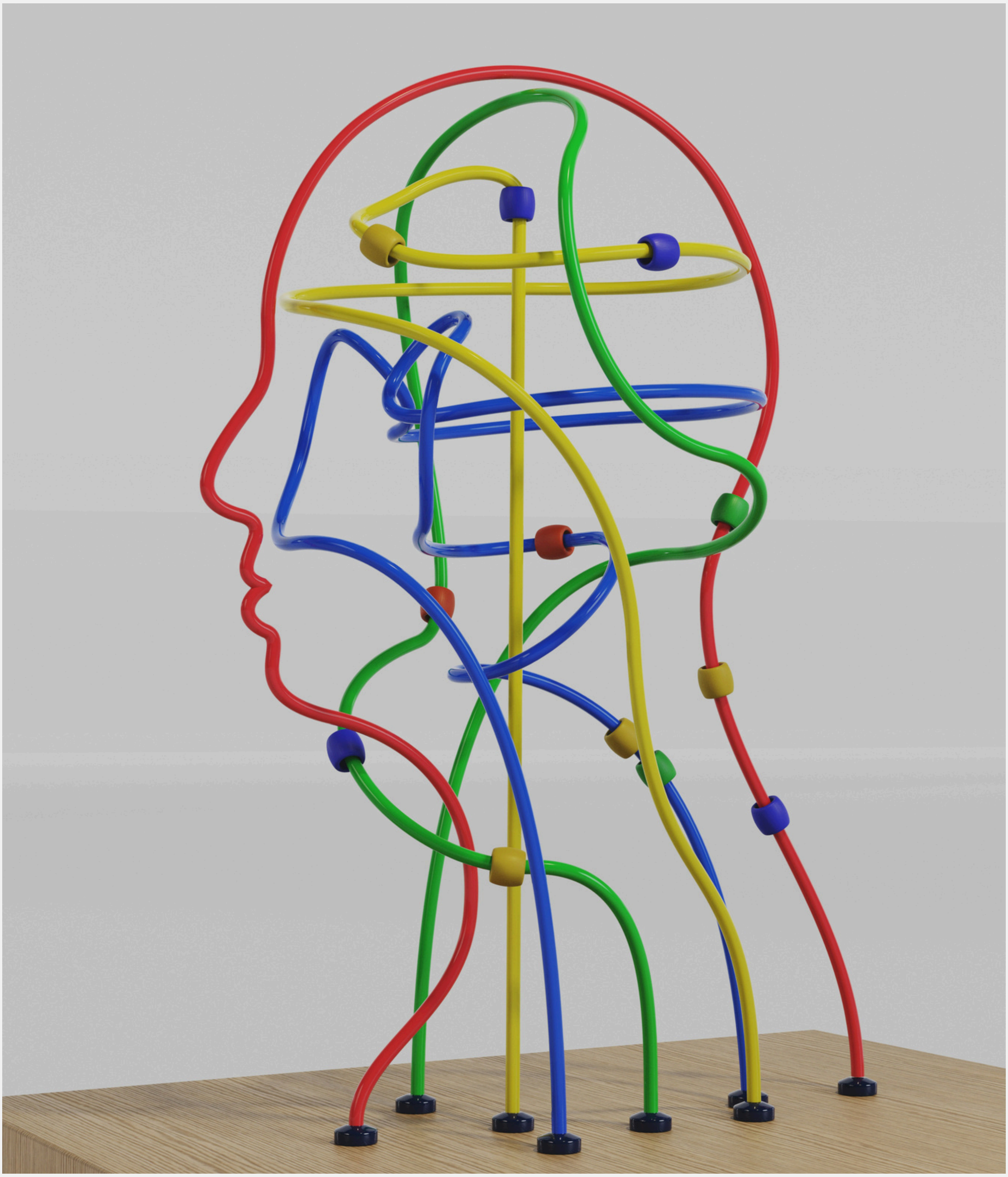
WINTER 2026

Future Psych



RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

FOR MEDICAL STUDENTS & FOUNDATION DOCTORS

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MESSAGE FROM THE EDITORS

Welcome to the Winter 2026 edition of *FuturePsych*, an issue we're proud to present as your co-editors.

This edition showcases the breadth and depth of contemporary psychiatry, covering everything from innovative early intervention strategies in autism and cutting-edge neuromodulation therapies, to the critical intersections of mental and physical health. We've sought to highlight both the scientific advances shaping our field and the human stories that make psychiatry so compelling.

You'll find groundbreaking research on parent-mediated interventions in early autism, personal accounts of recovery through novel treatments like transcranial direct current stimulation, and vital explorations of underrecognised communities. Our colleagues have also ventured into forensic psychiatry across different healthcare systems, reflected on the dangers of self-diagnosis in our digitally connected age, and discovered unexpected wisdom in literature that speaks to the psychiatric experience.

Whether you're a medical student taking your first steps into psychiatry, a foundation doctor beginning your medical career, or a Resident Doctor navigating specialist practice, we hope this issue offers both inspiration and practical insight. We believe you'll find something that resonates with your own journey in this evolving field.

