



**Theme: Mental health in the
workplace, training and university**

The Psychiatric Eye

The London Division e-Newsletter

In this spring edition we have turned our “Psychiatric Eye” inwards to the topic of our own mental health in the workplace, training and university. I certainly remember, not so fondly, my first stressful and difficult jobs as a foundation doctor and hearing the whispered horror stories of other young doctors who had ended their lives far too soon, but quietly putting this to the back of my mind. One of my reasons for entering psychiatry was that I felt it would have a better “work-life balance”, so I’m glad to hear of new initiatives such as mindfulness courses being used to help foundation trainees manage the stress and anxiety of the job, but hope this isn’t just a quicker fix for trusts than ensuring rotas aren’t stretched, juniors are properly supervised and there is adequate time for training.

The Royal College has also published a Position statement in July 2018: [“Supporting the Mental Health and wellbeing of Psychiatrists”](#), which highlights the College’s perspective on the issues that need to be addressed in order to support the wellbeing of psychiatrists and makes recommendations on how psychiatrists should be supported. The [Psychiatrists’ Support Service](#) (PSS) has been available through the College since 2007, which is a telephone advice service that provides one-to-one support and signposting to appropriate treatments. Many NHS trusts are also providing health and wellbeing initiatives for staff as part of NHS England’s Healthy Workforce Programme that incentivises trusts to do so. These are all positive steps to maintaining the welfare of psychiatrists and other mental health professionals but there is still a long way to go.

Thank you to everyone who has submitted an article for our theme or one of our regular features. We were pleasantly astounded by the number of fantastic submissions we received addressing our theme which have ranged from asking what work-life balance actually means and whether it is an achievable aim; to thinking how we can maintain our own health in a pressurised system from a variety of perspectives; as well as a personal account of when things go wrong.

Many congratulations to our two prize winners – Rebecca Heath, for their succinct take on the issue as a medical student and Dr Elinor Wyn Hynes for their thoughtful and personal piece using an intersectional theory to look at why doctors may be at increased risk of mental illness.

We hope you enjoy this thought-provoking edition’s theme alongside our message from the Chair and regular Culture Vulture pieces.

Editorial from Dr Afia Ali and Dr Alexander Adams



Inside this issue

Chair’s Message	2
Winning medical student submission	3
Winning trainee submission	5
Why do Medical Students Choose Psychiatry?	7
Tackling burnout in medical school	9
When my consultant wasn’t practicing safely	11
Punishing the Mentally Unwell Doctor	12
Karojisatsu - suicide from overwork	14
“Who watches the Watchmen?”	16
‘This too shall pass’: is resilience enough?	17
Promoting resilience only goes so far	19
Work-life balance. Fad or fiction?	21
The Work/Life Balance?	23
Culture Vulture - Les Miserables	24
Exhibition Review	25
The Psychiatric Eye	27

Chair's Message

Dr Peter Hughes

Chair of the London Division Executive Committee

I would like to welcome readers to this new edition of The Psychiatric Eye.

There have been some new developments in the London Division since the last edition. There is now a new website and London Division is working hard to modernize our webpage.

It has been a pleasure to see the energy of the 'Choose Psychiatry' recruitment committee. We are hoping to have a pan-London PsychSoc event with all of the London medical schools. This will be the first of its kind, and we hope it proves to be an inspirational event.

We continue to face the major challenges of recruitment and retention. This is always on our radar and is likely to continue as one of our biggest challenges. We recently held our annual StartWell event for new consultants and are also planning a StayWell event to support existing consultants and promote retention in the profession.

We plan to engage more with the trusts through the MAC chairs. Mostly we want London psychiatrists, foundation doctors and students to be able to relate to the Division. We are also working on how we can raise the profile of the London division and make it relevant to the profession in London.

There are a number of events which have already been announced over the coming year but we also welcome ideas for future events. We are currently considering "Awards for London", an event on the theme of domestic violence and stigma within the profession, and health workers with mental health difficulties.

We also aim to link in with other local divisions to synergize some future activities.

Recently there have been challenges in the London division with changes of staff and short staffing. I would like to thank the London division staff for their hard work and commitment through this time.

On a personal note, I've moved overseas for a few months to work in Bangladesh with Rohiungya refugees but will remain with London division at a distance.



**Studies have shown doctors to have higher rates of mental illness and suicide.
In the current climate of increased interest in mental health, is this filtering down to the
places we work, train and study?**

Rebecca Heath

Mental health awareness is expanding. The climate is shifting from one of shame and isolation to one of openness and candid speech. With increased understanding and awareness of the prevalence of mental health problems, millennials are leading the way in sharing stories of their own struggles more openly; with friends, on social media, and in articles like this one.

But has this culture shift been exemplified within the medical community? The statistics suggest there is a long way to go. The medical profession demonstrates a suicide risk of between two and five times that of the general population.¹ As a fifth year medical student, my own personal experience with the system has shown me it is sometimes necessary to come up for air.

As students, we are taught that confidence and self-assuredness are key. Whether it is to request the radiographer to do the MRI you need, or persuading a stranger on the phone to take your handover seriously, we are shown that assertiveness is an integral component of being a competent doctor. Displaying anxiety, a lack of confidence, or just being unsure in front of colleagues is perceived as a weakness and that we may not be 'cut out' to be doctors.

Yet still, despite this knowledge, teaching by humiliation is too often still part of the curriculum. Cold calling, ridicule when a fact cannot be rapidly recalled, and playing students against one another does nothing but perpetuate the misconception that if you can't handle the heat, you should get out of the kitchen. This view is sadly prevalent amongst medical students.² These practices can have a significant effect on the mental health of students right at the start of their careers.

And so we learn to put our 'game face' on. We must be robust, resilient and take it on the chin because as doctors, we must not show fragility if we wish to be taken seriously. This attitude breeds stress, anxiety and feelings of inadequacy and yet, ironically, it is unnecessary. Teaching is a wonderful opportunity to inspire, enthuse and set an example to our juniors that asking questions, being unsure and asking for help is integral to the learning process and crucially, for patient safety.

From a student perspective, universities can offer mental health support to those of us who struggle. However, once we enter the working world we run the risk of suffering in silence and our problems going unnoticed. Encouragingly, there are support systems in place nationally – the NHS Practitioner Health Programme allows accessible mental health support for all UK doctors, but relies on self-referral.³ Yet with the stigma associated with these conditions, self-referral may not be the solution.



But is the onus all on us? Prevention is better than cure. How can educators create a healthy teaching environment that encourages lively discussion, does not stigmatise uncertainty and promotes questioning?

Calls have been made for national training schemes by the GMC to aid doctors to recognise and change their behaviour with regards to intimidation, and pilot schemes are running aimed at tackling the issue for junior doctors.⁴ Yet with issues arising from students' first clinical years, is this too late? How can we ensure this practice dies out?

Perhaps the answer simply lies with tomorrow's doctors. Has experience taught us that success arises from cultivating curiosity rather than resilience, from help seeking rather than self-doubt? This approach is vital to support the mental health of medical students and the junior doctors we will soon become.

References:

- [1] Gerada C. Doctors, suicide and mental illness. *BJPsych Bull.* May 2018;1-4. doi:10.1192/bjb.2018.11.
- [2] Timm A 'It would not be tolerated in any other profession except medicine': survey reporting on undergraduates' exposure to bullying and harassment in their first placement year *BMJ Open* 2014;**4**:e005140. doi: 10.1136/bmjopen-2014-005140.

[3] <https://www.england.nhs.uk/2018/10/nhs-to-prioritise-doctors-mental-health/>

[4] <https://www.theguardian.com/society/2017/nov/29/bullying-bad-medicine-surgeons-domineering-sexism>



Rebecca Heath
Medical Student, UCL

Reflections on the relevance of intersectionality on mental health in medicine.

