miller's wonderful and enchanting BBC version of Alice in Wonderland, 1966, shot as if in the haze of a drug-fuelled dream (or perhaps a nightmare).

My main criticism of the exhibition was the lack of decent explanatory material. For example, there was brilliant video footage of the landmark late 1970s experiment by Bruce Alexander, known as 'Rat Park', but little, in fact, almost no notes to aid the viewer to make sense of it. This is a shame because it was a landmark addiction experiment, which challenged the orthodox theory of addiction, still very current in addiction research and treatment today, that dependency is a property of the drug itself. Alexander, who worked with addicts for years as a clinician, thought dependency was more about social and environmental factors than the intrinsic power of the drug concerned.

The experiment consisted of caged rats versus rats in a park called 'Rat Park'. Rat Park was a large plywood construction designed so rats could roam free with ample space for social interaction and play, food, and nests for raising

young. Both sets had the choice between morphine-laced water or tap water. Despite many attempts and variations on the experiment, Alexander could not make addicts of the rat park rats. The caged rats preferentially took the morphine solution and became dependent, while the rats in Rat Park overwhelmingly preferred water. In one variation, Alexander exploited the fact that rats are very partial to sweet things by adding sugar to the morphine solution (morphine has a bitter taste). As before, the caged rats preferentially drank morphine but, in general, the rat park rats snubbed it for water. It was only when naloxone was added to the water that the rat park residents started drinking the sweet morphine water. In another striking variation, Alexander transferred addicted caged rats into the Rat Park to see what would happen. The transferred rats mostly took up tap water instead of morphine, suffering mild withdrawals only. Alexander concluded that in optimal social conditions, the rats did not want anything that would interfere with their normal social interaction and attachment. Alexander's theory was that it was not an inherent property of the drug that led to dependency but social and environmental deprivation and distress. Alexander could not get his work published in Nature or Science and it was later published in the minor journal, Pharmacology, Biochemistry and Behavior, and failed to have any impact. It's interesting to note that this experiment was replicated on a human scale when the Vietnam veterans returned to the USA. Thousands had severe heroin dependency but back in their home environments most just stopped using when they returned home, also suffering only mild withdrawals.

Dr Lisa Conlan, ST5 General Adult, currently in an Addiction Post

"High Society' charts humanity's long and intimate relationship with mind altering substances"

“Supervision makes Polonius of us all”



Dr Nick Dunn tells us about books that have shaped his practice and recommends reading for curious trainees

When I started clinical training at The Westminster the Dean spoke to us. He talked in a tired world-weary manner: “every year I am presented with about five students about whom we on the staff say ‘how they could have possibly learnt so much in so little time?’ And then...sadly there are another group of student about whom the staff say ‘but how could they have learnt so little?’” He went on to urge us to read a decent newspaper as a way of beginning our lifetime study as doctors. This is the first example that I can recall of a medical colleague championing reading. In the same hospital the charismatic and wily Harold Ellis advised that you learn surgery by seeing a patient and then reading about the diagnosis. He insisted that we purchased and memorise Hamilton Bailey’s ‘Demonstration of clinical signs’. Lord Cohen of Birkenhead advised all his students to read Jevons ‘little book of Logic’ which is one the shortest and smallest book I have read.

But what books should supervisors of Psychiatry advise a trainee or medical student to read? The books I recommend are the ones that most influenced me and most influenced the doctors whose opinions I respected. As a trainee I quizzed my supervisor not what I should be reading but what was the book they thought most influenced them. After all time is short, and why use a scattergun approach when there was help at hand. They were generally less forthcoming than I expected and parried with replies such as “everyone asks me that” or “no I only read papers”. The late Edmund Harvey Jones sug-

gested ‘Scheidner’s Personality Disorders’ which I read but found it amounted to merely a list of personality features and I don’t think I was ready for it. But Kingsley Norton at the Henderson Hospital suggested Derek Steinberg’s ‘Models in Mental disorder’ and then I felt I was getting somewhere. Now with Work place based assessments and the European working time directive there is even less time for learning so I don’t wait to be asked. I suggest that Antony Clare’s ‘Psychiatry In Dissent’ is a good book to start. His interpretation of the famous Rosenhan experiment where actors feigned psychosis was not that diagnosis is a waste of time but that the psychiatrists in the study could not diagnose.

