



# The Royal College of Psychiatrists London Division

# Newsletter

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## Goodbye !!.....

from the Chair

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## *Division Activities*

### Thank You and Farewell from George Ikkos

**In 6 months the London Division will have a new Chair.**

During the last 4 years the division executive has had a slowly changing membership. It is my pleasure to be in a position to thank all elected, ex-officio and co-opted members of the executive who, without exception, have made it an effective committee, with high levels of mutual solidarity and ready tolerance of differences of opinion. Thanks also to **Philomena Conlon**, our new administrator, whose support has made a major difference.

Special thanks go to **Mike Shooter**, immediate past President and **Vanessa Cameron**, Chief Executive, Royal College of Psychiatrists for their visionary commitment to strengthening the division and their success in making this a reality. The securing of a full time administrator and new premises for the division has markedly increased our capacity. We have been able to engage in an increasing number and range of activities, including more and better meetings, higher profile newsletters and website and increasing links with important partners such as London Mental Health Trusts' Medical Directors, the London Development Centre for Mental Health and King's Fund. Devolution has been instrumental in strengthening our Clinical Excellence Awards procedures in transparency, efficiency and effectiveness.

Psychiatrists received 10% of bronze and silver level and 20% of gold level national Clinical Excellence Awards conferred in London in the 2005 round! These awards reflect the work the recipients have contributed over the years. By their consistent championing of psychiatrists **Mike Shooter** and the current President, **Sheila Hollins**, have made a huge contribution to the recognition of such work. The

burden of championing has been made easier by the division clinical excellence procedures that owe most to the leadership of our Director of Clinical Excellence, **Tom Sensky**. Both presidents have praised the procedures as a model for the other divisions and faculties of the college.

**Hagen Rampes**, who was initially co-opted to develop the division website and then as Honorary Secretary, has been successful in both activities. In the long-ago days, before devolution and administrative support, his workhorse like capacity carried him, single-handedly, through a combination of roles, which, in effect, included those of honorary secretary, academic secretary, conference manager, finance officer and joint newsletter editor, all of which he carried out to high standard. At the same time he continued his extensive clinical and academic activities. Thank you Hagen.

Also, many thanks to **John Newbury-Helps and Ros Furlong**, Chief Executive and Medical Director, respectively, of Barnet Enfield and Haringey Mental Health NHS Trust and **Fred Middleton**, Clinical Director of Medicine, Rehabilitation and Paediatrics, Royal National Orthopaedic Hospital NHS Trust, for the consistent support they have given to the division. They have shown in practice a clear understanding of the importance of a strong psychiatric profession in ensuring high standards of care for those with psychiatric disorder, irrespective of the setting in which they present. Support from medical managers is essential for the success of the division.

The division executive is now constituted by a balanced combination of clinicians, academics and medical managers. I see clinicians as the blood and guts of the profession who sweat on the service frontline; academics I see as the air and lungs that breath life into our future and medical managers as the bones, muscles and joints that carry us around. As for the brain and heart, we all share in these! The future of psychiatry will be best served if we consistently work together in a climate of mutual respect and understanding and a willingness to learn from each other. The London Division can help faculties improve mutual understanding and cooperation locally. It has consistently attempted to acknowledge a wide variety of interests and to reflect these in its academic activities.

What about other thoughts for the future? We need to be an outward looking organisation that increasingly engages with service users, carers and the public (including public health and mass media), as well as organisations such as the London Development Centre, King's Fund, the London Mayor and the Government Office for London. As the present newsletter attempts to do, we need to acknowledge and respect diversity and the contribution the humanities can make to our professional practice. We

also need to ensure that we engage consistently and effectively with and give a voice to trainees and to SAS doctors working in London and consultant psychiatrists, who, for a variety of reasons, are not members of the College. Failure to do so will harm the College, our members and our patients.

3000 members (out of 11,500) are actively involved in the College either by serving on Committees or holding some College post such as Tutor, Examiner, Assessor etc. Many many more participate in College activities by attending conferences. To all those of you who took part, either through attending our conferences or in other ways, "thank you". It has been an amazing privilege to meet and work with you and I have no hesitation in encouraging the engagement of as many members as possible in College activities. To promote this it is essential for the division to ensure that it is seen as fair and welcoming, through ever increasing effective communication and transparency.