Dr Elinor Wyn Hynes

My experience of both life and work in medicine tells me that we need to look beyond the surface concerns of stress and responsibility to more fully understand how the career may impact our mental health. I write from the position of having had depression myself, being queer, having worked as a psychiatrist in practitioner psychiatric health, and existed for periods of my life amongst marginalised, activist and academic communities. These experiences give me insights into the way the medical world limits our capacity to exist fully in our intersecting communities.

There are studies that indicate increased rates of mental illness in doctors amongst other professionals and that some specialities might have increased rates of mental illness compared to others (Gerada, 2018). The data often seem to refer to depression and burnout with the risk of suicide being more prevalent.



To address wellbeing, I believe we need to look deeper than rates of suicide to truly understand the malady that afflicts professions like medicine. Unsurprisingly, I do not think the origins of the malady are particularly different from those experienced by the rest of the population and I find a framework based within intersectional feminist theories most helpful to explain this. If we think of society as being made up of canopies of groups of belonging, be that geographical, race, gender, class, profession, family etc, we are all part of more than one group of belonging that hold us

more or less strongly and carry with them greater or lesser meaning whether that is conscious or not. Within those groups, we may be more or less accepted on account of factors both personal and external to ourselves.

To exist comfortably within these groups, we need to be familiar with the language and the idea of “thinking as usual” of the group. Starting in medical school, students are rapidly taught the language and the expectations of “us” and how to think. It is an immersive education with an expectation to “work hard and play hard”. Gerada (2019) has riffed off of Foulkes’ concept of the Foundational Matrix (Foulkes, 1964) to frame the identity that comes with this educational and professional experience “the medical matrix”. She found that doctors losing this identity for whatever reason then had a job to recreate their personal identity without it. Who are doctors when they are no longer doctors?

Beyond the medical matrix, when the individual is faced with a constant conflict across these different groups around being and viewing the world, a tension is created that puts strain on mental wellbeing. I believe this strain contributes to rates of depression and other mental illness.

This got me thinking on the reflections of Patricia Hill-Collins (2004) and her experience as a black woman working in the white male dominated academic discipline of sociology. She talked of the challenges and benefits of working at the margins of the two groups; black women and sociologists. I imagined the difficulty of holding the two, often conflicting, world views and related to them with my own experience of coming to exist as a queer trans masculine doctor in the normalised and normalising culture of medicine. Queers and medicine, as much as queers are officially welcomed, actually hold some quite conflicting views. By queer, I do not mean merely LGBTQ+, but a questioning of norms around gender and sexuality and a resistance to labels which limit us.

Medicine of course works on establishing norms, measuring them, monitoring them and trying to coax every parameter back towards the norm, be that physiological or, in the case of psychiatry, behavioural.

As much as I have discovered great rewards, resilience in the form of community and satisfaction in my belonging to these two groups, I have also faced internal and psychological conflict and feelings of marginalisation and disadvantage. A similar conflict can be seen in international medical graduates coming from other places and cultures having to navigate the norms of the place they come to and feeling an intrinsic lack of belonging. The same goes for minorities of any sort within medicine, be that race or class or ability.

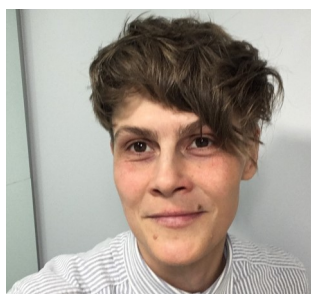
These differences play out differently for different people and the more minority identities that an individual associates with, the more the dislocation and struggle to manage the spaces of different groups is exacerbated, and the more stigmatised or marginalised those groups of identities are within the group of medicine.

References:

1. Gerada, Clare. "Doctors, Suicide and Mental Illness." *BJPsych Bulletin* 42, no. 4 (August 2018): 165–68. <https://doi.org/10.1192/bjb.2018.11>.
2. Gerada, Clare. "The Making of a Doctor: The Matrix and Self." *Sage Publications, Group Analysis.*, January 2019. <https://doi.org/10.1177/0533316418823117>.
3. Giffney, Noreen. "Introduction: The 'Q' Word." In *The Ashgate REsearch Companion to Queer Theory*. Farnham: Ashgate Publishing, 2009.

4. S. H. Foulkes. "Therapeutic Group Analysis." In *Therapeutic Group Analysis*. Karnac Books, 1964.

5. Patricia Hill-Collins. "Learning From The Outsider Within: The Sociological Significance of Black Feminist Thought." In *The Feminist Standpoint Theory Reader*, 103–20. Routledge, 2004.



**Dr Elinor Wyn Hynes MRCPsych, Ma, MBBS, IBSc
ST5 General Adult Psychiatry, ELFT**

Why do Medical Students Choose Psychiatry? The Influence of Close Contact with Mental Health Conditions

Lucia Almazan Sanchez

"As you all know, the statistics say that 1 in 4 people have a mental health problem, and for medical students and doctors, that figure will be higher... there are many of you that will have had mental health problems, or people in the family with mental health problems" - Dr. Wilson-Jones.



This is how my first day of Psychiatry teaching in medical school started, and is how many arguments for choosing the specialty will begin. However, some of us can relate to this more than others.

In his memoir *Because I Come From A Crazy Family: The Making Of A Psychiatrist*, Dr. Hallowell, an American psychiatrist, explains "I wanted to become a psychiatrist because I wanted to understand my people in particular and crazy people in general"¹, and thus he had made a career choice from this childhood drive to cure and understand his loved ones.

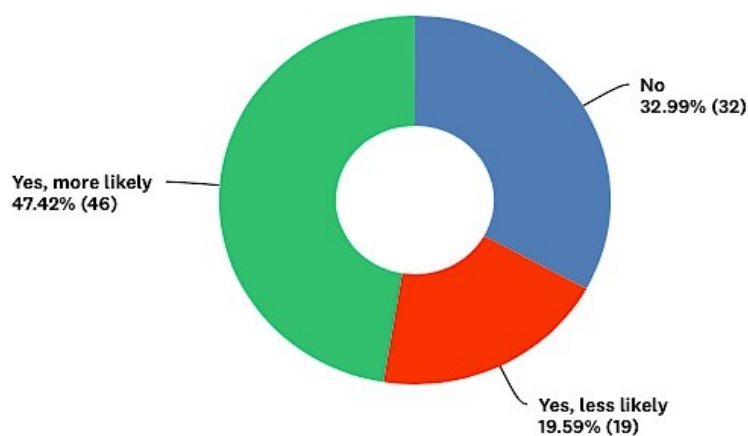
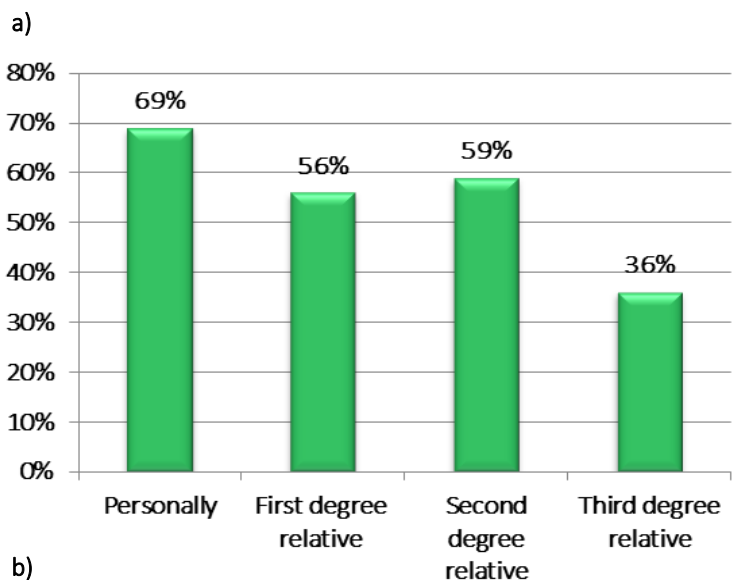
Moreover, previous surveys including medical students across 20 countries have identified that personal and/or family experience of mental illness did indeed significantly influence the choice of this specialty².