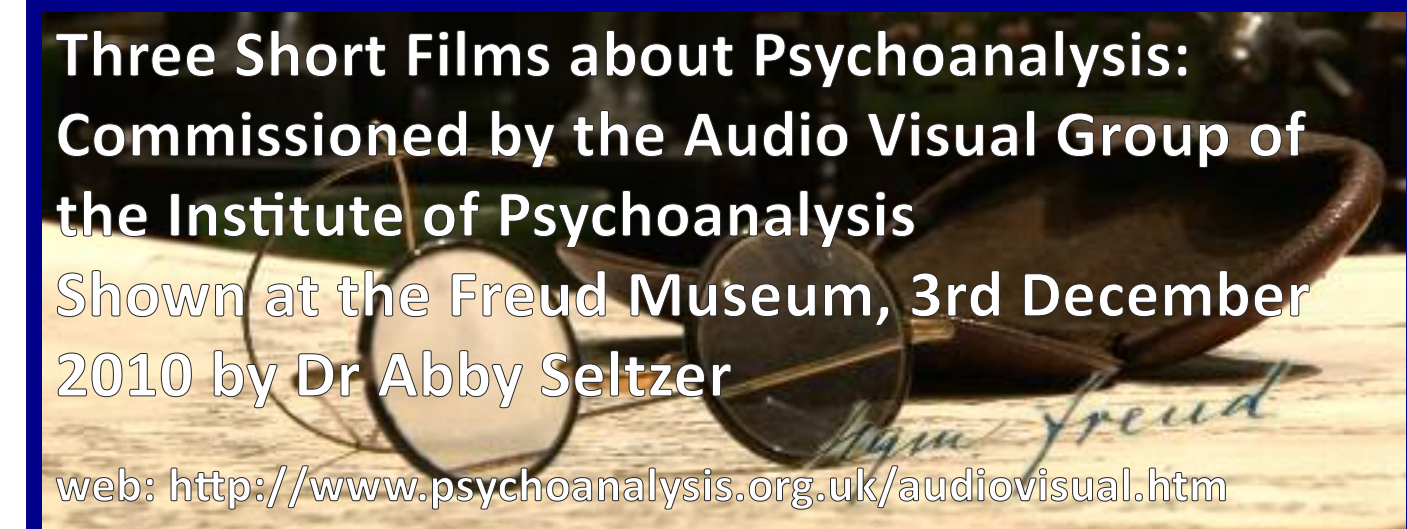
The best books are those that seem to answer something you were searching for. Without doubt the book that most impressed me was McHugh and Slavney’s ‘Perspectives in Psychiatry’ which I found to be more sophisticated than “Models for Mental Disorder”. It can be seen as an accessible summary of Jaspers’ ‘General Psychopathology’ and saves the reader having to wade through those formidable two volumes. When one feels frustrated with another patronising request for a medication review I found Rutter’s ‘Helping Troubled children’ useful to adult psychiatry because it is so clear about assessment and management without drugs.

I remained dissatisfied with books about clinical interviews in that they did not add anything that could not already be found in the early chapters of the Oxford textbook of psychiatry. That is until I read Othmer and Othmer’s ‘Clinical In-

terview’ and I have not found a better book that realistically represents the difficulty of interviewing patients who are reluctant to give information. Considering a different subject, I was surprised how much more statistics there was in training in psychiatric compared to colleagues in others specialities. The statistics chapter in ‘How to read a paper’ by Trisha Greenhalgh helped, but then I found Cooligan’s ‘Statistics’ was what I sought forcing one to be numerate without the usual agony.