I wish the new chair and executive committee members an equally happy time and greater success!

**George Ikkos**

## The 2005 Clinical Excellence Awards



### Congratulations to London colleagues on their Clinical Excellence Awards

The London Division is pleased and proud to congratulate the following members on being awarded Clinical Excellence

Awards (CEA) in the 2005 round, the results of which were published on 9 November 2005 on the website of the Advisory Council for Clinical Excellence Awards (ACCEA):

**Gold:** Anthony Bateman, Dinesh Bhugra, Tony David, Lenny Fagin, Janet Treasure;

**Silver:** Jane Garner, Geraldine Holt, Mike Kopelman, Brian Martindale, Iqbal Singh;

**Bronze:** Peter Hindley, Rob Howard, George Ikkos, Eric Johnson-Sabine, Simon Lovestone, Jane Marshall, Mike McClure, Gill McGauley, Lester Sireling

### The Division and Clinical Excellence Awards

As colleagues will know, nominations can reach the ACCEA by a variety of routes. Many psychiatrists seek support for their nomination from the Royal College. In deciding which CEA nominations to support, the Royal College in turn relies on

recommendations from the Divisions, Faculties and Sections. The Division's CEA decision-making body comprises the Division's Executive Committee, together with representatives of Faculties not already represented on the Executive.

How decisions are taken on which CEA nominees to support varies from one College constituency to another. The London Division has pioneered a procedure for systematically appraising and ranking CEA nominations based on the ACCEA's published criteria. There are 14 such criteria, covering the four main categories in the ACCEA form - delivering a high-quality service, developing a high-quality service, managing a high-quality service, and research, education and training. For each nomination form, each member of the decision-making body rates each of the 14 criteria, and also decides whether or not to support that particular nomination. At the subsequent decision-making meeting are available summary ratings of all the nominations, including not only the scores are detained from the ratings above, but also the number of people among those making the ratings who support each nomination. The aim of this procedure is to make Division's decisions more robust and consistent. However, the process is very time-consuming – last year, rating the nominations as just described is estimated to have taken approximately 200 person-hours.

### **The London Division's support of nominees**

Judging by the awards made in the latest round, the Division's procedure worked very well. Only one of the colleagues who gained an award did not submit the nomination through the Division. Of the other successful nominations, all but one were recommended by the Division to the College.

The Division supported 15 nominations for Bronze awards. Eight of these nominees gained a Bronze award, all eight being ranked in the top ten of the Division's list. Of those nominees who were not ranked sufficiently highly to get the Division's endorsement, none gained an award.

Seven nominations were supported for Silver awards. Of these, four gained Silver awards, and two (including the nominee ranked highest in the Division's list) were awarded Gold awards. Only one of the nominees who was not ranked in the Division's top seven gained a Silver award.

The Division gave its support to three nominees for Gold awards, all three of whom gained awards.

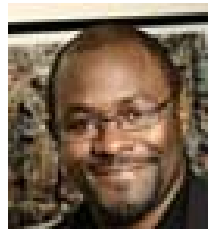
### **Support for future nominees**

The Division hopes to run a workshop in 2006 for colleagues aiming to submit nominations. Our experience has been that colleagues vary considerably in how they complete their ACCEA forms of art and in the information they include, and we hope to be able to share with colleagues the lessons the Division has learned from going through nomination forms and also from those nominations that lead to successful ACCEA awards.

**Tom Sensky**

## *Diversity*

### **Delivering Race Equality**



**Disparities in the rates of mental illness, the care received and the outcome of service intervention for Black and Minority Ethnic groups (BME) compared to English White groups are well documented.**

Though many of these findings have been common currency for some time there had been no nationwide strategy to address them until January 2005 when the Department of Health published its long awaited strategy "Delivering Race Equality in Mental Health Care an action plan for reform inside and outside of services" (DRE) <http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle>

The Department of Health drew on three key documents "Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England"; "Delivering Race Equality: A Framework for Action"; and the independent inquiry into the death of David Bennett (although DRE itself is not a direct response to the inquiry's report).