In order to further explore this, I created a brief survey to try disentangle how often medical students have experienced mental health problems closely and how this has affected their likelihood of choosing psychiatry. Out of 100 medical students, across several universities in the UK, a large majority of 97% declared that they had either personally, or from a first, second or third degree relative experienced mental health conditions (figure 1). So, as my lecturer said on the first day, it is definitely true that we live in close contact with these issues. And, what's more, of those that did have close personal or familiar contact with mental illness, for 47% this made them more likely to pursue a career in psychiatry, although for about 20% it made them less likely.

So, whether, like for Dr Hallowell and I, experiencing psychiatric illness in our family propelled us into this career, or for others, where this contact has deterred them, it is an important factor that influences our vocation. The questions that remain include *how* these experiences can either positively or negatively influence our views of the specialty.

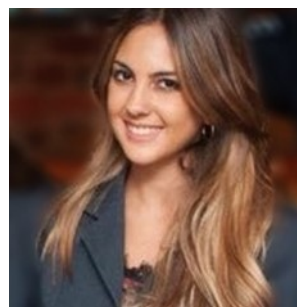
I believe that it is here where *stigma* comes into play. Contact, and more specifically, face-to-face close contact has been found to be the most significant factor that improves outlooks and behaviours of the public towards mental illness³. So, ultimately, although we do not choose the family that we are born into and the conditions that they or we, ourselves, suffer from, it shapes our attitudes and convictions, and may lead to the makings of psychiatrists.

Figure 1: a) Graph showing the percentage of medical students that have experienced mental health conditions at varying degrees b) Chart showing whether experience of mental health conditions has influenced the likelihood of choosing Psychiatry as medical specialty amongst students that did have close personal or familiar contact with mental illness.



References:

- [1] Rhodes, Giulia (2018). Mental Illness Swam in My Genes': Why I Was Born to Be a Psychiatrist. The Guardian, Guardian News and Media. Web
- [2] Farooq Kity, Lydall J Gregory, Malik Amit, Ndeti M David, ISOSCCIP Group and Bhugra Dinsesh. (2014) Why medical students choose psychiatry- a 20 country cross-sectional survey. BMC Medical Education. 14:12.
- [3] Corrigan, PW, Morris, SB, Michaels, PJ, Rafacz, JD, Rüsche, N (2012 b). Challenging the public stigma of mental illness: a meta-analysis of outcome studies. Psychiatric Services 63, 963–973.



Lucia Almazan Sanchez
4th Year Medical Student
King's College London

Tackling burnout in medical school - what's the point?

Ahmed Al-Shihabi

You must have been living under a rock to not have heard about the growing issue of physician burnout over the last few years, but what is becoming increasingly evident is that burnout is not waiting until graduation to latch onto its victims. Research suggests that nearly half of medical students experience burnout¹. Despite these findings, education and support regarding burnout hasn't stepped up over the course of the medical degree.



Some things will never likely change: the sun, bar an unprecedented cosmic event unforeseen by modern physics, will always rise in the east; the weather will always be the first port of call for semi-awkward small talk in this country; and your time at medical school will always be somewhat stressful. This might inspire a sense of futility to the thought of attempting to make medical school, or a career in medicine as a whole, less stressful; after all, it always will be. What this doesn't mean, however, is that we can do nothing about preparing our medical students and trainees to be better able to handle the pressures their careers can place on their mental health. Given that prevention is

better than a cure, the earlier we start to educate students and trainees on the recognition of symptoms of burnout and mental health conditions, as well as what support is available, the better. As progression through the medical profession slowly shifts away from a culture of 'you'll figure out how to cope on the job', the onus really is on the institution of medical education to give students a firm grounding in skills and strategies for managing psychological distress and encouraging help-seeking behaviours.

Yes, part of growing as a clinician includes learning how to cope with the psychological stressors that a career in medicine entails, but we all stand to benefit from training medical students and trainees in these skills. Even if the person isn't likely to burn out from incessant studying in the run-up to finals, these skills stick, and could make all the difference years down the line, when working in a high pressure, understaffed environment may start to take its toll.



Whilst I say that we all stand to benefit from giving medical students and trainees skills and strategies to maintain their wellbeing, I do believe that psychiatry would especially benefit. Out there are medical students with their eyes set on psychiatry; maybe because their empathetic nature drives them to a field where the ability to understand emotions is not just recommended, but critical, or perhaps they have lived experience of psychiatric disorders. These students are often at the biggest risk of burning out, emotionally or otherwise, sometimes because of the traits that might make them fantastic psychiatrists. If we could supply them with skills to better handle the emotional drain and psychological stress of training to be a doctor, we could well usher in a new golden age of psychiatrists; their ranks swelling with those who have been patients themselves and possess the extra understanding that brings, and those who have a natural propensity for the job but who may have been held back by a predisposition for emotional burnout.

So is there any point to focus our efforts on burnout prevention on medical students? I think there just might be, and that psychiatry may well reap the best part of the ensuing harvest.

References:

- [1] Frajerman, A., Morvan, Y., Krebs, M., Gorwood, P. and Chaumette, B. (2019). Burnout in medical students before residency: A systematic review and meta-analysis. *European Psychiatry*, 55, pp.36-42



Mr Ahmed Al-Shihabi
4th Year UCL Medical Student

When my consultant wasn't practicing safely: the stresses and ethics of working with a struggling senior colleague

Anonymous

It was the first day of my new job that I initially experienced a sense of unease working with this consultant; a feeling that would become all too familiar and eventually intolerable over the coming weeks and months.

I had been participating in a ward round and noticed my consultant had completely misunderstood what the patient had said. It felt strange to witness this. But I didn't say anything. I felt as though I couldn't; it was my first day in a new environment and speciality, and this was my senior. Thankfully, someone else corrected the consultant and the misunderstanding was clarified. Phew.

The other times I witnessed misunderstandings, there wasn't always someone else to speak up and so the role fell to me. Soon, I found myself over-assisting on ward rounds so prescriptions were correctly written and so leave was granted safely.

Brimming with unease, I began to enquire discretely of other multidisciplinary team members about what they thought of the consultant's errors. I watched their faces when we witnessed his mistakes during MDTs, but did not see in colleagues the same unease that I experienced. I felt isolated. I started to wonder whether I was imagining things (how was I to know if the unusual prescriptions were simply 'off-label'?). So I waited.

I waited until my conscience felt too heavy to witness another error. Until I was completely sure my consultant really was 'unsafe' and when the evidence I had collected was enough for me to call out the person who was meant to be supervising my work, not the other way round.

So one day, I found myself blurting out all the events that had occurred to one of the other consultants. Recognising the seriousness of the mistakes I had witnessed, the discussion quickly escalated to involve senior managers and the Clinical Director; all of whom appeared equally concerned by the situation and seemed to recognise the burden I had been carrying so far. Action was swiftly taken, the doctor was moved

from his role, and for the first time I truly felt as though my concerns were understood and validated. I felt an enormous weight was lifted from my shoulders.

