

## Editorial from Dr Zaubia Alyas and Dr Rowena Carter

Welcome to the 2nd edition of this year's newsletter! The theme for this issue was:

### **'Is social psychiatry a meaningless entity in the 21st Century'**



Hope you had a nice Easter break and welcome to the Spring edition of The Psychiatric Eye! We were delighted to receive many impassioned themed articles in this issues postbag, we hope you enjoy reading them as much as we have.

This edition's theme is "Is social psychiatry a meaningless entity in the 21st century?". The term social psychiatry is challenging to define, its scope crosses multiple disciplines including philosophy, medicine, sociology, anthropology and psychology. Its focus is on the interpersonal and cultural context of mental disorders, as well as the socioeconomic factors relating to mental illness. It was a dominant force in psychiatry throughout the 20th century, a time when we lacked neuroimaging, genetic analysis and had only limited medication options. This is not to say that the approach to psychiatry in the 20th century was entirely based in social theory, in fact psychoanalytic psychotherapy looked at the patient as an individual, largely disregarding the social and political context surrounding them. The 1930s found its first social psychiatry champion in Karen Horney and this was later followed by the likes of Erikson and Sullivan, with social psychiatry being influential in developing therapeutic communities. While the 21st century psychiatry has shifted its focus to a more biological approach, social psychiatry still plays an important role in cross-cultural diagnosis, linking psychiatric conditions to social deprivation, rehabilitation and facilitating social inclusion.

Many thanks to our contributors. They have provided us with nothing less that what we have come to expect, an extremely high standard of articles which are imaginative and approach the topic from several different perspectives. Our authors conclude that in the modern day with neuroscientific advances it is time for rounded clinicians to realign the way they see social aspects in psychiatry.

[Prof Bebbington](#) highlights the historically polarising and divisive nature of the biopsychosocial model; looking to the future, [Prof Ikkos](#) wants to see social psychiatry housed in 'meta-communities,' seeking to focus on integrated treatments via state-of-the-art models of service delivery; [Dr Rezaque](#) advocates London Psychiatry adopts a successful Scandinavian model capitalising on the therapeutic effect of the social network around a patient. Also on the side of Social Psychiatry [Dr Velivasis](#) speculates about the underlying dynamics behind our title and suggests that in a professional context where esteem is measured in technical biological knowledge maybe a desire to knock Social Psychiatry off its pedestal preserves our fantasies of Omnipotence; [Dr Howe](#) then looks to 'an unlikely spokesman'; while finally [Dr Marsh](#), [Dr Roots](#) and [Dr Tully](#) consider feeling valued within the work place.

Our prize for the edition goes to [Dr Chouhan](#) who submitted an entertaining and original argument surrounding the importance of social psychiatry and its role in the 21st century. Congratulations! You have won yourself two tickets to an upcoming London Division event. For future editions, we would also like to highlight that we welcome artistic submissions to feature in our forthcoming editions, as we feel the illustrations and artwork we have had so far really enhance our written features. We hope you enjoy reading this edition and don't forget to also join the conversation [@ThePsychEye](#)

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## Chair's Message

*Dr Shakeel Ahmad , Chair of the London Division Executive Committee*



Is social psychiatry a meaningless entity in the 21st Century? One of the main beauties of psychiatry is that while being a medical science it encompasses the social and psychological aspects of the human being. Of course, we are continuing to learn more and more about the social and psychological consequences of physical morbidity, but no other medical science encompasses the physical, physiological, social and psychological aspects of our lives into one branch of medical science as psychiatry does. Further on, one does not have to suffer from a

formal mental illness to understand this link; even our day to day life teaches us that our social experiences affect our emotions and cognition. And the reverse is equally true when a change in our emotions or thoughts can affect how we interact socially within our communities. Psychiatry means a bridge between the mind and the brain, and an attempt to separate the two is like trying to separate the texture of the fruit from its juice or its nutrients. Do we really want to go in that direction?

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*Themed Article: The demise of Social Psychiatry is Science without guts* Dr  
Viraj Chouhan

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Is social psychiatry in the 21st century a meaningless entity?' In a word, Yes. If we operate from the premise that all human beings are social animals, then the term 'Social Psychiatry' is, frankly, tautological. All psychiatry is social. What is usually meant by Social Psychiatry, however, is a fairly vague and niche branch of psychiatry that doesn't attract much funding, struggles to articulate clearly what it actually does, and is only invoked during after-work pub conversations where bleeding hearts might try and reconcile bureaucratic demands with social ideals and moral principles.

One notices that the glaze-eyed dismissal of Social Psychiatry as pseudoscience is rarely accompanied by any comprehensive understanding of what it actually is, or by any good answers to the questions it asks of us. And perhaps the reason is because, as medics, we have not learnt to think that way. Sociological-mindedness and a habit of philosophical inquiry develops despite, not because of, our medical training. And yet the importance of such intelligence, in our speciality arguably more than in any other, cannot be overstated.

The philosophy which Social Psychiatry draws from often points to the subtle but powerful influence that value assumptions or political interests have on our epistemology (see Canguilhem, 2008; Dupre, 1998; Hacking, 1996). Psychiatry, as an agent of state control, is counterpoised by a tradition of reflexivity, social engagement and political consciousness. This balance is crucial to sustain respectively both real-

world impact and ontological autonomy from the State. An understanding of how culture, politics and values influence our science is analogous to an understanding of how Mind and Body are in constant dynamic interplay. It asserts that a values-out Psychiatry is a naïve conceit. Retreating into a reductive model that blinds itself to these considerations is dangerous; the influence of socio-political forces on us then goes unwitnessed, and applies to our clinical treatments down to our classification system and epistemological frameworks.