DRE is a hefty and some say complex document, this is for two reasons, first there have to be changes in many arenas for there to be a viable and sustainable impact on patient care, second because it is a plan that specifies particular actions and who should be taking them rather than an outline strategy.

However, it can be simplified into three 'building blocks':

- 1) more appropriate and responsive services** - achieved through action to develop organisations and the workforce, to improve clinical services and to improve services for specific groups
- 2) community engagement** - delivered through healthier communities and by action to engage communities in planning services.
- 3) better information** - from improved monitoring of ethnicity, better dissemination of information and good practice, and improved knowledge about effective services. This will include a new regular census of mental health patients.

To promote the successful development of more equitable services 9 race equality leads based in the NIMHE regions have been recruited, money has been

made available for the employment of 500 community development workers, a national census has been commissioned and a number of research and development projects.

DRE itself is just one component of a wider programme of action bringing about equality in health and social care. It will support the implementation of race equality in the NHS, it will help NHS trusts to fulfil their obligations under the Race Relations (Amendment) Act 2000 and their core standard for equality of access set out in the planning framework.

A new BME Mental Health Programme Board, directly accountable to Ministers, has been set up to oversee this action plan and the wider BME mental health programme.

The Healthcare Commission will be assessing every trust's performance against core national standards, including those relating to equality and discrimination. The new annual census of mental health patients will allow us to monitor progress, along with other sources of information such as Healthcare Commission surveys.

The vision for DRE is that by 2010 there will be a service characterised by:

- less fear of mental health services among BME communities and service users;
- increased satisfaction with services;
- a reduction in the rate of admission of people from BME communities to psychiatric inpatient units
- a reduction in the disproportionate rates of compulsory detention of BME service users in inpatient units;
- fewer violent incidents that are secondary to inadequate treatment of mental illness;
- a reduction in the use of seclusion in BME groups;
- the prevention of deaths in mental health services following physical intervention;
- more BME service users reaching self-reported states of recovery;
- a reduction in the ethnic disparities found in prison populations;
- a more balanced range of effective therapies, such as peer support services and psychotherapeutic and counselling treatments, as well as pharmacological interventions that are culturally appropriate and effective;

- a more active role for BME communities and BME service users in the training of professionals, in the development of mental health policy, and in the planning and provision of services; and
- a workforce and organisation capable of delivering appropriate and responsive mental health services to BME communities.

DRE will be independently evaluated so in 2010 we will see whether the ambitions have been realised.

**Kwame McKenzie**

## A Carer Perspective



**I am a pharmacist by profession and a member of the Barnet, Enfield and Haringey Mental Health NHS Trust Medical Education Committee and a carer representative on the College**

**Education and Training Centre's Advisory Board for one year.**

My wife Sheila and I have been caring for a member of our family who has had schizophrenia for twenty-four years. Whole families- parents and siblings- are affected by the mental illness of a family member. It is something they never recover from and their lives are changed forever. I have been involved with carers through my work for the Charity Mencare ([www.mencare.info](http://www.mencare.info)) where I run a supportive family training course for carers.

In your newsletter dated January 2005 your Executive Committee agreed a number of priorities for the coming eighteen months. No 8 read: "Ensure greater engagement of users and carers in the work of the committee and the division".

As you may know it has become mandatory to involve carers and users in psychiatric training. I met Dr George Ikkos at a Tutors' and Training Programme Directors' Conference. He asked me if I would be interested in becoming involved as a trainer-carer and I agreed.

My first session was with a group of trainees at Edgware Hospital. I gave a presentation, in which my wife Sheila was involved, on our personal experiences. I was able to outline the problems and issues that arose during initial diagnosis, from a carer's perspective. The response of the doctors was to ask me lots of questions about our interactions with hospitals and doctors during this time. It seemed to be quite a shock to them to realise the kind of problems that carers had to deal with.

## Sex and the City: Gay and Lesbian Diversity Issues for London Psychiatrists

Diversity is not sexy. For many psychiatrists, even if diversity trumps psychopharmacology on the CPD list, probably the last item on the diversity list is all things gay and lesbian.