The following days, however, were not straightforward. Ward staff asked questions, speculations were made and I experienced some unexpected guilt that I had been the one to negatively impact the career of another doctor, who despite appearing unsafe was still a pleasant and kind person who seemed to simply want to do his job. However, the Clinical Director reassured me that the situation was being managed and that the consultant, too, had the right to necessary confidential support should he require it. In turn, my inadequately supported learning over the past few months was discussed, and ways to redress and compensate for any loss were considered with me.



As time goes by, I do believe I did the right thing to raise my concerns about my consultant. It wasn't easy; it goes against the grain of medicine's typically hierarchical system of practice, but I believe it also goes to the core of the ethics of our profession. As trainees we just expect our consultants to be clinically effective, and I'm not sure that we always have the experience or training about what to do with one who is not. It is an isolating, stressful, and exposing situation, but is one we all need to talk about. I couldn't have left the task to the next trainee to deal with: I felt it was my duty and I do sleep much better at night.

Punishing the Mentally Unwell Doctor? The Responsibilities of Colleagues and the Medical Council

Dr Jin Kim and Dr Ksenia Marjanovic-Deverill

Mental health illnesses, ranging from anxiety/depression, to substance misuse, emotional exhaustion, and suicide, disproportionately affect doctors worldwide [1]. The issue is multifaceted. Among many explanations, the causes are rooted in the temperament of the individual, the culture and expectations of the healthcare role, and in the medical system itself [2]. Initiatives are now set in place to optimise mental health in the workplace, such as mindfulness sessions and reflective practices [3]. However, some important questions remain: should the mentally unwell doctor hold absolute accountability for their mental illness, and what is the appropriate response of colleagues and the Medical Council when issues arise as a result of mental illness? To highlight the reality of the above questions, we present a case study that captures the dramatic oversight of a mentally unwell senior doctor at the end of their medical career.



A gentleman in his 60s presented to hospital from a nursing home with reduced consciousness. He had practiced as a senior doctor until a number of clinical concerns were raised against him; allegations regarding clinical malpractice, uncharacteristic altercations with colleagues, and general change in personality. During the investigations performed by the General Medical Council (GMC), he did not attend the tribunal processes or prepare a legal defence. As a result of the claims as well as his non-engagement with the GMC, he was erased from the GMC register.

Additionally, at this point, he was estranged from his family and was left with no financial or social support. The culmination of these events led to a gradual deterioration in his mood over 2 years, and he ultimately required an admission to a psychiatric unit where he was diagnosed with bipolar affective disorder (BPAD).

During the medical admission, investigations revealed moderate-severe cerebral atrophy in keeping with a neurodegenerative process (Figure 1). The changes were significantly marked at this point, strongly pointing to the possibility of early symptoms of dementia having been present during the time of his GMC investigations. Together with his likely concurrent BPAD symptoms, his undiagnosed mental health conditions may have contributed towards his change in personality, altercations, forgetfulness and frequent clinical errors.

Doctors are increasingly likely to experience poor mental health when facing the ever-changing working culture, regardless of seniority [4]. In light of this, identifying and reconciling issues that impact patient care should be a collective responsibility that reaches beyond the mentally unwell individual. This role of accountability must be adopted by their colleagues, and further, the Medical Council. The fundamental importance of accountability is highlighted when considering the undermining of insight by mental health conditions, which limits the merit of personal probity in an unwell doctor declaring their fitness to practice themselves. Additionally, clinical errors influenced by mental health illnesses must be weighed appropriately and with a nuanced approach; incorporating a combined recognition of both the individual's responsibility and the systemic oversight of the individual.

A careful decision should be made not to blame the integrity of the individual, thereby permanently undercutting the merit of their service prior to their mental illness.

By virtue of their profession, doctors are subject to pressures that increase the risk of mental health illnesses. In recognition of their vulnerabilities, efforts must be made to minimise isolation of doctors and to encourage healthcare professionals to support the mental health of their colleagues. This paradigm shift may reduce ostracising or ‘punishment’ of mental health illnesses.



Figure 1. A transverse plane image of the patient’s CT Head demonstrating: “periventricular low attenuation change and cerebral atrophy in keeping with small vessel disease.”

Disclaimer: The manuscript was reviewed by the gentleman and full written consent was obtained to use the case scenario.

References:

- [1] Firth-Cozens J. A perspective on stress and depression. *Understanding doctors’ performance*. 2006:22-5.
- [2] Brooks SK, Gerada C, Chalder T. Review of literature on the mental health of doctors: are specialist services needed?. *Journal of Mental Health*. 2011 Apr 1;20(2):146-56.
- [3] Miller L. Doctors, their mental health and capacity for work. *Occupational Medicine*. 2008 Sep 16;59(1):53-5.
- [4] Taylor C, Graham J, Potts HW, Richards MA, Ramirez AJ. Changes in mental health of UK hospital consultants since the mid-1990s. *The Lancet*. 2005 Aug 27;366(9487):742-4.



Dr Jin Kim
FY2 Doctor, Liaison Psychiatry Department, Ealing General Hospital

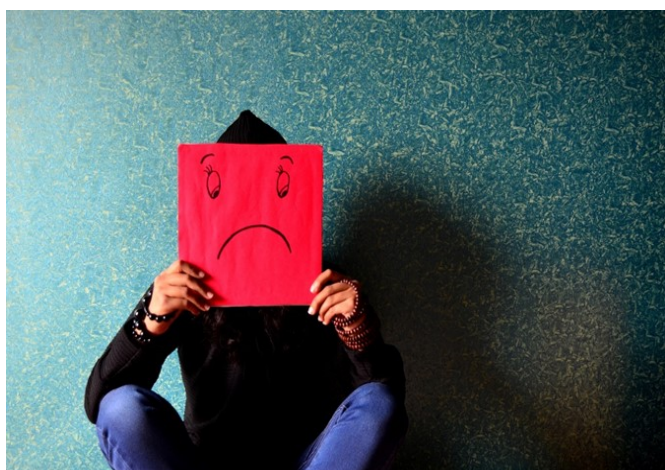


Dr Ksenia Marjanovic-Deverill
Consultant Psychiatrist, Liaison Psychiatry Department, Ealing General Hospital

Karojisatsu – suicide from overwork

Dr. Sachin Shah

In 1999, Yuji Uendan was found in his apartment in Kumagaya City, Saitama Prefecture, Japan, having ended his life by suicide. Written on his whiteboard was the statement “The time I spent has been wasted.” He had reportedly been depressed in the context of his job as a temporary worker at a Nikon factory, where he’d been working 11-hour rotating day and night shifts. His final run at the factory totalled 15 days in a row without a day off, and he had been experiencing physical symptoms and sleeplessness.¹



Karoshi is a Japanese term referring to death as a result of overwork, for example from early heart attack or stroke. The term had been in use since the 1970s. *Karojisatsu*, referring to suicide as a result of overwork, was recognised as an issue in Japan from the late 1980's, continuing to escalate on the background of a long recession. In 2016, 84 worker's compensation claims were accepted for suicides and attempted suicides related to work.² This is likely an underestimate of the size of the problem, as not all cases are officially recognised. Legally *karojisatsu* can be considered a work-related accident only if it is decided that the work resulted in a mental disorder that caused the individual to lose the rational ability to evaluate suicide.³

Reasons for increased occupational stress in Japan included the collapse of the bubble economy in the 1980's and 1990's, resulting in layoffs which left the remaining workers with a heavier workload. Despite the

recession, companies kept their demanding goals, adding to the psychological burden upon workers. The International Labour Organization also notes that emotional pain was suffered by middle management, who bore responsibility to lay off employees.⁴

Japanese work-life balance is poor. The average worker will use only 9 of their 18 permitted vacation days. This low take-up is due to saving days in case of illness, and the lack of an established mechanism for taking long vacations.⁵ Such was the case of Junichi Watanabe, a middle-manager at a steel manufacturer, who had not taken more than 2 days off in the previous six months before ending his life at the company's headquarters.⁶ In the months leading to his suicide, he had reportedly been increasingly irritable, and had reportedly stated “I cannot speed up the work. I feel like dying. Am I a horse tied to a carriage?”