If we do not acknowledge this, we effectively endorse it. We have all had cases in clinical practice that strike us as being understandable products of social malaise. We know this intuitively, and the most assiduous amongst us will try and intervene with whatever referrals and endorsements we can provide; yet we remain frustrated at our inability to make the necessary changes in the broken families and communities around us. Even in our own employment as psychiatrists we can experience a particular feeling of impotent fury in the face of managerial obtuseness, budget cuts, and target-constraints. Working in the NHS, we are all witness to the detrimental psychological effects of social destabilisation and political negligence. When we view the problems of context through the lens of a biomedical model, not only do we avoid the elephant in the room, we become complicit in the deceit of a public that has placed a great amount of trust in our scientific credibility. Responsibility would mean we examine what we do with both sincerity and scepticism.

And our history serves as a humbling warning. Social revolutions in the last century have almost all involved the psychiatric institution in some way; be it the emancipation of slaves (Drapetomania), women (Hysteria) or the LGBT community (Homosexuality). The automatic invocation of reified disease entities like 'Depression' or 'Substance misuse' when describing, for example, Native American communities in the USA or the untouchable classes in India, or closer to home, a disenfranchised, socially isolated, immigrant wage-slave in Dagenham, is to place the focus primarily on that individual's diathesis and not on the overwhelming influence of their milieu. The demise of Social Psychiatry would be to throw our hands up in the air, symbolically retreat from the Parthenon of socio-political engagement, and march sure-footed into the security of our narrow-windowed laboratories.

This is a period of rapid, seismic social change, and the what we are witness to here in London is humbling: epidemics of self-harm and suicidality in our communities, a blind assault on emergency services by personality disorder and institutionalised behaviour, higher rates of diagnosis of mood and conduct disorders and ADHD in children, compared to arguably better rates of recovery for mental illness in the developing world. Let us not assume that, with rapid technological advancement and better understanding of the material substance of the brain, we have made similar strides in humankind's moral evolution for the better. What we see is, in fact, significant social pathology, and to cast aside our ability to question ourselves is to assume that we have got it completely right and there is no room for further progress in our understanding of what is mental illness. It is to ignore that our disease constructs are, at best, tentative entities liable to constant revision, inextricably tied in with the social values within which

we create them.

In the middle of all this great political and social upheaval, and being as we are advocates for the suffering and disenfranchised casualties of Progress we sometimes call our patients, it is all the more important for Social Psychiatry to remain as a platform for introspection and dialogue with the world outside our ivory walls.

## References:

[1] Canguilhem, Georges. 2008. 'The Normal and the Pathological' In: Knowledge of Life. Trans. Stefanos Geroulanos and Daniela Ginsburg. New York: Fordham UP. 121-133

[2] Dupre, J. 1998. 'Normal people,' Social Research, 65: 221 - 248.

[3] Hacking, I. 1986. 'Making up People' In: Reconstructing individualism: Autonomy, individuality and the self in Western thought (eds.) T. Heller, M. Sosna & D. Wellbery. Stanford: Stanford University Press, p 222-236.

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*Themed Article: Exploring the phantasy of a future obituary*

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**Dr Alkis Velivasis**



In the era of population movements and rapid socio-political changes, the debate on the significance of social psychiatry remains surprisingly vibrant. From highly influential journals [1] to periodical newsletters and from international conferences [2] to MDT discussions in community mental

health teams, professionals discuss the benefits of investing in the disciplines of social psychiatry and argue about its meaning in the future.

I argue that the idea of a meaningless future for social psychiatry is a phantasy; a phantasy that derives from the doctor's frustration in applying the advances of social psychiatry in everyday clinical practice.

Why phantasy? Part of the determination of mental illness involves evaluating amongst others the loss of social functioning and the degree of deviation from social norms. Assessment of an individual can only be comprehensive when social aspects of their history (e.g. upbringing, education, employment, relationships, trauma and life events) are explored. Epidemiological studies have now firmly established the key role of ethnicity, social class, migration, urbanicity, bullying and substance abuse, amongst others in the pathogenesis of mental disorders. Changes in social norms, pressures from lobbying organisations and social movements have historically influenced modern diagnostic classification of certain conditions and determined their inclusion (e.g. PTSD) [3] or elimination (e.g. homosexuality) [4] from International Classifications and Diagnostic Manuals. Definition, causality, assessment and diagnosis of mental illness have traditionally been rooted within the realm of social sphere and impacted by it. As long as the world continues to evolve through its social and moral structures, networks and dynamics, isolating mental illness from its social determinants will be detachment from its reality.