We hope FuturePsych continues to serve as a companion as you develop your careers and contribute to the future of mental health care.

MAMOOR WAHEED

Foundation Doctor Representative

Mamoor Waheed is a CT1 psychiatry trainee currently working in Birmingham. He graduated from the University of Leicester in 2023 and completed his Foundation Training in the West Midlands. He was a recipient of the RCPsych Psychiatry Foundation Fellowship and serves as Foundation Doctor Representative for the PRDC.

HOLLIE MEYERS

Medical Student Representative

Hollie Meyers is a fifth-year medical student at Imperial College London. She aspires to train as a psychiatrist after her foundation years and is in her first year as the Medical Student Representative for the PRDC, where she represents medical students on college committees.

REWIRING THE INFANT BRAIN:
The Case for Parent-Mediated Interventions in Early Autism Risk as a New Frontier in Autism care.

By Leanne Kade, Henry Needham, and Naomi Garner.

Parent-mediated interventions (PMIs) may transform autism care from reactive to proactive, by leveraging infantile brain plasticity. Our systematic review and meta-analysis, guided by a neuropsychiatric framework, found PMIs delivered to infants under 15 months at high risk of Autism Spectrum Disorder (ASD), can significantly enhance early social communication and modestly reduce symptom severity, altering developmental trajectories. With emerging neurobiological evidence of early brain changes, integrating such interventions into NHS visitor pathways could reduce long-terms costs and improve outcomes.

Challenges with timing Autism Care

ASD is typically diagnosed after age two, despite its neurodevelopmental origins emerging earlier. Conventional interventions appeared reactive and delayed until infant diagnosis post-24 months old. This misses a crucial window of neuroplasticity when neural circuits are already established. With modern neuroimaging, EEG studies, and AI-assisted diagnostics revealing alterations in brain function and social attention as early as 6 months, earlier identification of high-risk infants is possible. Our review asked: what happens if we intervene before symptoms fully develop?

This review provides a comprehensive synthesis of PMIs' effectiveness during the earliest window of vulnerability, supporting infants at high risk of ASD. Our systematic review and meta-analysis synthesised data from 247 high-risk infants (≤15 months) across nine studies. We found moderate-to-large improvements in social and parent-child engagement (Hedges' $g = 0.58$, $p= 0.001$), particularly in joint attention and early communication within the first 16-20 weeks of intervention. ASD symptom severity - often more resistant to treatment - demonstrated modest but statistically significant reductions ($g = -0.12$, $p = 0.011$). These meaningful shifts in diagnostic outcomes are promising.

The Neuroscience of Connection

The implications of the review and early PMIs extend beyond behavioural change; promoting neural plasticity and synchrony during a critical window of brain development. Structural MRI studies show atypical overgrowth in the amygdala, medial prefrontal cortex, and superior temporal sulcus in high-risk infants as early as 6 months (1-3). These social cognition regions may be shaped by enriched parent-infant interactions. EEG and fMRI studies suggest repeated, structured parent-infant interaction may regulate gamma-band oscillations in high-risk infants, indicating disrupted neural synchrony during social processing (4). PMIs promote emotionally attuned interactions that enhance infant's social responsiveness, potentially regulating gamma-based oscillations, supporting social brain development.

Parent-Led, Clinician-Guided: The Hybrid Model: Our review compared PMIs delivery models. Therapist-supported interventions like iBASIS-VIPP produced the strongest effects (SMD = 0.51), followed by hybrid (SMD = 0.42) and self-directed models (SMD = 0.32). Adherence was highest in therapist-led formats (78%) and lowest in self-directed formats (52%). We propose a hybrid model: 16-weeks of therapist-led training followed by remote parent-driven support; balancing oversight and scalability within NHS care.

A Case for NHS Integration

Current 'reactive' NHS ASD support typically begins post-diagnosis; often delayed by long waiting lists, straining families. Pre-existing 12-15 month health visitor checks provide an opportunity to screen for ASD risk and offering early intervention. Integrating a hybrid PMI model in this pre-diagnostic phase could reduce service demand and costs; utilising pre-existing infrastructure for screening and implementation with health visitor checks.

Limitations

Despite promising findings, limitations include modest sample sizes and unclear long-term outcomes. While social communication improved, effects on core ASD traits such as repetitive behaviours and sensory sensitivities were limited.

Future research should prioritise:

1. Longitudinal neuroimaging to assess enduring brain changes.

2. Standardised outcome measures across studies.

3. Pilot NHS-integrated PMI models with cost-effectiveness evaluation.

Conclusion

While PMIs cannot yet be claimed to prevent autism, evidence demonstrates they can reshape early social development, enhance quality of life, and reduce later psychiatric vulnerabilities. PMIs represent a paradigm shift in autism care; early intervention showcases proactive and personalised neuropsychiatric care rooted in neuroscience.

Meet the Authors...