Outside books aimed at psychiatry professionals, Peter Ackroyd’s ‘London the Biography’ opens one’s eyes to the psycho-geography of the great city. ‘Enduring Love’ by Ian McEwan makes you take stalking seriously and Antony Storr’s chapter on Sexual Jealousy in Othello in ‘Churchill’s Black Dog’ made sense for me of jealousy in clinical practice. Richard Asher - the physician from the Middlesex who coined the term Maunchausen Syndrome and Myxoedema Madness - enjoyed a swipe at psychiatry: “what psychiatrists called dissociation the rest of us call kidding yourself”. His demolition of Thomas Szasz’s theory that chronic anger causes baldness by scalp tension shearing the hair roots made me audibly giggle. Finally because the exam has changed so much I recommend Psychiatry PRN because it is instantly readable and invaluable for the OSCEs.

Dr Nick Dunn consultant psychiatrist South London & the Maudsley NHS Trust



Three Short Films about Psychoanalysis: Commissioned by the Audio Visual Group of the Institute of Psychoanalysis Shown at the Freud Museum, 3rd December 2010 by Dr Abby Seltzer

web: <http://www.psychoanalysis.org.uk/audiovisual.htm>

The audiovisual group of the British Psychoanalytical Society is a relatively recently formed group of younger analysts whose aim is to disseminate knowledge about psychoanalysis to the 'outside world'. This is not as easy as it sounds. Traditionally, psychoanalysts have tended to shy away from talking openly about the world of psychoanalysis, so these films, funded by the

International Psychoanalytic Association, are trailblazers, intended to convey something of the complex psychoanalytic process to those with minimal previous knowledge.

The first of the three films was a short cartoon of an analytic session, in which the (male) patient's free association is represented as a series of animated drawings for his (female) analyst, an 'amuse-bouche' of a piece which ended with the patient's inevitable sexual fantasies about his analyst, drawing appreciative laughter from an audience composed mainly of analysts.

The second sketched out the history of British psychoanalysis through a series of interviews with practising analysts, outlining the importance of both Sigmund and Anna Freud, Melanie Klein, Wilfred Bion and Donald Winnicott. The strengths of the British School were outlined: its eclecticism and the success with which different analytic ideologies and practices have managed to co-exist

without serious schisms – unlike analytic societies in some countries which have been characterised by splits and secessions; and the diversity of the analytic community. In common with many European Societies – and largely unlike the American Society, where the majority are psychiatrists – British analysts come from diverse backgrounds, including all health professions, social

work, education and even philosophy and the arts, not to mention sport in the case of the illustrious cricketer career of the Institute's immediate past president, Mike Brearley, who featured in these films.

The last film focussed on training, and used the device of a supposedly naïve would-be trainee coming to the Institute (cue shots of well stocked library) to interview various analysts about the selection and training procedure. We learnt about the way in which a candidate is selected. After rigorous but never formulaic interviews with two separate analysts some are accepted straight away, some are recommended to start their personal analysis and come back later, and those who are unsuitable – the overly dogmatic or anxious, for example – are tactfully (one hopes) refused.

The training itself lasts for a minimum

of around four years, but may be interrupted to accommodate family or work commitments. In the first year, a candidate observes an infant and mother in their home setting, as well as being introduced to theoretical concepts through seminars and lectures. The theoretical component continues throughout the training, but only infant observation is 'tested' by a formal written paper which must be passed.

Two patients are taken on under supervision during training, and most importantly, the candidate must undergo a full five days a week personal analysis. Possible career paths for analysts are full time private practice (nice shot of requisite couch), a combination of private and NHS work, the latter mainly in less intensive psychoanalytic psychotherapy, or other clinical or non clinical work which is now informed by a psychoanalytic perspective.