One noted characteristic of *karojisatsu* is the sense of responsibility victims seem to feel. Suicide notes focus on apology and remorse for causing trouble, rather than anger and blame towards the company responsible.⁶

Factors culturally specific to Japanese working society may contribute to the burden workers experience. In addition to universal desirable qualities in a worker, the Japanese value highly cooperative attitudes, demonstrated in workers by a willingness to take on more work than is strictly defined or expected. For example, an efficient worker who completes their tasks and leaves on time may still be viewed negatively for not going above and beyond.⁶

Though Japanese work hours are reportedly below those of the USA, and labour laws dictate a 40-hour work week, there is a hidden burden of unreported, unpaid overtime. *Sabisu zangyo* is the term used, which translates literally as “service overtime”, but the use of the term “service” is better regarded to mean “freebie”. There is an unwritten sense of obligation to take such overtime. Ishiro Oshima was a man who, in 1991, ended his life at the age of 24, having pulled overtime shifts that lasted until 6am at his workplace, and having slept only half an hour on some days.⁷

Severe mental health impact of work is by no means restricted to Japan, but it is interesting to look at a country that is developing a vocabulary and framework to address it. We have much to learn as a profession in which we too are guilty of working unclocked hours, donating our time and our bodies to the NHS, and in which we can too easily take on more work than is explicitly described, out of sense of duty. And we too are coping with the burden of reduced staffing and increased workloads.

I suspect *karojisatsu* would apply as a label to some of the suicides our colleagues have fallen victim to. Consider if we also romanticise being the generous worker who doesn't go home on time, and if we are embarrassed to be the worker who finishes on the dot and hands over all our remaining tasks, and whether our own work culture contributes to this.

References:

1. Hida, M. (2008). The land of *karoshi*. Geneva: International Labour Organization.
2. Ito, H., & Aruga, T. (2018). Japan imposes a legal overtime cap, but mental health issues are complex. *The Lancet Psychiatry*, 5(8), 616-617.
3. Inoue, K., & Matsumoto, M. (2000). *Karo jisatsu* (suicide from overwork): a spreading occupational threat. *Occupational and environmental medicine*, 57(4), 284-285.
4. Case Study: *Karoshi*: Death from overwork. (2013, April 23). Retrieved from http://www.ilo.org/safework/info/publications/WCMS_211571/lang--en/index.htm
5. Yamazaki, Y., Togari, T., & Sakano, J. (2011). Asian Perspectives and Evidence on Health Promotion and Education. In *Asian Perspectives and Evidence on Health Promotion and Education* (pp. 118-132). Springer, New York.
6. Kawanishi, Y. (2009). 2. Mental Health At Work. In *Mental Health Challenges Facing Contemporary Japanese Society* (pp. 24-60). Global Oriental.
7. Sim, W. (2017, January 16). Employees in Japan are on the clock - but off the record. Retrieved from <https://www.straitstimes.com/asia/east-asia/employees-are-on-the-clock-but-off-the-record>



Dr. Sachin Shah
General Adult Psychiatry Trainee, SWLSTG
Mental Health NHS Trust

“Who watches the Watchmen?”

Dr Stephanie Young

I remember the responses from friends and family when I told them that I was interested in being a psychiatrist. Mostly, they ranged from incredulity to disbelief but there were some who were concerned that being around “mad people” would take a toll on my own wellbeing.

Working in the mental health field for over 20 years has certainly been illuminating, and has made me reflect on how this may have affected or influenced me as a person and also the trainees whom I have come in contact with as a clinical and educational supervisor.

It has been no surprise that over the years, the job of a psychiatrist has noticeably changed. The admin burden has increased with the evolution of electronic notes, appraisal and revalidation, and the European Working Time Directive has caused more fractured team working. We don't have protected office space anymore and there is increasing pressure to do more “quality improvement” with fewer resources.

All this potentially contributes to increased stress and even burnout. This is why I believe in the importance of maintaining a good work-life balance and to convey this explicitly to trainees. It is not uncommon that trainees report isolation from their colleagues and despite the ethos of MDT working in psychiatry, it can often feel like they are getting the brunt of the pressure. It is disingenuous to blame it on lack of resilience, when it may be the system which is primarily at fault.

There are currently a variety of existing mechanisms and areas in different Trusts to support trainees such as regular supervision (clinical and educational), Balint groups, encouraging exception reporting and signposting to other organisations like the Practitioner Health Programme (<https://php.nhs.uk>). Some organisations offer mentoring for new trainees in their core years where they are linked up with a more senior trainee for the first year or so. Some trainees have set up whatsapp groups to encourage more regular contact with each other.

Other things we as senior doctors might consider if not doing already, include giving more regular informal

feedback outside of supervision or work-place based assessments, explicitly acknowledging the hard work our trainees do. We could talk about burnout, talk about our own experiences with dealing with stress, develop or improve our own coaching and mentoring skills and tackle bullying seriously. I think it is important to encourage our trainees to foster a wide range of interests outside of psychiatry. This is not just for maintaining one's own mental health but in order to better understand our patients, as I do believe that appreciating aspects like literature, the arts and participating in hobbies whether it be sport or singing in a choir, makes us better well-rounded individuals and as a result, better psychiatrists.

From a consultant perspective, those of us who missed out on the earlier retirement option of the mental health officer status, are ourselves apprehensive about whether we can effectively continue to work in areas with squeezed budgets and unrealistic target-driven expectations from management. For all the leadership training that we might be encouraged to do, there is often little acknowledgement of the mental toll our jobs take on us.

Therefore, I wonder whether there ought to be better support for consultants as we do at the trainee level. Should we also get access to dedicated regular supervision? Other team members have been flabbergasted to hear that we don't get supervision when even their senior team leaders receive it. Is being a member of a peer group or having access to a mentor enough? There are new initiatives such as the “Start Well” programme (<https://www.rcpsych.ac.uk/members/supporting-you/new-consultants-startwell>) which supports new consultants in their first 5 years of training, but one could argue that it is even more important to concentrate on what helps us “stay well” longer in our careers to help staff retention. We have to practise what we preach.

Dr Stephanie Young
Consultant Psychiatrist, South London and Maudsley
NHS Foundation Trust

'This too shall pass': is resilience enough?

Dr Jemma Theivendran

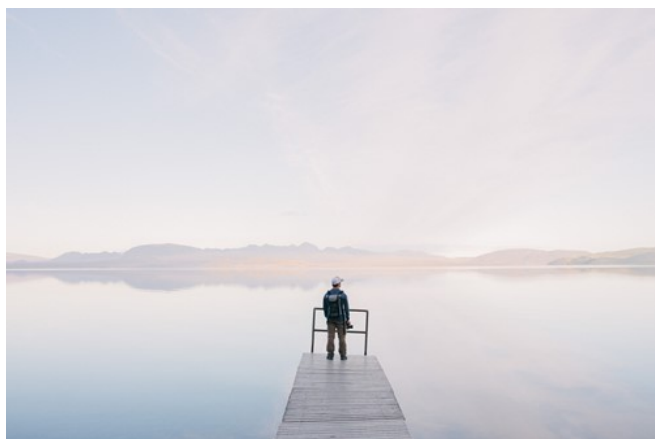
A NHS staff [survey](#) found almost 40% reported feeling sick from stress in the last year¹. A [culture](#) of bullying and intimidation is reportedly on the increase in hospitals². [Staff](#) leaving the NHS due to poor work-life balance has almost trebled in the last seven years³. Junior [doctors](#) are repeatedly working past their shift ends⁴. These news stories are folded in amongst the stories of Trump and Brexit on a weekly basis, they are all too common and unsurprising.