In London, there is a good case for pushing gay and lesbian issues to the front of people's minds. As a metropolitan area with a large population of gay men and lesbian women, every psychiatrist in the city will have some gay and lesbian patients, even though these patients may not be rushing to tell you who they are. We may be teenagers, we may be elderly, we may have children but we are often an invisible minority. Similarly, you will work in a team or a service in which gays and lesbians will be represented, perhaps by you. This may happen in as open a way as most heterosexuals discuss their partners or marriage at work. It may not. You may know colleagues who are careful about disclosing their gay or lesbian sexuality, even if they are sure of it. They may tell no one but everyone guesses. They may tell just a few people who they trust not to be homophobic. Then again you may believe you have never encountered a gay or lesbian colleague, in which case you may wonder why you have not done so.

Recently, the front pages have been full of celebration of gay and lesbian lifestyle. Frankly, it has been hard to avoid stories about Elton John and "my partner David Furnish". A rash of recent headlines has greeted the advent of Civil Partnership in December 2005. The tabloids have covered this with conspicuous and perhaps surprising enthusiasm, as have the more respectable parts of the Fourth Estate. Civil Partnership is the most radical law reform for gays and lesbians in my lifetime. It will have far reaching implications for family composition, the children of gay and lesbian parents and the social and legal status of gays and lesbians lucky enough to manage enduring relationships. It is more than a way to avoid inheritance tax. Its inherent symbolism will grow and change over time, just as the symbolism of marriage has done, over the centuries, in different communities.

Civil Partnership is a good news story for the gay community. However, most of the issues which the Gay and Lesbian Special Interest Group has considered over the last four years have been more downbeat. The reason for this is straightforward. The relationship of mental health services and gay and lesbian people has not been an easy one. For many years psychiatric textbooks, teaching and practise pathologised gay and lesbian patients. It was believed that simply to be gay or lesbian was to be abnormal. This was reflected in earlier diagnostic classifications where homosexuality could be diagnosed (King and Bartlett 1999) and treated (Smith et al 2004). Some people, both inside and outside mental health services, still hold to that or a similar view. This can affect both how they view their patients and how they view their colleagues. It has made many patients wary of mental health services (PACE 1998).

The next session I took part in was "What do carers want from Doctors?" This is a question I have discussed with carers on many occasions during supportive family training sessions. These are some of the things carers say they need from doctors.

- Be aware that carers have physical and mental stresses and need help.
- Listen to their personal experiences in caring for a family member. Their caring is for life, and with fractured relationships at home helping recovery is very hard.
- Understand that carers need guidance on how to best help and support their relative.
- Professionals to recognise that carers have crucial information to share with them, i.e. changes in behaviour and first signs of the start of a breakdown. They can also give feedback on the effectiveness of medication and whether or not the patient is taking it regularly.
- Carers know the patient much better and understand the limits of their abilities.
- Explain confidentiality issues to carers and the legal obligations of the professionals. Carers need access to key information to help them become more effective.
- Carers need to understand how they can communicate with professionals in the care team.
- Seeing patients and carers together can give professionals a more accurate picture of the situation.

Another session was on "Breaking Bad News". One of the hardest things for carers is accepting that their relative is mentally ill. It is only when they can do this that they are able to "step back" and try to live a life of their own. There is no doubt there is a lot to be gained for both sides when professionals and carers work together and share information.

I have also been involved with sessions with the junior doctors at St Mary's Hospital "Communication Skills and Carer Awareness" Workshops.

I have found these sessions to be extremely beneficial. They have certainly been emotionally satisfying for me. I hope that my participation in these sessions has contributed to greater understanding by professionals of the needs of carers.

**Jeffrey Breslaw**

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### There is a Panther stalks me down

(Reading Plath)



Sylvia Plath was born in 1932 in Boston Massachusetts. In 1953, whilst still at College she took an overdose of tablets and nearly succeeded in killing herself. She was admitted and treated at McLean Hospital where she began a long relationship with Ruth Barnhouse,

her psychiatrist. Plath later described her experience in the autobiographical novel *Bell Jar* which was published in 1963. By the time of death, by suicide, in 1963 she had published *Colossus*, a volume of poetry and *Bell Jar*. *Ariel*, *Crossing the Water* and *Winter Trees* were published posthumously.