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The Intersection of Mental and Physical Health: My Experience of a Diabetes Mental Health Clinic

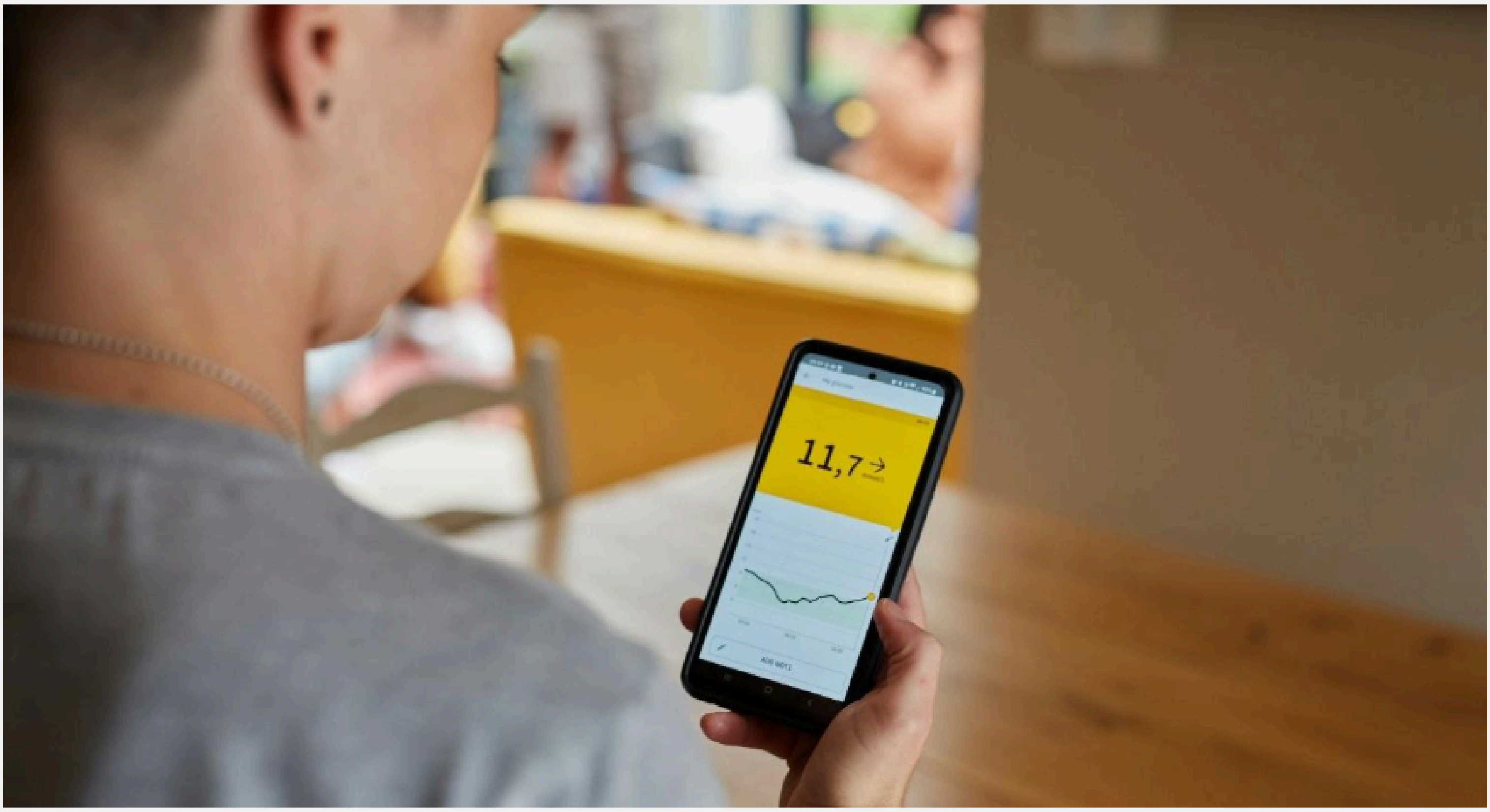
By Lina Ling

Whilst on my liaison psychiatry rotation I was given the opportunity to attend Scotland's only consultant-led Diabetes Mental Health Clinic. This experience gave me a greater insight into the mental burden of living with diabetes and widened my perspective and knowledge of the condition. People with diabetes are known to have disproportionately high rates of mental health problems, such as depression, anxiety and eating disorders (1), and so in some diabetes outpatient clinics patients are screened using mental health questionnaires. Those flagged up with higher scores can be referred by their diabetologist to this specialist clinic. The requirement for referral is having diabetes and a mental health problem, either directly because of diabetes, or one that is significantly affecting management of diabetes.

The psychiatrist sees patients with type 1 and type 2 diabetes. However, on the specific day I attended we saw three women in their 50s who have been living with type 1 for 30+ years.

They all described what is referred to in the literature as 'diabetes distress'(2), feeling overwhelmed by the continuous demands of managing their chronic condition. Distress can lead to burnout, where an individual begins to neglect management, which may lead to poorer outcomes and increase the risk of diabetes-related complications.