The Sufi poets did not have NHS staff in mind with the phrase 'this too shall pass' but the idea becomes a mantra to power through the hard times – the endless hours, challenging patients, low staffing levels and fraught work environments, cultivating an ethos of 'getting on with it'. 'This too shall pass' implies resilience and endurance will carry through, but resilience is not a given and the hard times are relentless.

Resilience is defined as the ability to adapt and maintain competent functioning in the face of major life stressors and adversity⁵ and is a skill that requires development. An article in the Harvard Business Review suggests five components to developing resilience: exercise mindfulness, compartmentalise cognitive load, take detachment breaks, develop mental agility and cultivate compassion⁶. It becomes clear that time, investment and compassion are required to build resilience.

A [study](#) by PwC in 2004 showed, across a broad range of industries, that investment in initiatives that fostered resilience and good mental health returned \$2.30 for each dollar spent, with lower staff turnover, lower absenteeism and higher productivity⁷. In addition to building skills in resilience and supporting staff with mental health conditions, it identified a positive working environment as a key action for developing a mentally healthy workplace. A [review](#) of the implementation of whole-system healthy workplace interventions based on the Boorman recommendations showed significant improvement in physical and mental health of staff⁸.

The evidence therefore suggests that with the right resources and investment, improvements to the workplace and resilience training can benefit the staff and business alike.



Compassion makes space and allowances for colleagues to practice techniques in resilience. This may be not piling on work that would be considered a valuable learning experience or a boost to the CV, but instead checking in on a personal level. NHS staff do not expect bonuses or away days, and sometimes our work ethic is traded on the idea that our work is a vocation and intrinsically rewarding. This may be true, but [factors](#) such as being treated with kindness, positive relationships with colleagues and feeling valued and supported by managers are highly valued by healthcare staff⁹. A [study](#) on resilience across a cross-section of NHS staff found clinical staff reported lower resilience compared to administrative and clinical staff with line management responsibilities¹⁰. The authors suggested that clinical staff may not make use of social support available perhaps due to shift patterns or movement between hospital areas indicating that despite being surrounded by people, working in healthcare can be lonely.

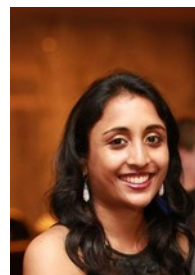
Is resilience enough? The definition of resilience specifies major life stress or adversity, and implies perseverance in the face of a short-lived crisis. The daily grinding pressures of working in the NHS are not short-lived, and the wellbeing of healthcare staff is repeatedly reportedly in crisis - this will not pass any time soon.

Resilience alone may not be enough, but as a first step towards improving the mental health and wellbeing of healthcare staff, it is surely worth the investment.

References:

- [1] Campbell, D. (2019). *NHS England survey reveals 'alarming downturn' in staff wellbeing*. [online] the Guardian. Available at: <https://www.theguardian.com/uk-news/2019/feb/26/nhs-england-survey-reveals-alarming-downturn-in-staff-wellbeing?> [Accessed 27 Feb. 2019].
- [2] Marsh, S. (2019). *Bullying and sexual harassment 'endemic' in NHS hospitals*. [online] the Guardian. Available at: <https://www.theguardian.com/society/2019/feb/24/bullying-sexual-harassment-nhs-hospitals?> [Accessed 27 Feb. 2019]
- [3] Campbell, D. (2019). *Record numbers of NHS staff quitting due to long hours*. [online] the Guardian. Available at: <https://www.theguardian.com/society/2019/feb/17/nhs-staff-quit-record-numbers-work-life-balance?> [Accessed 27 Feb. 2019].
- [4] Campbell, D. (2019). *Junior doctors repeatedly working past shift end, NHS data shows*. [online] the Guardian. Available at: <https://www.theguardian.com/society/2019/jan/15/junior-doctors-working-past-shift-end-nhs-data-england?> [Accessed 27 Feb. 2019].
- [5] Herman H, Jane-Llopis E (2012). The status of mental health promotion. *Public Health Rev.* 34(2):1–21
- [6] Fernandez, R. (2016). *5 Ways to Boost Your Resilience at Work*. [online] Harvard Business Review. Available at: <https://hbr.org/2016/06/627-building-resilience-ic-5-ways-to-build-your-personal-resilience-at-work> [Accessed 27 Feb. 2019]
- [7] PwC and beyondblue (2014). *Creating a mentally healthy workplace - Return on investment analysis*. [online] Headsup.org.au. Available at: https://www.headsup.org.au/docs/default-source/resources/beyondblue_workplaceroi_finalreport_may-2014.pdf [Accessed 27 Feb. 2019].

- [8] Brand, S. L., Thompson Coon, J., Fleming, L. E., Carroll, L., Bethel, A., & Wyatt, K. (2017). Whole-system approaches to improving the health and wellbeing of healthcare workers: A systematic review. *PloS one*, 12 (12), e0188418. doi:10.1371/journal.pone.0188418
- [9] Barker, R., Ford, K. and Cornwell, J. (2018). *What does staff engagement mean in the NHS and why is it important?* - *The BMJ*. [online] The BMJ. Available at: <https://blogs.bmj.com/bmj/2018/05/16/what-does-staff-engagement-mean-in-the-nhs-and-why-is-it-important/> [Accessed 27 Feb. 2019].
- [10] Sull, A., Harland, N., & Moore, A. (2015). Resilience of health-care workers in the UK; a cross-sectional survey. *Journal of occupational medicine and toxicology (London, England)*, 10, 20. doi:10.1186/s12995-015-0061-x



Dr Jemma Theivendran
ST6 Child and Adolescent Psychiatry

Promoting resilience only goes so far...

Dr Gabrielle Pendlebury

Mental health has slowly been accepted into the mainstream political discourse with Simon Stevens, NHS Chief Executive, announcing on 5th October 2018 that there will be national funding for a new mental health support scheme for all doctors working in the NHS.

According to the BMA's Doctors' Health Matters, doctors have one of the highest prevalence rates of mental health problems, compared to other professions [1]. UK studies suggest that between 10% and 20% of doctors become depressed at some point in their career [2,3].



In a survey of almost 8,000 US surgeons, 30% of the sample screened positive for symptoms of depression, particularly in those with higher workloads and increased night shift working.[4]. A follow-up article noted that as many as one in sixteen (6.3%) had experienced suicidal thoughts in the previous year. Only 26% of those sought professional help. As might be anticipated, making a medical error was significantly associated with suicidal thoughts [5].

In the UK, a study looked into the suicides of 38 doctors over a three-year period [6]. It concluded that most were suffering from a psychiatric disorder at the time of their death, with depression the most common diagnosis. Only two of the doctors had taken voluntary leave from work because of their mental health problems.

A cultural shift is needed to allow for recognition of how working as a doctor can impact on wellbeing with the aim of promoting mental health and self-care.

The Society of Occupational Medicine's report '*What could make a difference to the mental health of UK doctors? A review of the research evidence*' [7] highlights the role of occupational and individual factors that contribute to distress, such as emotional labour, personality and coping styles. Poor working conditions seem to have the strongest effect on wellbeing. Other risk factors include high perceived workload and work intensity, poor staffing levels, a lack of autonomy and support and experiencing bullying, harassment or abuse. Poor work-life balance was identified as one of the most powerful predictors of mental health problems in doctors, with long working hours limiting time available to pursue activities that replenish mental and physical resources.

Many doctors have poor psychological boundaries between their work and personal life and this can lead to pervasive rumination about work. This lack of distance can inhibit recovery from stressful events and impact on ongoing job performance, leading to an increase in the risk of mental health problems over time.