Why frustration? A psychiatrist deals with the individual. The individual comes to a psychiatrist for help but the psychiatrist in order to offer help needs to have a formulation of what causes distress in this individual. A psychiatrist does this by synthesizing the individual's inner psychic procedures with the complexity of their external life in both personal and social level. (S)he collects historical data from the individual and tries at the same time to bring to surface actual facts from subjective and emotionally loaded narratives. (S)he uses observation and language as means of reaching diagnosis; the latter being only the result of experts' consensus. (S)he needs to be up to date with epidemiological data but is also required to use the subjectivity of their judgement. A psychiatrist can establish pathology by assessing a belief system and at the same time ought not to ascribe pathology to experiences considered normal under certain subcultures. (S)he prescribes treatments and for the treatments to be effective (s)he relies on models of service organization, multidisciplinary teams, and sometimes families, friends, employers or even care homes and housing associations. What is more, a psychiatrist needs to consider that the body and mind dualism is central in western psychiatry but may not exist in other health belief systems. The above demonstrate that the level of complexity in applying principles related to social psychiatry is clearly far from straightforward.

There is consistent evidence that the incidence of schizophrenia is elevated in migrant and minority ethnic populations [5]. In the most deprived areas

increased inequality is associated with increasing incidence of schizophrenia [6]. These are only two good examples of the contribution of social psychiatry to the understanding of schizophrenia. But what does this mean when seen on the individual level of clinically diagnosing and treating an impoverished patient or a migrant? A psychiatrist can acknowledge this evidence but not practically use it. A psychiatrist cannot directly attribute the migrant's psychosis to their immigration status, determine how poverty affects auditory hallucinations or measure how a refugee-related trauma increases depressive feelings. A psychiatrist cannot prescribe an anti-poverty drug nor prevent displacements or mass population movements. Seen from the eyes of a clinician, social psychiatry gives universality and broader understanding of where our patients come from; however it doesn't offer direct clinical answers, practical solutions and conclusions on a personal level. To clinicians, the gravity of the patients' problems, their complexity and multidimensionality causes disillusionment. And this is difficult to bear.

How does frustration lead to a phantasy of meaningless future? Allowing trust in social psychiatry, in its disciplines and its outcomes means allowing loss of our omnipotence as doctors. Being unable to reinstate the aetiology and treatment of mental illness exclusively to a presupposed biological and inherited source, quantifiable and easily measurable, without determinants from an external world of social movements and relationships destroys a phantasy that intrinsically motivates us to continue assessing and treating; in other words that motivates us to continue being doctors. Under this existential threat, psychiatrists need another, an overcompensating, phantasy. And what a great phantasy would that be, to reassure ourselves that the study of social determinants will soon come to an end!

## **References:**

- [1] Ventriglio A, Gupta S and Bhugra D. (2016), Why do we need a social psychiatry? *The British Journal of Psychiatry* Jul 2016, 209 (1) 1-2
- [2] Rutz W. (2006), Social psychiatry and public mental health: present situation and future objectives Time for rethinking and renaissance?. *Acta Psychiatrica Scandinavica*, 113: 95–100
- [3] Wilson j (1977), *Forgotten warrior project: identity, ideology and crisis - the Vietnam veteran in transition*, Cleveland State University
- [4] Spitzer R L. (1973). A proposal about homosexuality and the APA nomenclature: Homosexuality as an irregular form of sexual behavior and sexual

orientation disturbance as a psychiatric disorder. American J. Psychiatry 130: 1214-1216.

[5] Cantor-Graae E, Selten JP, (2005), Schizophrenia and migration: a meta-analysis and review. Am J Psychiatry. 2005;162:12–24.

[6] Boydell J, van Os J, McKenzie K and Murray R.M (2004), The association of inequality with the incidence of schizophrenia. An ecological study. Soc Psychiatry PsychiatrEpidemiol (2004) 39: 597–599

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ST6 in General Adult Psychiatry/Community Rehabilitation

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*Themed Article: From “Community Psychiatry” to “Meta-Community Psychiatry”*

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**Prof. George Ikkos**



Most psychiatrists remain committed to the biopsychosocial model. However, in light of the promise of the neurosciences, **many** take an increasingly **biocentric view**. This narrowing of vision presents a **threat to the professional mission of all clinical psychiatry**.

We should not allow the as yet unfulfilled, and difficult to fulfil, **promises of neuroscience** and the mixed results of “**community psychiatry**” to blind us to the importance of social and psychological factors. There is direct correlation between social inequality and the prevalence of common mental disorders and substance misuse in advanced societies, such that the incidence of the former in Japan (the most equal advanced society), is half that found in the US, the most **unequal**. With increasing inequality and de-industrialisation in the US, there has been an **explosion of mortality** amongst white middle class male US citizens from poisoning by pain killers, liver disease and suicide.



During the evolution of the human species there has been a dialectic process between the increasing size and abilities of the brain on the one hand, and the formation and increasing complexity of groups and socially achieved progress on the other. It has not been a one way influence from brain to socialisation. The human brain is **biologically social**. The ability to form larger and increasingly effective groups has been crucial to the increasing size and abilities of the brain. Uniquely, the human brain is specifically developed so that each one of us may be subject to interpersonal influences and predisposed to work together; even display altruism for the advantage of **the group**. Any psychiatry that aspires to be scientific, needs to put brain and social processes on an equal footing as well as **psychological processes**.

Unlike neurologists, affect, not the brain, is the object of psychiatrists' specialist medical expertise. Defined as feelings, emotions and agitations, affect integrates human responses and drives brain and body changes, thinking, perceiving, relating and acting. In no particular order, it depends on genes, evolution, culture, physiology, personal experience, social history, chance, meaning, the environment and a sense of self and others. Disturbance in any of these may lead to psychopathology, the understanding and treatment of which demands biomedical training, empathic curiosity about the human soul, a pluralist perspective, tolerance of anxiety and engagement with **public perceptions, policies and ideologies**.