The clinic gave the patients the opportunity to open up in a safe space to a professional, and explore the contributing factors to their mental health difficulties and how their diabetic control had been affected. One patient who was struggling with her mental health, largely due to familial stressors, found it difficult to prioritise her diabetes management. The outcomes of this were that her HbA1c levels increased and her overall diabetes control deteriorated. Management of this case was challenging due to the contributing social factors. Unlike the first patient I saw, who fit the diagnostic criteria for depression and therefore was eligible for anti-depressant therapy,



this patient did not fit into an easily defined box. There was not a clear answer to her problems and by observing the consultant compassionately explain this, I saw the importance of the existence of a space where patients can share their troubles without feeling pressured or rushed by the constraints of other services.

Another patient described her experience of feeling the need to constantly check her sugar levels on her FreeStyle Libre app. This opened my eyes to some of the psychological effects of technological advancements in diabetes management, like how subcutaneous continuous glucose monitors may make patients check their glucose levels more often and how unfamiliarity with insulin pumps may increase stress in management.

Through my experiences of attending diabetes outpatient clinics I saw these technologies as an overall positive as they benefit patients by reducing the burden of checking glucose levels via finger pricking and aid clinicians in interpreting trends in levels through the data produced. However, I had not considered that this easily accessible data may result in patients checking more frequently, and was surprised that one of the psychiatrist's patients was checking their FreeStyle Libre app up to fifty times a day.

Overall, attending the Diabetes Mental Health Clinic, and learning more about the intersection of physical and mental health through this lens, was an eye-opening experience
and a great ending to my psychiatry placement. It has allowed me to link my interests in psychiatry and endocrinology and further appreciate the importance of psychiatric care in the wider medical setting.

Meet the Author....

Lina Ling, fifth year medical student at the University of Edinburgh

When Labels Shape Minds: Self-Diagnosis in the Age of Social Media

By Mary Obigbesan

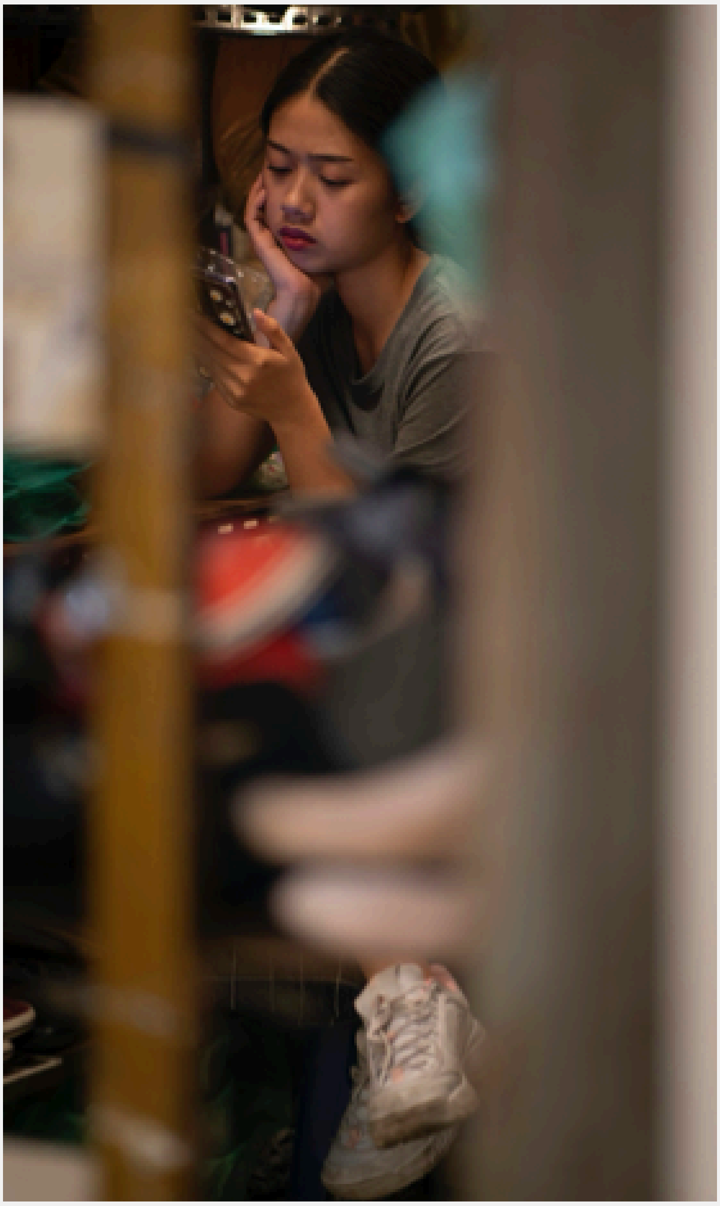
On platforms such as TikTok, you might come across a video of someone openly discussing their lived experience of a mental health condition. You find that you wholeheartedly relate and as you engage with this video, your algorithm adapts, promoting more of this content until you convince yourself that you have the same condition. But it doesn't stop there. You might start watching similar videos and begin to label your family members or friends based on the behaviours you've observed. Your friend mistreats you; you call them a "narcissist". Your sister occasionally lashes out; you assume she has bipolar disorder. Your partner has mood swings; they must have borderline personality disorder. Although these labels are often carelessly thrown around online, the role of social media in shaping our understanding of psychiatric disorders is far more nuanced and not entirely negative.