Perhaps the most fascinating aspect of these films was what they did not say. No mention was made of the cost – both financial and personal – of undergoing training. If anything, the experience of training was depicted in rose coloured soft focus as enlivening and exhilarating. The trainee is welcomed as into a family, and forms strong bonds with fellow trainees who were described in sublime terms as stimulating people with fascinating and diverse backgrounds and beliefs. Most of my patients could, in all fairness, be described in much the same way, although perhaps with a little more by way of obvious psychological baggage. It was hard for this jobbing psychiatrist to escape the sense that training still contains a strong component of initiation and ritual in way that is recognisable in bodies such as the army, religious orders,

“these films, are trailblazers, intended to convey something of the complex psychoanalytic process to those with minimal previous knowledge”

and indeed in medicine itself. Initiation rites and professional rituals are well recognised as means of promoting identification, and psychoanalysis, for all the welcome attempts to demystify, clearly still has its share.

Neither was any mention made either of efficacy and outcome, a thorny subject, but one with which psychoanalysis, through the works of such researchers as Peter Fonagy and others, is rightly beginning to engage. CBT was mentioned – and more or less dismissed – in passing, but not in a way that would satisfy the evidence inclined. Unless psychoanalysis is deliberately setting out to attract ‘more of the same’, which perhaps it is, then it risks becoming an even more elitist, marginalised and, dare I say it, self-satisfied activity.

The films may well serve as useful educational tools for psychiatric trainees or even medical students (I was alarmed to learn from the star of the training film that the majority of



trainees these days don't learn much about psychoanalytic theory and thinkers except in a tick-box way), or indeed as a means of enlightening GP commissioners, though that may be dangerous ground. They are definitely a step in the right direction, but if psychoanalysis is to maintain its rightful place not only as one of many valid treatments, but also a valuable tool for

interrogating modern life, then it will have to find a more forceful way of answering its critics.

**Dr Abby Seltzer Consultant
Psychiatrist Camden and Islington
Foundation Trust**

‘Madness: A Brief History’ reviewed by Dr Sarah Jones

“Not to know what has been transacted in former times is to be always a child.”

- Marcus Tullius Cicero (106-43BC)

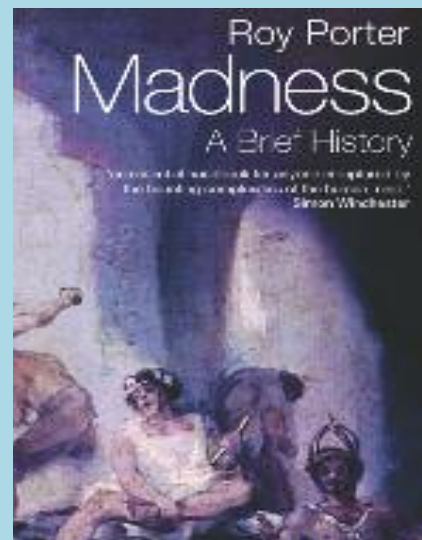
Psychiatry is a specialty with a long and rich history; there have been many key developments, figures and movements. A basic knowledge of these enables a deeper insight into issues that concern us today for example the stigma of mental illness, ongoing resistance to psychiatry and the development of psychiatric services. For us to really understand our patients and our field, we have to learn about the past.

In *Madness: a brief history* Roy Porter takes on the challenge of covering the history of psychiatry from 5000 BC to the year 2000. Over 218 pages, he leads the reader on a story from trephination to Prozac and all the weird and wonderful in between. With such a rich history and so much ground covered, one might think that this book would be factual, dry and hard-going. However, Porter's easy writing style and ability to focus on salient points whilst subtly conveying changes

in attitudes of the day through art and literature makes this book a total success. He also illustrates this book with dramatic pictures; Drurer's "Melancholia", Tenier's "Stone of Folly" and pictures of The Bethlem punctuate the text and help to transport the reader back to the era of lobotomies and asylums. As the book approaches the present day Porter leads us through the psycho-pharmacological revolution, the anti-psychiatry movement and the development of modern-day classification. We are re-acquainted with Morel, Kraepelin, Szasz and Laing along the way.