The polarity between biological and social psychiatry is a scientifically untenable remnant of old thinking and circumstances. Community psychiatry emerged as a reaction to the now defunct **Mental Asylums**. Both biological psychiatry (e.g. antidepressants, antipsychotics) and social psychiatry (e.g. community services and ideologies of 'normalisation', 'empowerment', 'advocacy' and 'recovery') offered the promise of maintenance in or return of patients to the community. Though psychological (e.g. CBT, family therapy) and biomedical (e.g. ECT, mood stabilisers) treatments have made a crucial difference to many, when it comes to the severely mentally ill, many patients remain markedly **disabled and socially isolated**. During my 35 years as an NHS psychiatrist, the greatest difference in patient experience for the severely mentally and learning disabled has come from the impact of social ideologies on **service design provision**.

The two areas that seem to have flourished best during the last 30 to 40 years in the UK have been forensic psychiatry and liaison psychiatry. In neither case has this been due to biological or social psychiatry. Rather, they have reflected social pressures and clinical services research. In the US, social influences have been so pervasive that the vast majority of detained mentally ill people are no longer in psychiatric facilities but in **penal institutions**. In the UK, the explosion of liaison psychiatry has followed research that has shown primarily a

health economic benefit to the NHS, as well as facilitating the [earlier return of patients to their homes](#).

We need to get away from the old dichotomies of biological/ psychological and institutional/ social. The future of clinical psychiatric practice depends on [conceptual clarity](#), evidence -based mental health services development and a pluralistic approach, which balances properly the relevance of biological, psychological, social and spiritual influences on affect and their associated disturbances, in psychiatric disorder. It is time to move on from “Community” to “Meta-Community” psychiatry. Meta-Community psychiatry builds on the successes of biological, psychological, social and community psychiatry. It incorporates the further insights of neuroscience and is delivered wherever the evidence shows that it makes a difference, whether nursing home or general or community or forensic hospital; whether school, court-room, place of work, refugee camp or battle-front.

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Prof. George Ikkos |

Lead Consultation Liaison Psychiatrist, Royal National Orthopaedic Hospital, Hon. Fellow, Hon. Archivist and former Hon. Treasurer and Chair-London Division, Royal College of Psychiatrists and Director of “Psychiatry in Dialogue with Neuroscience, Medicine and Society” and former President Pain Medicine and Psychiatry Sections, Royal Society of Medicine.

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*Themed Article: Open Dialogue Brings New Momentum to Social Psychiatry*

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**Dr Russell Razzaque, Dr Ebru Lumley**

We have known for many years that what happens in a patient's social context makes a major difference to their vulnerability to mental ill health as well as their subsequent prognosis. Having family members and a social network around you has a significant impact on outcomes, [1] and each year the annual report from the National Confidential Enquiry Into Suicide and Homicide consistently finds that involvement of families in care substantially reduces

suicide rates. Furthermore a string of RCTs [2] show that on average hospitalisation rates are reduced by 20%, with overall relapse rates reducing by 45% when people receive family therapy as part of their care. This is, of course, why various forms of family work are recommended by NICE across a range of diagnoses. The question should therefore not be whether or not social psychiatry has a future, but rather what shape that future will take, and on this front Open Dialogue shows a great deal of promise.

It was in Western Finland in the 1980s when the first experiments with Open Dialogue took place, the service having been set up in response to some of the worst outcomes and highest suicide rates in the Western world. As a result, this team in Finland decided to do something radical and train every member of staff in family therapy, systemic and related skills. The emphasis, on day one, was to work with networks rather than individuals, but with the patient always at the centre of care so they decide which family or friends to invite – or none at all if preferred. Either way, the lens through which every presentation was explored was a social and relational one. However, the means of such exploration was different to even traditional family therapy in that staff were taught to focus on engendering a sense of agency in the network from day one. This means that, rather than putting forth answers and solutions early on, the emphasis was on creating a safe space where shared experiences could be understood by the network themselves, and ultimately solutions forged from within the network also. After working this way for several years the Finnish team found that 72% of all their patients with psychosis returned to work or study within two years of their initial presentation, not returning to mental health services thereafter [3]. This figure is many orders of magnitude higher than what the rest of Europe and America is used to and so as a result versions of it have sprung up in a number of countries. Though the original data was published for their psychosis patients, the service itself was actually trans-diagnostic and the replicated services that emerged in Norway, Sweden, Denmark and, more recently, Germany and the U.S. were based on this open access model.

In the U.S., for example a service known as “Parachute” enshrined the Open Dialogue principles alongside peer work in down town New York City, and their success was ultimately rewarded with a \$50 million commission when Obamacare was introduced, to continue the provision in one of their most deprived inner city areas. Like the Finnish experience [4], these services are said to have seen a reduction in medication use, hospital bed use and overall cost, which seems to have driven their expansion more than anything else [5]. Versions of Open Dialogue have now been launched in Massachusetts, Vermont and Georgia.