Are there any benefits?

For some, finding an explanation for their feelings or behaviours can create a sense of validation. It can encourage them to seek a formal diagnosis, and they can consequently receive the help and support they need. Furthermore, the sense of community through these videos is undeniable. Reading the comment sections makes you feel less alone, and the anonymity provided through online platforms makes it easier to open up about your mental health struggles. The use of these platforms has also helped to destigmatise many mental health and neurodevelopmental disorders. Watching someone you relate to talk about how they navigate life with a particular diagnosis can act as a source of inspiration, empowering you to take care of your own mental health.

What are the risks?

Social media can sometimes justify or even glamorise harmful behaviours. In these cases, the condition becomes a shield and accountability may be avoided. Comment sections can easily become echo-chambers where no one challenges destructive behaviour. There is also a significant risk of misdiagnosis. Someone with Attention-deficit/hyperactivity disorder (ADHD) might share an anecdote about not being able to concentrate and viewers who relate to this symptom might hastily conclude that they must also have ADHD.

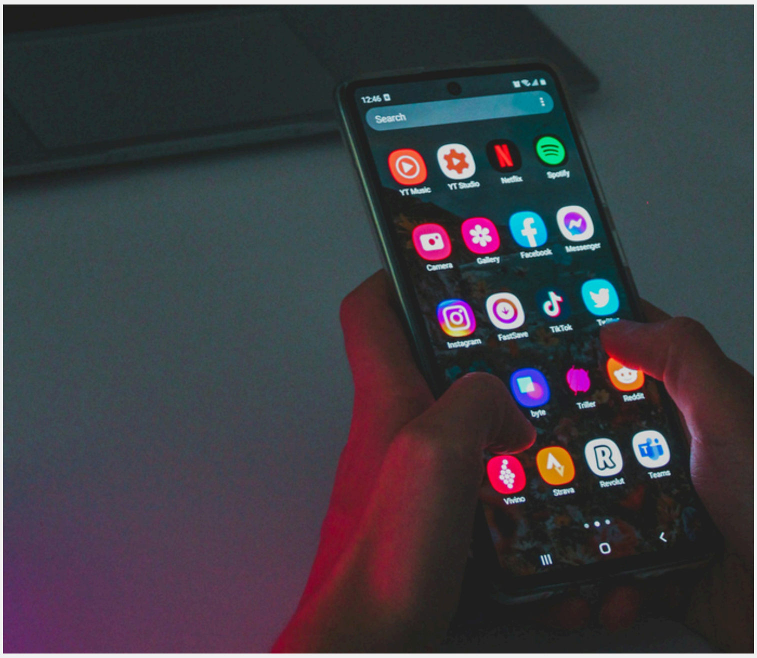


This results in the over-pathologisation of symptoms that might fall within the range of normal human behaviour. Unfortunately, some end up forming an identity around a condition that they don't have. Once you give yourself a label, you may either consciously or subconsciously begin to behave in ways that fit that label, a subtle form of confirmation bias that ends up becoming a self-fulfilling prophecy.

In more extreme cases, individuals resort to obtaining medications without a prescription, putting themselves at significant risk.

Lastly, the casual misuse of psychiatric terms trivialises them. For example, there is a concerning trend of individuals on dating apps seeking women who are "slightly autistic". This not only makes light of autism but also reflects a broader misunderstanding and romanticisation of neurodivergence.

What is the solution?
As future clinicians, it is becoming increasingly important for us to recognise how online spaces shape people's understanding of their own mental health. Social media inevitably influences how patients interpret their symptoms and seek help, and these conversations need to be approached with sensitivity and understanding rather than dismissal. Ultimately, clearer signposting is needed on platforms such as TikTok to direct users toward reliable information and professional help. Content creators who frequently discuss mental health should collaborate with qualified professionals to create accurate content and reduce misinformation. At the same time, addressing barriers to accessing formal psychiatric assessment will help ensure that increased awareness leads to proper evaluation and meaningful support.



Meet the Author....

Mary Obigbesan – 5th Year Medical Student at Imperial College London

Breaking the Silence: Understanding Mental Health in Somaliland

By Meriem Ait Ziane

When I began researching mental health in Somaliland, I was struck by how sharply the realities of care contrast with what we take for granted in the UK. A country of over four million people with just 216 psychiatric beds, and entire regions lacking any formal mental health services[1]. Within this system, families face a painful dilemma: seek help and risk social ostracism or suffer in silence.

The Weight of "Waali"

In Somali culture, the term waali, meaning "madness," carries damaging connotations and is understood through a strict binary: a person is either waali or they are not. This mirrors Goffman's distinction between the "discreditable," those whose symptoms can be concealed, and the "discredited," whose symptoms are visible by their apparent behaviour.[2] Depression and anxiety often go unrecognised because their struggles can be hidden, while individuals with psychosis are quickly labelled as "mad," leaving little space for empathy and understanding the spectrum of mental illness.