Plath is usually described as a ‘confessional’ poet. This term was initially used to describe the writings of Robert Lowell, the American poet. In his case it referred to the themes of sexual guilt, alcoholism, confinement in a mental hospital and the use of the first person pronoun which directly pointed in the direction of the poet. In essence, the poet was the centre of the poems although some would argue that in Lowell’s case it was his literal, if literary, self that the poems aimed at. It is true that Plath as well as Anne Sexton, another confessional poet, attended Lowell’s poetry seminar taught at Boston University in 1959. There is little doubt that both poets were much influenced by Lowell and that both sought to turn their personal experiences of mental illness to literary use. In Plath’s case, her earlier poems were formally precise, elegant but unoriginal. She found her own voice in the poems from 1962 until her death in 1963. In these later poems she mined her emotional anguish for material but unlike Lowell she was able to imbue her poems with a mythic dimension, such that they were not merely tied to her own biography but at once appeared more stylised but yet direct and brutal. Plath herself said ‘I think my poems come out of the sensuous and emotional experiences I have, but I must say I cannot sympathise with these cries from the heart that are informed by nothing except a needle or a knife, or whatever it is. I believe that one should be able to control and manipulate experiences, even the most terrifying, like madness, being tortured, this sort of experience, and one should be able to manipulate these experiences with an informed and intelligent mind’ (quoted Uroff, 1977).

The question is whether there is any gain for a psychiatrist in reading Plath. Allan Beveridge has examined the case for psychiatrists reading fiction (Beveridge, 2003). The arguments for reading fiction, simply put, are that 1) we can explore the lives and inner worlds of a wide variety of individuals by imaginatively engaging with them in novels; 2) fiction allows doctors to

However, a shift, of which Civil Partnership is one element, has occurred in the UK in recent years. It has become easier for gay men and lesbian women to talk about their lives and to be open about the way they live.

Mental health practitioners, be they psychiatrists or from other disciplines, have a duty of care to all patients they encounter. In an increasingly diverse society, we need to know enough about gay and lesbian life to deal well with patients and colleagues who are gay or lesbian, as well as those less sure of their identity but who have or want same sex sexual relations. We also need to be up to date with the developing robust literature on gay and lesbian mental health problems (King and McKeown 2003).

The Gay and Lesbian SIG has generated a half day training pack for use with clinical teams to address these issues in a safe and non-judgemental way. It provides factual information about gay and lesbian mental health. It encourages participants to explore common clinical scenarios and is designed to improve the confidence and skills of the mental health workforce in relation to gay and lesbian issues. It has taken the real life experiences of professionals in the SIG and used them creatively. “Gay and Lesbian Mental Health Matters” is a grounded workshop that will be meaningful to participants and useful in their everyday work. Anyone who would like to commission the workshop for their team should contact me at the email address below.

It is one example of the work of a SIG that has been very active since it was set up.

Next year’s activities will include presentations at the 2006 College Annual Meeting in Glasgow and a SIG seminar on “Understanding Homophobia: Inside and Out”. Anyone interested in knowing more about these events or joining the SIG should find us on the College website.

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**Annie Bartlett**  
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get a deeper understanding of patient's emotional and existential life; and 3) reading literature helps to develop empathy. The case for poetry has yet to be made. But, is poetry different from fiction and here I mean specifically for the purposes of a doctor. Letters, journals, autobiographical accounts and memoirs have an immediacy that fiction does not possess. Letters and journals also have the quality of opening a window and letting in light into the private life of an author. The letters of Franz Kafka for example, *Letters to Felice* and *Letter to Father*, reveal more that is psychologically interesting than the short stories and the novels. Furthermore, the letters enrich our reading of the fictional works. Confessional poetry, particularly, allows the reader rare insight into the mood, thoughts and motivation of a poet. Poetry like Plath's is similar to reading a letter or a diary but is more than that. Where the poetry is able to go beyond the anguish, that is, where the poem is not strangled or aborted by the sheer intensity of the emotional life, the poem sheds light in a unique way into that territory that is usually the provenance of the psychiatrist. Poetry is in this sense an encounter with the spirit of the Other. Language is everything in poetry. The use of rhyme, rhythm, cadence, alliteration, assonance, and diction combine to evoke what constitutes emotion. Where fiction works obviously through the story, poetry is in the end the triumph of language, for the language is constitutive of the poem. And language is at the core of what it is to be human. I am arguing that poetry allows the psychiatrist to encounter the Other, that is, to encounter the subjectivity of the Other in a direct and powerful way, and in this encounter to learn what emblems and symbols emotional life is disguised in. And, in many respects that is what a psychiatrist experiences in the clinic. Poetry, thus, allows a clinician to encounter the imaginative world of another being within the safety of a book. Plath's poetry is a good case in point.