The original Finnish data was based on non-randomised follow ups, compared to treatment as usual. Italy is currently launching a seven centre non-

randomised study, and Poland and Holland are looking to do the same. So the missing piece in the growth of Open Dialogue is a national randomised trial, which is what we are proposing to do here in the U.K. A total of six Trusts have started training staff in Open Dialogue, via a course established by North East London NHS Foundation Trust (NELFT). The course is accredited by the Association of Family Therapists and will soon be a postgraduate diploma with London South Bank University that has been designed to be accessible to all front line clinicians. A £2.4 million programme grant has been applied for from the National Institute for Health Research in order to evaluate these new teams as part of a multi-centre cluster randomised trial, and currently another six Trusts across the country – most in London - are in discussions around potentially joining the trial via a local Trust based training, funded by the research, that NELFT is now also looking to roll out. The nearly 200 staff trained so far have nearly all emerged from the training with a genuine enthusiasm for this way of working – with psychiatrists as the largest professional group among them - and a growing service user movement is now developing from those who have received care this way from the pilot teams, to advocate for its implementation. The ultimate aim of the study is to see if some of the Finnish outcomes can be replicated in the U.K., which, if possible, will have a major impact on the future of mental health, bringing a social model of psychiatry once again to the fore.

## **References:**

- [1] Giacco D, McCabe R, Kallert T et al. Friends and Symptom Dimensions in Patients with Psychosis: A Pooled Analysis. PLOS ONE, Oct 2012, 7: e50119
- [2] Pharoah F, Mari JJ, Rathbone J, Wong W. Family Intervention for Schizophrenia (Review). The Cochrane Collaboration, 2012
- [3] Seikkula J, Aaltonen J, Rasinkangas A, et al. Open dialogue approach: treatment principles and preliminary results of a two-year follow-up on first episode schizophrenia. Ethical Human Sciences and Services, 2003, 5: 163–82
- [4] Seikkula J, Alakare B, Aaltonen J. The Comprehensive Open-Dialogue Approach in Western Lapland: II. Long-term stability of acute psychosis outcomes in advanced community care. Psychosis: Psychological, Social and Integrative Approaches, 2011a, 3: 192–204.

[5] Coe S. Parachute NYC: a new approach for individuals experiencing psychiatric crises. *Mental Health News*, 2013, 15 (2): 16 (available at [https://www.leaders4health.org/images/uploads/files/Parachute\\_NYC\\_Article](https://www.leaders4health.org/images/uploads/files/Parachute_NYC_Article))

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*Themed Article: Is social psychiatry a meaningless entity in the 21st century?*

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**Professor Paul Bebbington**

This statement can be taken two ways. The obvious interpretation is that social psychiatry has no meaning, because there is no sense in which it is useful to acknowledge a social dimension to psychiatry. The opposite, but equally radical interpretation is that it is meaningless because all psychiatry is social. I will argue that evidence for the second position is overwhelmingly stronger.

There are three elements to the argument. The first is conceptual, the second concerns the social context of psychiatric disorders, and the third is the failure of the endophenotype project.

Psychosis is the condition often regarded as being most independent of the social context. However psychosis is conceived in terms of symptoms that are clearly about the social world (thus hallucinations and delusions have social meaning to the individual experiencing them). It is also identified clinically from such symptoms, the key issue being that they are judged to be erroneous in relation to the general consensus about how the world is. In

other words, psychosis is social because the symptoms are primarily defined socially.

The second argument relates to the powerful social antecedents of psychiatric disorders. Vulnerability is often clearly the result of social trauma, whether in the form of recent stressors that trigger onset, or earlier circumstances that shape cognitive and emotional style. There is substantial literature about this: in particular research over the past 15 years or so has strongly established the association of sexual abuse with most types of psychiatric disorder, perhaps particularly with psychosis. Moreover, the approved treatment and management of long term mental illness has for a considerable period involved interventions that are either directly social, or psychosocial.

Finally, alternatives to social aetiology are in trouble. This is certainly true of the endophenotype project as a whole (eg. Schmitt et al., 2016), and there are clear problems with the genetics of schizophrenia. The discovery of hundreds of common gene variants minimally associated with schizophrenia in GWAS studies (Schizophrenia Working Group of the Psychiatric Genomics Consortium, 2014) means that individual disease risk scores may bear little relation to one another and makes it difficult to accept that a genetic basis underpins mechanisms in any easily determined manner. Indeed, Bruce Cohen (2016) has recently suggested that there may be more individual genotypic patterns associated with schizophrenia than there are people with schizophrenia on the planet. A recent alternative interpretation (network approach) is gaining some support. It suggests that a stressor causes symptoms that activate other symptoms, in a circular, self-reinforcing way (McNally et al., 2016). This theory moves away from mental illness being traditionally conceptualised as categorical or dimensional models.

I could go on (!) but must now conclude that it is meaningless to see social psychiatry as meaningless.

## **References:**

[1] Schmitt A et al (2016). Consensus paper of the WFSBP Task Force on Biological Markers: Criteria for biomarkers and endophenotypes of schizophrenia, part III: Molecular mechanisms. *World J Biol Psychiatry*. 2016 Oct 26:1-27. [Epub ahead of print]

[2] Schizophrenia Working Group of the Psychiatric Genomics Consortium. Biological insights from 108 schizophrenia-associated genetic loci. *Nature*. 2014; 511(7510):421-7.

[3] Cohen BM.(2016).Embracing Complexity in Psychiatric Diagnosis, Treatment, and Research. JAMA Psychiatry. 2016 Dec 1;73(12):1211-1212.

[4] McNally RJ et al. (2015). Mental disorders as causal systems: A network approach to posttraumatic stress disorder. Clin Psychol Sci. 2015; 3: 836e849.