This oversimplification is reinforced by language itself. Many psychiatric concepts lack direct Somali translations. Terms like qulub or buufis blend emotional and physical symptoms, making psychological distress harder to identify, distinguish, or treat.[3] Without specialised vocabulary, mental illness becomes misunderstood or dismissed, feeding stigma that isolates the patient and their families.

When Faith and Culture Intersect

Islam is the predominant religion in Somaliland, with over 99% of the population being Muslim[4], shaping many aspects of Somali culture and daily life. As a result, religious healing practices are deeply embedded in community responses to mental illness, most notably through Ilaaj centres: unregulated religious facilities that often operate without medical protocols[10]. Their existence reflects attempts to reconcile spiritual belief with the need for treatment amongst limited formal services.

Islamic scripture itself acknowledges psychological suffering. The Qur'an describes the grief of Prophet Yaqub, who cried so intensely after losing his son that he lost his eyesight[5]. These narratives highlight that emotional pain is both human and validated within faith. However, cultural interpretations often diverge from these teachings, framing mental illness as a spiritual weakness, a punishment, or a sign of jinn possession[6]. This disconnect reflects how religious belief becomes filtered through historical trauma and societal pressures, shaping understandings of mental illness in ways that do not always align with Islamic tradition.

These interpretations do not arise in isolation. Decades of conflict, displacement and generational trauma have forged a culture where resilience is essential for survival. With 60% of the population under 25 and raised amid instability[7], endurance becomes a communal expectation. Acknowledging psychological distress can therefore be seen as contradicting ideals of strength, faith, and perseverance.

Coping in the Absence of Care

Where formal mental health services are limited, people turn to the resources available to them. Khat, a stimulant leaf widely chewed for its euphoric effects, is a common coping mechanism, yet evidence links its use to worsening anxiety, depression, and psychosis[8,9]. With no substance misuse treatment available, a coping mechanism becomes another barrier to recovery.

For those with severe illness, many families turn to Ilaaj centres, where patients may be chained, confined in overcrowded rooms, and held without medical protocols. A recent survey documented 24 such centres caring for approximately 1,600 patients, all managed by religious leaders without mental health training[10]. Their prevalence reflects a system pushed to its limits, leaving families desperate for alternatives.

Why This Matters to Us

For clinicians working with Somali diaspora communities in the UK, these cultural narratives influence help-seeking, engagement, and expectations of care. Understanding this context allows us to practise with cultural humility rather than assumptions. Somaliland's challenges also raise universal questions: How do we bridge traditional beliefs with evidence-based practice? How do we support communities where psychiatric language doesn't exist? How do we address stigma within our own healthcare systems?

Progress is emerging. The King’s THET Partnership has helped establish Somaliland’s first mental health nursing programmes[11], and community-based services in Borama are challenging stigma through education and outreach[12]. These initiatives demonstrate that change is possible when clinical knowledge works collaboratively with cultural understanding.

As future doctors, understanding global mental health contexts enriches our practice and reminds us that breaking silence, wherever we are, remains one of our most powerful interventions.

Meet the Author....

Meriem Ait Ziane – 4th year Medical Student at King’s College London

Like a Wall Coming Down: My Forensic Psychiatry Electives in the UK and Poland

By Bianka Lewandowska

“They attacked me with an axe – two of them, out of nowhere!” The patient’s voice rose with conviction. “It hit me straight in the neck, and under my ribs... I was bleeding out... They hooked me up to medical equipment to collect all my blood. I was as good as dead, but the angel saved me”.

“But Mr., how come you’re here now, in the mental health hospital? Is it possible that you were the one who attacked?” I asked, feeling my heart speed up. It was one of my first assessments of forensic psychiatry patients, and although I knew I was safe, my nervous system seemed less convinced.

His facial expression changed to disbelief.

“Oh no, have I?”

In my quest to gain a practical experience of forensic psychiatry, I organised two three-week electives in medium-security forensic psychiatry units – the John Howard Centre in London, UK, and the Institute of Psychiatry and Neurology (IPiN) in Warsaw, Poland. In my tale of two cities, I explored the same discipline across two settings, learning about both clinical care and medicolegal work in action.

My first elective was in the John Howard Centre in London, where I was mainly based in the Learning Disability and Autism forensic ward. What I really value from this experience is learning to consider forensic patients holistically, while retaining a specialised lens. I especially valued a discussion with my mentor on the effect of neurodiversity on offending patterns – I learned how core features of autism spectrum disorder (social communication difficulties, sensory processing differences, repetitive behaviours, and restricted interests) can, in some cases, contribute to sexual offending.

A few weeks later, I found myself on the wards of IPiN in my home city, Warsaw. Here, besides the usual medical student routine of MDT meetings and ward rounds, I gained hands-on, practical experience of medicolegal forensic psychiatry work. I was trusted to dive into a real ongoing last will investigation. My job was to analyse the legal files and construct an opinion, with ongoing input from my supervisor, on whether the person who wrote the last will had the mental capacity to do so at the time. It was an arduous task, but a very valuable introduction into the medicolegal aspect of forensics. The excitement of being able to contribute to an ongoing case was not lost on me.