Interventions

The current focus is on doctors developing resilience through reflective practice and other activities that promote understanding. This activity has proved invaluable to my own practice. However, there is some evidence that levels of resilience and other indices of positive mental health (such as optimism, self-efficacy and hope) are comparable with (or better than) the general population [8]. With this in mind, interventions need to address current working conditions if sustainable benefits for the mental wellbeing of doctors are to be achieved.

Secondary interventions, such as encouraging resilience as a way of helping doctors cope with the demands of the work environment, do not address the root cause: an under resourced system.

References:

- [1] BMA. Doctors' health matters. 2007.
www.bma.org.uk/images/HealthMatters_tcm41-146805.pdf
- [2] Firth-Cozens J (2006) A perspective on stress and depression In: Cox J, King J, Hutchinson A, McAvoy P eds. *Understanding doctors' performance* Oxford: Radcliffe Publishing, pp. 22-25
- [3] Ghodse H (2000) Doctors and their health – who heals the healers? In: Ghodse H, Mann S, Johnson P eds. *Doctors and their health* Sutton: Reed Healthcare Limited, pp. 10-14
- [4] Shanafelt TD, Balch CM, Bechamps GJ et al. (2009) Burnout and Career Satisfaction Among American Surgeons *Annals of Surgery* 250(3):463-471
- [5] Shanafelt TD, Balch CM, Dyrbye L et al. (2011) Special report: suicidal ideation among American surgeons *Arch Surg* 146(1):54-62
- [6] Hawton K, Malmber A, Simkin S (2004) Suicide in doctors a psychological autopsy study *Journal of Psychosomatic Research* 57:1-4

- [7] Kinman G, Teoh K (2018) 'What could make a difference to the mental health of UK doctors? A review of the research evidence.' *Society of Occupational Medicine*

- [8] McCain RS, McKinley N, Dempster M, Campbell WJ, Kirk SJ. A study of the relationship between resilience, burnout and coping strategies in doctors. *Postgrad Med J*. 2018;94(1107):43-47. doi:10.1136/postgradmedj-2016-134683



Dr Gabrielle Pendlebury

Clinical Lead, Forensic Child and Adolescent Mental Health Service, The Tavistock and Portman NHS Foundation Trust

Work-life balance. Fad or fiction?

Dr Mervyn Yong

In this golden era of humanity, where advances in technology, sciences and health have propelled us to the stars and beyond, why then are we at such an alarming rate of burnout? This is an epidemic that currently plagues the UK and research has indicated that those working in health and social care have an increased likelihood of burnout compared to those in other industries. In healthcare, GPs and consultants have the highest burnout scores. Factors significantly associated to burnout and psychiatric morbidity include low job satisfaction, work overload, increased working hours and neuroticism.¹

As mental health professionals, we shall look no further than to ICD-10 section Z73.0 for the definition of burnout: a state of vital exhaustion. Though not, strictly speaking, a mental illness on its own, it can be thought of as a chronic state of work-place stress, which is often correlated with common mental disorders such as depression and anxiety.

Then comes the rise of social media. We see and compare ourselves to family, friends and influencing strangers flaunting luxurious holidays abroad alongside Michelin-starred dining experiences, hashtagged #worklifebalance. Such envious lives lived, though clearly the ordinary, less fancy experiences are hardly ever shared so openly. The term 'balance' can be a dubious misnomer in itself, suggesting that if one were to lose balance, one would be in a state of risk which may lead to perilous outcomes if it was not restored.

Daily life is instead a series of ever-changing, fluid experiences. A spectrum of events that will never be in equilibrium. Unless one's job is a tightrope-walker, the term 'balance' should not be the main end goal. There may be occasions when you are backlogged with work and miss your scheduled break, or stay late dealing with an unwell patient, missing your train home.

This does not result in becoming 'imbalanced' in any way, and there is nothing wrong with either of those choices. These are just the natural sequence of events that has formed the flow of life. How one chooses to allocate the emotions related to an event, whether positive, negative or mixed, would determine the experience in itself.



Although we can strive to become as optimistically-minded as possible, we know that an organisational structure holds the larger piece to this pie. Experts point out that employee burnout can be seen as symptoms of an ailing organisation, rather than a sick individual.² The NHS itself has been facing recruitment issues for a long time, but has only quite recently identified retention of long-serving, experienced, valuable staff as a major problem, and has resourced large amounts of finances to dealing with it. It is somewhat arguably ironic in nature, having huge cuts to services only to rechannel some back to manage retainment.

There are some management strategies that can be implemented to help prevent and recover from burnout. Individually we should be recognising the signs and symptoms and raising it with managers at the earliest possibility.

Take a break, find a safe space to reflect and get support. A good manager would be able to reassess and agree on reasonable, realistic expectations. Workers mainly identify well with a clear sense of purpose, belonging and autonomy. All ideally co-existing in a 'balanced' way as much as possible.

Maybe one day we would be fortunate to achieve this plausible myth of work-life balance. Maybe organisations will be able to retain and reward its staff better, whilst continuing to deliver high quality of care. Until these happen or the system snaps, let's do a little less tightrope-walking and a lot more living.

References:

[1] Udemezue, Imo (2017). Burnout and psychiatric morbidity among doctors in the UK: a systematic literature review of prevalence and associated factors. *BJPsych Bulletin* 2017; 41(4): 197-204.

[2] <https://www.theguardian.com/society/2018/feb/21/how-burnout-became-a-sinister-and-insidious-epidemic>

Dr Mervyn Yong, CT3

The Work/Life Balance?

Dr Andrew Howe

Across cultures and throughout history, the symbolism of the unification of opposites is an often-repeated pattern. To use a Jungian term, it is an archetypal image, expressed for example as the yin and yang from Chinese culture. The significance of this concept to us as human beings is not to be ignored.

But what has this to do with the theme of this edition of *The Psychiatric Eye*, that of mental health in the work place? Well, I would suggest that another expression of this archetype is the notion of the 'work/life' balance.



Often quoted, often dictated as the paradigm of equilibrium that is the key to life satisfaction, it is something many of us, including myself, aspire to. Yet it also seems so unachievable, and this can leave one with a feeling of inadequacy when you just want to sit in your flat, binge-watch Netflix and finish off that cake your mother baked for you.

Given that we spend around forty hours a week at work, and likely extra besides doing work related projects, the idea that this can be equally balanced with 'life' is flawed at the outset. Throwing in smart phones and all the notifications from those work related WhatsApp groups, how is a balance even possible? The meaning of life, in this specific concept, is also hard to define, but seems to take the shape of going out and spending time with family and friends, which is of course important, but what about the rest of it? We are set up to fail.

I would like to suggest a new concept which is really just a reworking of a Jungian and Romantic era mental health ideal. It involves the idea of a balanced self that does not become too one-sided and considers the importance of opposites. Self in this case is an all-encompassing whole, allowing the different bits of us to exist, without having to fit into the work or life category. The idea of a balanced self is perhaps simplistic, that too much of anything probably isn't good for us, however simple is often better. If we find ourselves being too one sided in doing certain thing, then what is the opposite of it? A week of extraversion might need to be balanced with some introversion, for example. This can often happen without thinking; just think of the exhaustion that forces us to stop, sometimes. I would suggest that this being a conscious process is all the better, however.

Our world has changed immeasurably since the concept of work/life balance was created in the 1970s. I feel it is important to blur the lines of work and life as we are made up of so many different attributes and parts that need to be heard. Perhaps thinking a little differently will allow us to take that lunch break and leave the hospital premises for lunch with a friend, do an hour on that project at the weekend or binge watch that ten part series without feeling like we have failed.