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Emeritus Professor of Social and Community  
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*Other Article: A Workplace to Value and to Feel Valued Within*

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**Dr Will Marsh, Anna Rootes and Dr Katherine Tully**

Last year's junior doctor contract dispute highlighted widespread concern with regards [junior doctor's morale within the NHS](#) . Only recently a [survey conducted by the Royal College of Anaesthetists](#) suggested that almost two thirds of their junior doctor's physical or mental health is being damaged as a result of the pressures they face. Staff wellbeing at work has collateral effects outside of these personal impacts; it has been [shown to impact on patient safety and satisfaction as well as staff productivity and absenteeism](#).

Particularly important to staff wellbeing is the working environment. The working environment includes cultural factors; [leadership styles](#) that value the contributions of staff enable them to fulfil their own caring potential, practical aspects; lone working in isolated environments correlates with higher levels of [work-related stress](#), and physical features; design of healthcare facilities can improve [medical outcomes](#).

Research by the Royal College of Physicians highlighted the impact of a shortage of even the most basic amenities such as adequate workspace and rest facilities on [doctor's morale](#). Going one step further and enhancing a

workplace's environment using visual arts has been shown to reduce levels of anxiety, stress and depression, and increase staff morale.

Junior Doctors working in the Maudsley Hospital in South East London are based in a solitary on call room so as to provide cover for the whole hospital out-of-hours. This creates an element of lone working. Over the years the room had become a dumping ground for unwanted furniture, whiteboards and textbooks, likely adding to a sense of feeling under-valued that has been reported by junior doctors as whole.

In response to this, and inspired by the supporting literature referred to above, the authors collaborated with junior doctors on the Maudsley Training Programme to produce a visually striking and supportive wall mural. The aim was to provide trainees with a workplace to value, and one to feel valued within.

The authors first held a workshop with Maudsley junior doctors, asking them to draw images associated with home, work and their future aspirations. This provided the framework for the artists to design a large mural reflective of those working within the space.

The mural was completed by the authors in their own time and now sits proudly in the Maudsley on call room. The work produced for, and designed collaboratively with, Junior Doctors has helped to transition their lone working environment from a dumping ground to a restful working space that values trainees and their contributions.





## Reference:

[1] Staricoff, R.L., Duncan J.P. & Wright, M (2004) *A Study of the Effects of Visual and Performing Arts in Health Care*

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Dr Will Marsh

Core Trainee

Collaborator Details:

Dr Anna Rootes is both an Artist and trainee Art psychotherapist. Anna has worked in several NHS psychiatric hospitals, within both the community and ward teams. She is passionate about the role of creativity in the healing process, exploring it not just as a diversional and relaxation technique but as a powerful communication of the unconscious. Instagram: annarootesart

Dr Katherine Tully is a London based GP originally from the West of Ireland. She has a special interest in care of the elderly and art as therapy. She is currently undertaking a diploma in painting at The Art Academy, London, focusing on portraiture.

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*Culture Vulture Article: An Unlikely Spokesman*

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**Dr Andrew Howe**

The Grime music scene is not the first place one would look for songs that deal with depression. At first glance, Stormzy (a South London artist whose most well known song is titled “shut-up”), is no exception. However, he has recently revealed in an interview his struggle with depression and how it has influenced his debut album *Gang Signs and Prayer*. While this may not seem too much of a revelation, there is a stark contrast between Stormzy and other role models for coping with depression. Here was a man bearing his soul from a genre not well known for doing so.

In the interview[1] he talks about his previous attitude to depression. How he thought that you should just pick yourself up if you were down and how he dismissed a close friend who was suffering with it. “Just be happy...pull it together” was his therapeutic intervention. This was until he suffered with depression himself and gained first-hand experience of the folly of his previous advice. In his own words “it was a realisation of how fragile we are as humans”. As the interview continues he explains his initial reluctance to let any one outside of his family know about his difficulties. After some soul searching he came to the realisation that in his eyes, to be a good musician “you have to give everything”. He was so moved by the experience that he chose to talk about it on his debut album. He hoped that hearing his story would help others.

The last track, “Lay me bare”, discusses depression directly.[2] The track covers thoughts of suicide, drug use, difficult social situations, low mood and isolation. There is no glamour, just a frank and raw disclosure on the facts of his struggle. He also offers hope and explains that close beneficial relationships and being able to write music pulled him through. While *Lay Me Bare* is not a traditional way for the creative arts to look at Psychiatry, I would strongly recommend taking five minutes to listen to it.

Every celebrity who speaks out about mental health issues does their bit to raise awareness and encourage others to seek help. Stormzy is one of the few in his genre to do so. Through his honest and open disclosure he may have reached out to people in London that might have otherwise suffered in silence.

### References:

[1] Trendell A. Stormzy Speaks Out About His Battle With Depression - NME [Internet]. New Musical Express. 2017 [cited 2017 Mar 3]. Available from: <http://www.nme.com/news/music/stormzy-speaks-battle-depression-1999168>

[2] Genius Lyrics. Stormzy – Lay Me Bare Lyrics [Internet]. 2017 [cited 2017 Mar 3]. Available from: <https://genius.com/Stormzy-lay-me-bare-lyrics>

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Core Trainee 3rd Year

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*Conference Watch: Leaping into the mind – dance and psychiatry*

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Dr Andrew McWilliams



Although enjoying the lengthening evenings of the slowly warming London spring, I struggled to resist an invitation to spend

two days in Berlin at a meeting exploring the relationships between dance and health.