In the poem, *The Detective*, Plath wrote: "This is a case without a body. The body does not come into it at all.// It is a case of vaporisation./ The mouth first, its absence reported/ In the second year. It had been insatiable/ And in punishment was hung out like brown fruit/ To wrinkle and dry.// The breasts next. These were harder, two white stones./ The milk came yellow, then blue and sweet as water./ There was no absence of lips, there were two children, But their bones showed, and the moon smiled." This poem is ostensibly about a detective investigating a death, presumably a murder. Plath is able to render her feelings of rejection, bitterness and sense of worthlessness indirectly. It is a narrative poem that could be read without knowledge of the life history of the poet but with that biographical knowledge the reading of the poem is enriched. But, also the poem becomes emblematic of rejected mothers. In *For a Fatherless Son*, the poem opens "You will be aware of an absence, presently,/ Growing beside you, like a tree./ A death tree, colour gone," In *Elm*, Plath wrote: "I am inhabited by a cry./ Nightly it flaps out/ Looking, with its hooks, for something to love.// I am terrified by this dark thing/ That sleeps in me;/ All day I feel its soft, feathery turnings, its malignity.// Clouds pass and disperse./ Are those the faces of love, those pale irretrievables?/ Is it for such I agitate my heart?// I am incapable of more knowledge./ What is

this, this face/ So murderous in its strangle of branches? -// Its snaky acids hiss./ It petrifies the will. These are the isolate, slow faults/ That kill, that kill, that kill." What is so remarkable is that with economy and poise, Plath was able to communicate her distress in a way that engages both our interest and sympathy.

The title of this paper 'There is a panther stalks me down' is taken from an early Plath poem, *Pursuit*, which is prescient of her eventual life. She wrote:

**'There is a panther stalks me down:  
One day I'll have my death of him;  
His greed has set the woods aflame,  
He prowls more lordly than the sun.  
Most soft, most suavely glides that step,  
Advancing always at my back;  
From the gaunt hemlock, rooks croak havoc:  
The hunt is on, and sprung the trap.  
Flayed by thorns I trek the rocks,  
Haggard through the hot white noon.  
Along red network of his veins  
What fires run, what craving wakes?**

**Plath concluded:**

**'I hurl my heart to halt his pace,  
To quench his thirst I squander blood;  
He eats, and still his need seeks food,  
Compels a total sacrifice.  
His voice waylays me, spells a trance,  
The gutted forest falls to ash;  
Appalled by secret want, I rush  
From such assault of radiance.  
Entering the tower of my fears,  
I shut my doors on that dark guilt,  
I bolt the door, each door I bolt.  
Blood quickens, gonging in my ears:  
The panther's tread is on the stairs,  
Coming up and up the stairs.'**

In conclusion, I have argued that poetry, like fiction and other literary works, is worthy of our interest and also that reading poets like Plath is likely to enrich our imagination and by so doing enrich our capacity to work as psychiatrists.

Professor Femi Oyeboade will be the keynote speaker at a 'Poetry and mental health' event being held by *Poet in the City* in April 2006. For more information, or an invitation to the event, please contact [info@poetinthe-city.co.uk](mailto:info@poetinthe-city.co.uk), call 07908 367488 or visit the *Poet in the City* web site at <http://www.poetrysociety.org.uk/poetinthe-city/>