The book ends with an examination of the challenges facing modern day Psychiatric practice. Porter also takes a look at some of the different attitudes towards the development in mental illness. In (year) BMJ was optimistic: "in no department of medicine, perhaps, is the contrast between the knowledge and practice in 1800 and the knowledge and practice in 1900, so great as in the department that deals with insanity"

And this is contrasted with the cutting: "apparent inefficacy of medicine



in the cure of insanity" from the *Journal of Mental Science*. The reader is left in no doubt that a great deal has changed and hopeful that the claim by the *Lancet* in 1913 that "British Psychiatry [was] beginning to awake from its lethargy" is true. It is also obvious that there is still further to go.

Madness, a brief history is a stunningly concise book, a must for trainees and, not to mention, an aid to the MRCPsych course!

**Dr Sarah Jones CT2 Perinatal Psychiatry
Homerton Hospital East London
NHS Foundation Trust**

"Naked lunch, a frozen moment when everyone sees what is on the end of every fork" - William Burroughs



Religion, politics ... and psychiatry?

Dr Wojtek Wojcik on the perils of discussing psychiatry over the dinner table

Picture the scene: you're at a dinner party. Conversation meanders from topic to topic. Suddenly, we alight at what - depending on your view - is either a pothole or a scenic view rich with possibilities: the psychiatric anecdote. Another doctor at the table mentions something visceral from the canon of house job reminiscences, or their specialist training in proctology. The natural effect on the other guests is of squeamishness twinned with fascination; many questions follow. Next, someone at the table turns to you and asks if you have any interesting psychiatric anecdotes to share.

At this point you might legitimately wonder if you're reading a vacuous dinner party etiquette column. But there is an important point here. As psychiatrists, what are the reasons for abstaining from discussing work in a social setting, and what if any positive reasons are there for doing so?

First, the case against. As psychiatrists, we ask for a great deal of trust and personal disclosure from our patients. Any suggestion of flippancy, or careless use of case material in the tacit competition for social approval at a dinner party would leave the audience thinking "well, I'm glad he's not my doctor". Even if the anecdote is a composite and contains

no identifiable patient information, the audience, if convinced by the story, might be left wondering if it isn't an actual person you are discussing in a setting they would never have consented to. It may also be a slippery slope, a small step to a GMC referral for discussing patient-identifiable details on the bus home.

And the case for? Whether we like it or not, our role in the 'Cinderella specialty' inevitably involves advocacy on behalf of the people we see and mental health services generally. Statistics and lists of risk factors, whilst important and helpful, are not sufficient to interest or convince a lay audience. People empathise with the story of another individual, but less so with an account of 2786 patients recruited into a study of depression. Therefore one could argue that judicious use of clinical anecdotes has a role in helping de-stigmatise mental illness and communicate the difficulties of our work

I am inclined towards the second approach, but a fine balance is required. There are lots of situations where we might be invited to give a view when the motive isn't clear (or clearly sensationalist); or where there is indeed a risk that one's own motivations are in part to compete and provide a 'good story'.

And in any group it is likely that others will have personal or family experience of mental illness. Sometimes, this latter issue looms large and it would be unkind to begin a discussion where one person is likely to be more emotionally involved and therefore vulnerable.

Returning to the dinner table, I chose to sketch out a story about an apparently routine appointment, a young man with a diagnosis of Asperger's living at home whose anger outbursts were scary and a concern to his mother. I explained that I took a history, discussed antecedents and alternative strategies with him, but that he then mentioned that he had set the family cat on fire "for fun". What do I do? What does this mean? Does it make him 'abnormal'? The group was alive with questions, and discussion quickly moved around the themes of risk, individual and population perspectives, defining abnormality and the perils of making a snap judgement. The consensus that emerged was nuanced, appreciative of complexity and the many perspectives one can bring to thinking about another person. Which ultimately helps us all, ... but I'm happy to argue it.

Dr Wojtek Wojcik ST5 trainee general adult psychiatry at South London and the Maudsley

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