In 2016, I attended a conference entitled “The role of dance in lifelong healthy living” hosted by the 'Dance and Creative Wellness Foundation' at Sadler's Wells. At this event, the talking and the dancing were never well-separated, such that during each session there would always be a cry of “Let's get moving!”, a DJ in the corner would turn up the decibels and myself and the doyennes of major international dance companies found ourselves on our feet gyrating again. Academic talks gave way to purely practical workshops and I joined a Dance for Parkinson's class given by English National Ballet, alongside bona fide class participants. The research of Dr Sara Houston shown the multiple benefits of dance and I left wondering about the benefits for Mental Ill Health.

I found myself at the Berlin Staatsballett in March 2017 at the Foundation's think tank event. The event drew together dancers, dance academics and practitioners of dance in healthcare from across Europe and further afield. Speakers included Andrew Greenwood from Amsterdam, who pioneered dance in multiple sclerosis and Ulrike Anders from Berlin Health 2.0, who encouraged us not to resist the increasing technologification of healthcare. David Leventhal from Mark Morris Dance Group in New York, a former dancer who founded the world movement for using dance in Parkinson's, discussed ways to push beyond pilot projects to move into forming dance “programmes” with longevity embedded into their fibre.

I started to think more deeply about his particular use of the word “wellness” and there might be an industry which focuses on helping people feel they are experiencing optimal health but also an existential sense of wellbeing.

The second day involved more participation with fewer opportunities to get your breath back. This was labelled the dance-ability session and it transpired, that in my case, it was more about effort than ability. In a session on improvisation with a group of people with neurological disease, led by Claudia Neumayer. I had to improvise a partnered dance to tango music. We weren't allowed to use a ballroom hold. I was paired with a contemporary dancer and it quickly seemed that I was to spend most of the time rolling on the floor, whilst rather aware of being watched by a plethora of professional dancers

The workshops on use of the imagination, mindfulness and Tanzhologie. A holistic view of the body dominated our thoughts and practice, such that barriers with the mind became inherent in the work and seemed to collapse

away. I wondered that these types of experiences could have great potential with medically unexplained symptoms.

At the meeting, I shared my own ideas that dance and psychiatry can interface and create natural alliances in multiple ways. Alain de Botton and John Armstrong treat the visual arts as useful ways for any person to connect with and embrace seven processes, namely: remembrance, hope, sorrow, rebalancing, self-understanding, growth and appreciation. Dance might be seen as an inherently more powerful art form than the visual arts to achieve these aims. Synthesising the visual, auditory and tactile (internal and external), and affecting our physiology directly, it also is delimited by a time course. Touch explores relationships. That dance exists only transiently lends each moment great poignancy, resonating with the experience of human loss. To partake becomes easier than to paint a picture, as the risk of embarrassment is mitigated by each pirouette or body-ripple being over a moment later.

If we could just get past the stigma of involvement in dance - the sexism, the homophobia, ageism, racism, able-bodied or not - then once the damaged body had been coaxed awake, dance might teach new ways to interpret old experiences.

Dance can re-integrate awareness of ourselves and extend boundaries. Improvisation articulates the hitherto unacknowledged or inexpressible as our previously held anxieties of Cartesian dualism simply drop away. I left feeling lighter and inspired.

### **References:**

[1] Alain de Botton and John Armstrong (2013) "Art as Therapy" Phaidon Press

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*SUC - RCPsych Service Users and Carers' Fora Update*

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**Ms Sara Muzira**

**Meeting formats:**

The Service Users and Carers' Fora (SUCF) met in December 2016. Along with other committees and groups within the College the annual programme of meetings is being reduced in number to three a year, and with a view to making meetings more productive there will be a more robust system for picking up reports from members who attend other committees and groups. New members of the Fora will be recruited initially to specific Committees in the college, so that service users and carers can be effectively represented across the work of the college – once these changes are up and going it is hoped that SUCF members will be able to contribute effectively to College workstreams, and continue to actively represent views of carers and service users in as many areas of College work as possible. The SUCF look forward to this new streamlined process.

### **College workstream:**

At our December meeting the final reports resulting from our three on-going workshops were completed for presentation to the College. These were based on three areas of the College workstream:

Objective 5 – how the College can make 'parity of esteem' a reality, with resulting tangible benefits for patients.

Objective 9 - looking at how patients, families and carers can be involved in the training of psychiatrists in a meaningful way that will encourage young people and doctors in their early training to take up psychiatry.

Objective 11 – looking at the value of continuity of care for patients.

SUCF recommendations and comments in these three areas have now been passed on to the College for further discussion. Members have spent a significant amount of time discussing these issues, and hope that the debates over definitions and working practices will help to bring about real change over time. The royal family are making it look so easy to get over stigma and parity of esteem; SUCF members hope that they are doing their bit to get to grips with the reality of these big issues.

### **International Congress 2017:**

The Carers' Forum contribution to the International Congress this year is to be based on dementia – 'Has Psychiatry given up on Dementia?'. This will be a stimulating discussion about the role of psychiatrists in the long-term care of people with dementia, looking at physical and emotional needs as well as psychiatric needs. The discussion will be led by members of the forum, and we hope also to have a presentation by Professor Alistair Burns, Professor of Old Age Psychiatry, University of Manchester.