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## Femi Oyeboade

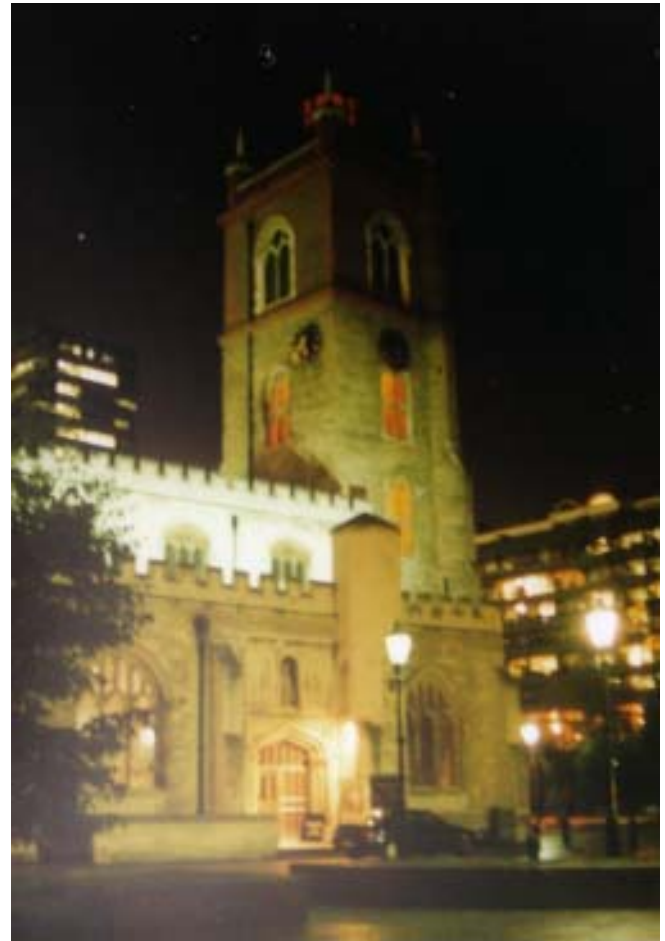


Photo of The Church of St Giles-Cripplegate by Anne Patterson

## London, literature and psychiatry: Paradise Lost ?

Hurrying along the High Walk on the way to a concert at the Barbican Centre, it is easy to miss the Church of St Giles-Cripplegate. Originating from the fourteenth century and rebuilt in the seventeenth, it is marooned amidst the unrelenting concrete, glass and steel constructions of the City and is of historical interest. It is in St Giles that Cromwell was married and the poet John Milton was buried, not far from his house in Bunhill Row where, almost blind, he dictated *Paradise Lost* to his daughter.

Readers of my first article on "London, Literature and Psychiatry" may recall Lud Heat, Iain Sinclair's psychogeographical account of a web of occult forces vibrating malevolence across London and, in his

opinion, deliberately chosen by Hawksmoor in siting his churches. Another location noted by Sinclair is Bunhill or Bonehill Fields close by the location of Milton's house. As the name suggests, Bunhill Fields has been a burial site since pre-Roman times and is now a Non Conformist Cemetery where Bunyan, Defoe and Blake are interred. It is also adjacent to the Honourable Artillery Company where the remains of the victims of the 7/7 London bombings were taken to a temporary mortuary.

I was inspired to read *Paradise Lost* by Phillip Pullman who retells Milton's poem in his recent trilogy: "His Dark Materials." I went to hear Phillip Pullman discuss *Paradise Lost* with Tom Paulin on the South Bank in September 2005. He movingly described his passion for the poem, proposing that it is best read aloud, reprising Milton's original dictation. Pullman suggested that *Paradise Lost* is the fundamental story of our lives and what it means to be human.

Milton published *Paradise Lost* in 1667. As everyone knows it tells:

*“Of man’s first disobedience, and the fruit*

*Of that forbidden tree, whose mortal taste*

*Brought death into the world, and all our woe,*

*With loss of Eden ...”*

His stated purpose in writing *Paradise Lost* was to justify the ways of God. There has been longstanding critical debate over where his sympathies really lay. Phillip Pullman, echoing Shelley, suggested that Milton unconsciously took the Devil’s part.

On reading *Paradise Lost* myself, I was struck by the blandness of life in a Paradise that was empty of any challenge except for that of remaining mindlessly obedient to a God who refused Adam and Eve any chance to think for themselves. His retaliation following their disobedience is disturbingly brutal and unforgiving. Eve tastes the apple and comes to understand that death, disease and hardship exist. Phillip Pullman talked about the necessity of leaving childhood behind. I think that she begins to face the reality of life.