Conquering natural stress responses to being exposed to a forensic and acute psychiatry setting is not talked about enough. In the beginning, my nerves had the upper hand. Observing aggressive patients, or even hearing them speak about their offences, like killing someone, would cause my sympathetic nervous system to fire up. I was impressed by the doctors who remained calm and unflinching even when facing a combative, unwell patient.

In my few weeks in Poland, I have attended group therapy and art therapy sessions at the Institute. These, I must admit, were a turning point for me. One of them focused on aggression –understanding how to recognise it arising in the body and strategies to stay calm. I observed how patients were brainstorming and taking notes, genuinely interested to understand this issue. It felt like a wall coming down. Looking back, what began with an uneasy awareness of my own racing heartbeat ended with a deeper sense of connection and understanding.

These electives not only exposed me to the many faces of forensic psychiatry, from acute wards to medicolegal work, but also solidified my decision to pursue psychiatry as a career. I can wholeheartedly recommend this kind of elective to anyone curious about the field.

Meet the Author....

Bianka Lewandowska – FY1 Doctor at Princess Alexandra Hospital, Harlow

Why is men's mental health such a major issue?

By Shashvat Swarup

Men's mental health is an underreported area[1]. Statistics paint a dark picture regarding men's mental health. Suicide rates are three times higher in men than in women and middle-aged men (aged 40 to 49 years old) have the highest suicide rates in the UK[2]. Additionally, men are far more likely to go missing, sleep rough, become dependent on alcohol and use drugs frequently[2]. This article will highlight reasons why men's mental health is such a pertinent public health and social issue.

There is no conclusive evidence to suggest "male depression" is different to "female depression". However, there are slight differences in how depression manifests in both genders. Men more commonly exhibit symptoms such as irritability, sudden anger and aggression in depression[2]. Men are also more likely to use alcohol, drugs or work as an escape from their depression[2]. There is also something to be said about income: less well-off middle-aged men are more likely to die by suicide and so are men in minority communities and men who are war veterans[2]. On top of that, systemic factors and race-based inequalities, such as in African and Caribbean men in the UK, are significant and make it more likely for them to develop mental health problems[3]. There is a higher rate of psychosis symptoms in Black men compared to other ethnic groups (3.2% compared to 0.3 % in white men and 1.3% in Asian men)[3].

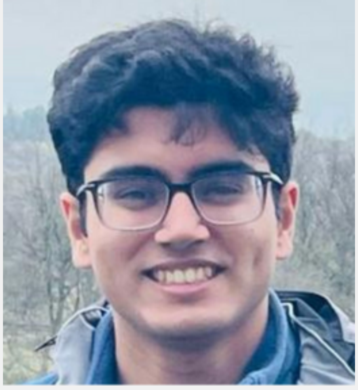
One reason mental health problems are more serious in men is due to large societal expectations on men. Men are often expected to be the breadwinners and societal expectations and traditional gender roles have created the stigma around men talking, which is why they are less likely to seek help[2]. Breadwinner status for men is much more important in minoritised ethnic communities[3]. Social media has also had an impact on men's mental health through cyber bullying, promoting unrealistic body standards and idealised lifestyles[3]. Additionally, when social media gets addictive, it can interfere with normal sleeping patterns of men.

Mental health in middle-aged men is an area to focus upon when talking about men's mental health. In a 2019 survey conducted by MIND, 29% of men aged 45 to 54 said feeling worried or low was not important enough to act upon. This troubling statistic correlates with data[2] showing that men aged 40 to 49 years old are most likely to die by suicide in the UK.

Two broad reasons are because men in this age demographic reported drinking alcohol or comfort eating to reduce stress and men would be less likely to be awarded custody of their children if their relationships broke down[3]. There also seems to be lack of social support networks for these middle-aged men, with men being more frequently ejected from the family home than women[3].

To summarise, men's mental health is a social issue which needs to be paid attention to. It is clear that a range of factors such as lack of social support networks and race lead to men's mental health being a larger issue. The stigma around men speaking up about their mental health has to reduce. It is important that men experiencing mental health issues seek help from their GP or therapist as this can reduce suicidal feelings and help them get back on track.

Meet the Author....