Members of the Carer's Forum are very pleased to highlight issues related to dementia, which is known to be an increasing problem, presenting very particular difficulties for carers and patients.

## Up-date on mental health and benefit reforms

The Fora heard a review of improvements the DWP are making to the system of benefits for people with mental health difficulties. It was reassuring to hear the view that the DWP are 'genuinely trying to improve things'. It is to be hoped that they take note of advice about things that will not help.

## College Website

Ms Kim Catcheside, Director of Strategic Communications, attended the meeting of the Addictions Faculty in November 2016, and talked about new developments for the College with respect to the website and communications with the media. A new team is working on updating the College's communications with the public as well as with its own members. Kim Katcheside is keen to include 'stories' from patients and carers as part of explaining the work of Psychiatrists. The Addiction Faculty Patients and Carers Group have been working on ideas for podcasts. A number of these are already on the website.

Members of SUCF are involved in many of the College working groups and committees, as well as groups in their own localities. A number of initiatives are being set up by members, including setting up a database of self help groups around the country, building up a network and a useful source of information for patients and carers.

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Ms Sara Muzira | [saralmuzira@gmail.com](mailto:saralmuzira@gmail.com)

Retired teacher

Member of RCPsych Addictions Faculty Patients' and Carers' Liaison Group

Member of RCPsych Carers Forum (since December 2015)

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*Round Up- London Division Executive Committee Meeting, 15 March 2017*

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### 1. **Feedback from the College Committees** **The following was reported by the Chair:**

Introducing Paul Rees Chief Executive, RCPsych - Professor Sir Simon Wessely introduced Paul Rees, newly appointed RCPsych Chief Executive Officer who joined the College from the Royal College of General Practitioners (RCGP) where he had been Director of Policy and Engagement.

Communication - There will be a revamp of the College website by the end of 2017. Additionally, there will be a light read magazine would be produced.

## **2. Recruitment Committee Dr Peter Hughes, Vice Chair**

A new recruitment strategy and gave highlights on some of the 14 points from the strategy. This included bursaries, career advice, work experience, school debates and foundation fellowships.

Pathfinder students have met and it was suggested that we hold two events instead of one. The Pathfinders would find an interactive and lived experience discussion/talks more valuable.

## **3. Primary Care Liaison - Training GP trainees Dr Mark Ashraph**

Mr Paul Rees (PR) Chief Executive and KP met following the last Exec meeting. PR was supportive by providing useful contacts at the RCGP. KP and TP have since been in contact with these contacts regarding collaboration for the Educational Event for GPs on 12th June 2017.

## **4. Regional Advisors feedback**

The Committee around further clarification on what classifies as a conflict of interest (COI): If you work within the same trust as the JD being reviewed or approved, it does not classify immediately as a COI, this arises only if you will be line managing the person in post.

It was highlighted personal specification to include mental health experience, it was clarified that this had been discussed before and it was agreed that personal mental illness experience in personal spec should state that lived experience is encouraged and not as 'desirable'.

## **5. Director of Development Ms Ann Paul, Director of Development**

AP informed the Committee of her role which included developing and supporting projects which linked to the College's overall strategic objectives and fundraising. Examples of projects; one of the successful projects has been the Pathfinders fellowship. Another big project is the Gatsby Wellcome Neuroscience project which is co-chaired by President Elect, Dr Wendy Burn.

## **6. Upcoming London Division Events**

Click on the link for the dates and for more events.



Time: 13:30-17:00



London Division Wellbeing Event for GPs

12th June 2017

Time: 09:50-17:00



Please note that registration is open, [book now!](#)

## London Division Info

### London Division Executive Committee

The [London Division Executive Committee](#) meets four times a year at the College's HQ. Approved minutes from previous meetings can be accessed via our [members login](#).

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### London Division Regional Representative Vacancies

We have a number of vacancies for College posts available and are keen to see them filled as soon as possible. Take a look at our [Vacancies](#) page to see how you can get involved and support your Division.

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## London Division Events

The London Division hosts a number of events each year. Take a look at our [Events](#) page for details.

London Division StartWell Event took place on 8th March 2017. StartWell is a Consultant led initiative for Psychiatrists in their first five years as a Consultant or Locum Consultant. StartWell focusses on 6 elements to support Psychiatrists in their first consultant role with the intention to establish good habits for their career.



Speakers for the StartWell Event photographed above. Listed Left - Right, Dr Francis Keane, Dr Matthew O'Brien, Dr Jane Marshall, Dr Alice Ashby, Dr Ros Ramsay, Dr Kunal Choudhary, Dr Shakeel Ahmad (London Division Chair).

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Dr Rory Sheehan  
Dr Chris Symeon  
Dr Stephanie Young



**Look out for the call for articles for the next themed newsletter**

**"How will advances in psychiatric research and understanding of mental illness change the practice of psychiatry?"**

*Rapid advances in genetic and molecular medicine have already revolutionised the way in which many medical conditions are diagnosed and managed. But how relevant are new scientific discoveries to everyday psychiatry and are they worth pursuing? How might their adoption change what it means to be a psychiatrist? What are the challenges with integrating and implementing new knowledge into current psychiatric practice, and what might be done overcome them?*

**Disclaimer:**

**The opinions expressed in this newsletter are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists**

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