The task of the psychiatrist might also be said to be that of trying to encourage our patients to face the uncomfortable vicissitudes of reality, leaving behind delusional worlds and bearing disappointments. Are we then the Serpents in Paradise?

I think it is interesting, in this context, that the image of the serpent has been symbolic of Medicine since antiquity. It is the attribute of Aesculapius, Roman God of Medicine and Healing. Ovid, in *Metamorphoses*, tells how Aesculapius transformed himself into a snake on the journey to rid Rome of plague. The caduceus or Hermes’ opiate rod is usually represented by two serpents twined around a wand and is also symbolically associated with Medicine. This is schematically adopted by the British Medical Association as one look at one’s membership card or British Medical Journal will attest.

I should like to leave the last word to Milton, who ended his epic with lines that express both the richness and despair of trying to live with reality. I think we do well if we are able to help our patients to avail themselves of the possibilities of leaving Paradise, like Adam and Eve.

*“...Some natural tears they dropped, but wiped them soon;*

*The world was all before them, where to choose*

*Their place of rest, and Providence their guide:*

*They hand in hand with wand’ring steps and slow,*

*Through Eden took their solitary way.”*

**Anne Patterson**



## Executive Committee Members

<b>Dr George Ikkos</b>	General Adult (Liaison)	Chair	E 2001
<b>Dr Michael Maier</b>	Academic (General Adult)	Honorary Secretary	E 2003
<b>Dr Trevor Turner</b>	General Adult	Treasurer	C 2001
<b>Dr Ken Checinski</b>	Addictions	Academic Secretary	C 2003
<b>Dr Michael Sinason</b>	Psychotherapy	Website Representative	E 2001
<b>Dr Cyrus Abbasian</b>	General Adult	Co-opted Member	C2005
<b>Dr Janet Carrick</b>	Old Age	Committee Member	E 2001
<b>Dr Nicholas Dunn</b>	General Adult	Regional Advisor SE	C 2005
<b>Dr Navina Evans</b>	Child & Adolescent	Committee Member	E 2001
<b>Dr Anthony Holton</b>	Old Age	Regional Advisor SW	C 2003
<b>Prof Robert Howard</b>	Old Age	Convenor South London	C 2005
<b>Dr Eric Johnson-Sabine</b>	General Adult (Eating Dis)	Regional Advisor NE	C2003
<b>Dr Mike McClure</b>	Child & Adolescent	Committee Member	C 2002
<b>Prof Robin Murray</b>	General Adult	Co-opted Member	C 2004
<b>Dr Amanda Owen</b>	Associate Specialist (Liaison)	Affiliate Rep	C 2002
<b>Dr Stephen Pereira</b>	General Adult (PICU)	Committee Member	E 2001
<b>Dr Nippani Ranga Rao</b>	General Adult	Committee Member	E 2003
<b>Prof Thomas Sensky</b>	Professor (Liaison)	Committee Member	E 2003
<b>Dr Iqbal Singh</b>	Learning Disability	Regional Advisor NW	C 2001
<b>Prof David Skuse</b>	Child & Adolescent	Co-opted Member	C 2005
<b>Dr Elizabeth Tovey</b>		CTC Representative	E 2005
<b>Dr Ian Treasaden</b>	Forensic	Co-opted Member	C 2005

### Website.....

Please refer to the College website for the full colour version of this Newsletter in PDF format

<http://www.rcpsych.ac.uk/college/division/londonNewsletter.htm>

### Newsletter.....

Please feel free to send your articles to [pconlon@londondiv.rcpsych.ac.uk](mailto:pconlon@londondiv.rcpsych.ac.uk) by 30th June 2006 for inclusion in the next edition of the Newsletter

### Diary Dates....

#### **EXECUTIVE COMMITTEE MEETINGS:**

**Tuesday 7th February 2006. 2pm Standon House, 21 Mansell Street, London E1 8AA**

#### **DIVISION ACADEMIC EVENTS:**

**Wednesday 10th May 2006.** For Details see Website

**Tuesday 14th November 2006.** Joint Autumn Academic Meeting with the Department of Cognitive Neuroscience at the Institute of Psychiatry

### Disclaimer.....

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