Dr Andrew Howe
ST4 General Adult Psychiatry

Culture Vulture - Les Miserables: Fairy Tale Therapy for Adults

Dr Harold Behr

I imagine that most of our readers will by now have seen 'Les Miserables', the longest ever running stage musical in the West End. But hands up, please, those of you who have read the novel by Victor Hugo on which the musical is based, one of the longest works in the classical literature. Far fewer, I would guess.

My own experience of 'Les Miserables' began as a child with the comic book – the story told through graphic illustrations, many of which stayed with me. Later, in adulthood, I regarded it as a challenge to wade through all fifteen hundred pages of the novel, including the author's numerous digressions, such as a detailed account of the Battle of Waterloo, which had little relevance to the plot itself. Nevertheless, I persevered and eventually finished it. The musical and the recent BBC TV dramatisation followed the comic book and the novel, leading me to the conclusion that theatre, song and graphic art are as effective a vehicle for telling a story as the printed word.

There is nothing explicitly psychiatric about 'Les Miserables' (except perhaps the title, which has stubbornly resisted translation from the French). The narrative, however, dips into themes of suffering, violence, abuse, loss and suicide, all of which scenarios resonate with psychiatric conditions which are familiar to us. The novel ends on a bitter-sweet note: the hero, an escaped convict on the run, redeems himself and proves to be a better man than the malevolent police inspector who has been obsessed with hunting him down. In a fairy tale ending, the lights go down on a romantic union between the dying convict's young ward and her lover, both of whom he has rescued, in different ways, from a terrible fate. At the same time the drumbeat of a social revolution provides an uplifting backdrop and stirs the public consciousness towards the need for change.

I have offered this example of a story written in the 19th century which has endured through to the present day in various forms to throw light on the dark corners of

suffering and offer hope for recovery. I could as well have chosen any of the novels of Dickens or any other great author to illustrate my point, which is that patients can benefit from hearing and seeing these stories when suggested as part of a broader therapeutic programme.



Dr Harold Behr

Culture Vulture - The Anatomy of Melancholy: Exhibition at the Bethlem Museum of the Mind

Dr Joan Rutherford

The exact centre of London, on the corner of the Strand and Charing Cross Road, is marked by this plaque in the Church of St. Martin's-in-the-Fields (1). But how far from here does the London Division of RCPsych extend? Do take the train to Hayes from Charing Cross Station, exit at Eden Park, and walk to the Bethlem Museum to see their current exhibition, *The Anatomy of Melancholy*. It's well worth the hour's journey.



In 1621, Robert Burton wrote his first edition of the *Anatomy of Melancholy*. The book is displayed open at its remarkable frontispiece, showing artistic depictions of hypochondria, mania, erotomania, and religious delusions.



Writing as 'Democritus Junior', Burton developed his ideas over five further editions, whilst a life fellow of Christ Church and vicar of St. Thomas's Church, Oxford (2), until his death in 1640.

The exhibition did prompt me to access the text later (3). Burton's advice meets current Public Health guidelines: be moderate in diet; get plenty of fresh air and exercise; and avoid strain and worry, or learn how to cope with these. He writes of obesity: "As a fat body is more subject to diseases, so are rich men to absurdities and fooleries..." He promotes herbal treatments: Hellebore, the Christmas rose (*Helleborus niger*) for the treatment of psychoses; the herb Borage (*Borago officinalis*) for its calming properties; and he suggested cannabis may treat depression.

Burton indicates he himself suffered clinical depression: "I write of melancholy by being busy to avoid melancholy". The 'Author's Abstract of Melancholy' contains these lines:

When I go musing all alone
Thinking of divers things fore-known.
When I build castles in the air,
Void of sorrow and void of fear,
Pleasing myself with phantasms sweet,
Methinks the time runs very fleet.
All my joys to this are folly,
Naught so sweet as melancholy.
When I lie waking all alone,
Recounting what I have ill done,
My thoughts on me then tyrannise,
Fear and sorrow me surprise,
Whether I tarry still or go,
Methinks the time moves very slow.

The theme of melancholy continues within the exhibition: here is Melancholia I by Xavier White (artist and sculptor), on loan from Mr Robert Lister. Painted in 2018, it shows us the French comedian Jacques Tati puzzling over parts of a bicycle, without the equipment to assemble it. Xavier White survived a life-threatening head injury at the age of 18 in 1985 and was rehabilitated at the Maudsley Hospital. A documentary of his work and life is available to view online. (4) It describes his concept of 'cohedia' (seen at the top of the painting) and vividly portrays his optimism.



Do visit the Exhibition, open until 27th April 2019 (check opening times) <https://museumofthemind.org.uk/visit>

NB: The next display at the Bethlem Museum of the Mind opens on 1st May to 31st August 2019. It's 'Brilliant Visions: Mescaline, Art, Psychiatry' - a display of drawings and paintings by Surrealist artists who took part in the Guttman-Maclay mescaline experiments of the 1930s.

Copyright

Photograph of Anatomy of Melancholy by permission of Museum Dr Guislain, Ghent (photograph J Rutherford)
Melancholia I, copyright Xavier White

References:

- [1] <https://www.thelondonhelicopter.com/interactive-map-of-london-tourist-attractions/the-exact-centre-of-london/>
- [2] **Anatomy of Melancholy 1621.** <http://www.gutenberg.org/files/10800/10800-h/10800-h.htm>
Project Gutenberg's requirement of access to the link is for this sentence to be included in references: 'This link/eBook is for the use of anyone anywhere at no cost and with almost no restrictions whatsoever. You may copy it, give it away or re-use it under the terms of the Project Gutenberg License included with this eBook or online at www.gutenberg.net'
- [3] <https://www.encyclopedia.com/people/literature-and-arts/english-literature-1500-1799-biographies/robert-burton>
- [4] for film of Xavier White's work <http://xavierwhite.weebly.com/>



Dr Joan Rutherford
Chief Medical Member, Mental Health Tribunal and
Honorary Consultant Psychiatrist, South West London
and St George's Mental Health Trust

London Division Executive Committee News

The London Division are delighted to announce that Diane Goslar has recently been appointed as the new Patient Representative for the Executive Committee. Please find below a message from Diane:

“ After teaching and translating French I set up my own public relations practice providing services mainly to London architects. However my business and career were brought to an abrupt end....

I’m now deeply involved as a service-user within the Royal College of Psychiatrists with a number of committees and groups addressing alcoholism. I also regularly give presentations and have made podcasts for the College, the last one being on alcohol and stigma.

I’m really pleased to have been appointed Patient Representative for the London Division Executive Committee and very much look forward to working with them.”



Keep an eye out for the call for articles via email and twitter for the next themed newsletter:

Technology and mental health



Congratulations to Rebecca Heath, medical student at UCL, and Dr Elinor Wyn Hynes, Higher Trainee (ST5) at ELFT for winning best articles for the Spring 2019 Edition — read these themed articles on pages 3 and 5!

Join us!

We’re looking for a new member to join the PsychEye newsletter team! Enthusiasm, creativity, and interest in writing and editing are vital. Please send us an e-mail if you’re interested in getting involved!

London Division Editorial Team:

ThePsychiatricEye@rcpsych.ac.uk | [@ThePsychEye](https://twitter.com/ThePsychEye)

Kindly note that The Psychiatric Eye Twitter has merged with the London Division account. Jump on over and follow us [@RcpsychLDN](https://twitter.com/RcpsychLDN).

Editorial Committee Members:

Dr Afia Ali
Dr Alexander Adams
Dr Matthew Francis
Dr Rory Sheehan
Dr Chris Symeon
Dr Sachin Shah
Dr Stephanie Young
Jen Edwards (London Division Manager)