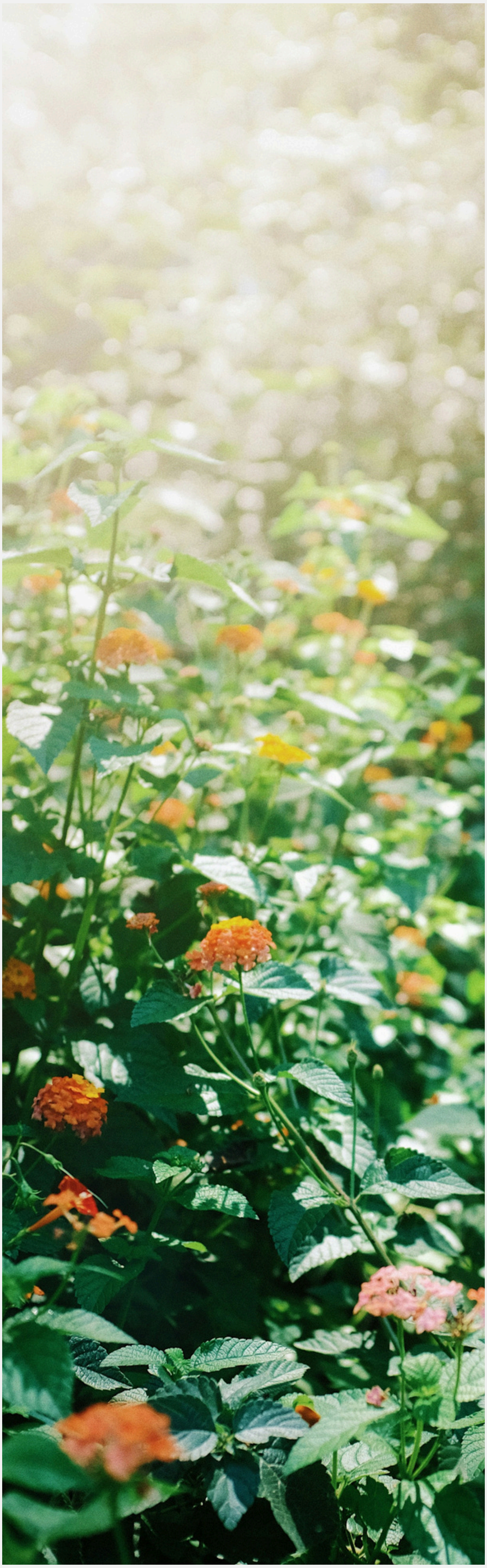
Shashvat Swarup – a medical student at University of Leeds

The Sunlight on the Garden – Louis MacNeice
How a poem can help

By Stella Gray

MacNeice's poem, 'The Sunlight on the Garden', is a balm for those struggling to find respite in a seemingly hopeless world. Despite immense personal waves of melancholy due to a childhood tainted by seeing his mother experiencing depression, MacNeice's poetry is laden with exultation for life and other people. On clinical placement, I see doctors attend to mentally and physically vulnerable patients. Whilst it is a privilege to be such an intimate part of a patient's life, it is not free of emotional burden. This poem offers a guide to the light in dark times. Life and healthcare are uncontrollable, churning systems, as MacNeice wrote in 'Snow', "World is crazier and more of it than we think". Through injecting a pocket of connection and support into a patient's life, solace from the "craziness" takes hold.

The setting of the poem, "the garden", echoes MacNeice's last memory of his mother walking up and down their garden path in tears(1). He never saw her again as she died in a nursing home a year later when he was only six. In 'Autobiography', MacNeice wrote "When I was five the black dreams came", confirming a childhood permeated with guilt and trauma as he blamed his own birth for his mother's death. MacNeice's exceptional vulnerability in his poetry reveals how grief engraves pain into the fabric of daily life. Though "The sunlight on the garden hardens and grows cold", MacNeice is still "grateful" for its very existence. Deeply painful memories can still be treasured ones. As Seamus Perry[2] describes MacNeice's poetry on childhood is a "beautiful intermingling [...] of fond memories with 'black dreams'". Through writing, MacNeice dissects his pain to find a fondness for the grief-stricken space that is "the garden". This emphasises the importance of an open dialogue regarding mental health, a crucial sentiment for healthcare professionals for whom difficult experiences are inevitable. MacNeice's meditation on



the coexistence of pain and gratitude teaches us not to hide from our emotions.

We are connected by our shared experiences of the duality of the world and the certainty of death. On placement, I have learnt that hospitals are the embodiment of this duality: in one room there may be immense suffering, and in the next, relief. To walk between each is to have unique insight into the human condition. MacNeice suggests the world is beautiful because it exists in harmony with hardship. On the one hand, “The earth compels, upon it / Sonnets and birds descend”, however, “We are dying, Egypt, dying”. The use of the forceful verb ‘compels’ leaves no room for apathy. The garden acts as a microcosm of the earth or indeed a hospital, demonstrating how, together, we can perceive both beauty in sunlight, but also accept its hardening and cooling. We are harmonised through our shared recognition of the earth’s paradoxes.

The poem’s final image: “But glad to have sat under / Thunder and rain with you”, offers the ultimate solace in hardship: shared shelter. As a student doctor, I am privileged to witness healthcare professionals provide emotional support to patients and each other.

The cruelty of illness and a struggling NHS are made endurable through connection. The poem begins and ends with “sunlight on the garden”. This creates a rolling sense of time as we know “we cannot cage the minute”. However, as the last line emphasises, there is still time to look back and be “grateful too / For sunlight on the garden”. As a medical student, I look forward to all the moments of sunlight yet to come.

Meet the Author....

Stella Grey, a third-year medical student from University of Liverpool

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From How a Poem Can Help by Stella Gray

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