



Autumn Edition 2022

The Psychiatric Eye

The London Division eNewsletter



'What I wish I'd known...'

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Welcome to the Autumn 2022 edition of The Psychiatric Eye. The theme of the newsletter is "What I wish I'd known..." and we have been really pleased to see lots of excellent articles submitted from authors at various stages of their career. As might be expected, the included articles cover diverse aspects of working in psychiatry and we value the many different perspectives brought to bear on the subject.

We would like to congratulate Dr Harold Behr on his winning article 'Then and Now'. Dr Behr gives us an insight into his long career including how he was drawn in different directions but ultimately found that being true to oneself an important principle to keep to.

Other highlights include Dr Sitki Anil Ustun's article sharing his insights as an international medical graduate, Dr Stephanie Chartes on the challenges and rewards of a consultant career, and Dr George Coates who provides a refreshing take on critical feedback and learning.

In addition to the themed articles, look out for our regular Culture Vulture and London Eye pieces. Many thanks to all our amazing contributors!

A warm welcome from the newsletter committee to Dr Suhana Ahmed, the new London Division Chair. Dr Ahmed's inaugural Chair's Message can be found on page 2 – please do have a look and take the opportunity to consider how the London Division network can work best for you. We have also seen some changes in the team that supports us in putting the Psychiatric Eye together; thank you to Gareth for all your hard work with past editions, and we look forward to working with Chesnei and Karen in the future.

Dr Rory Sheehan and Dr Mervyn Yong

The Psychiatric Eye editorial team are looking for new members!

If you're interested in being involved, please get in touch!

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Chair's Message

By Dr Suhana Ahmed

This is my first newsletter as Chair of the London Division. I would like to start by thanking the very wonderful Dr Peter Hughes, previous Chair, for all his hard work for the Division but on a personal front, his support of me over the years. The London Division wish him the best of luck in his future adventures (of which there will be many I am sure) and will miss him greatly. Also, a warm welcome to all our new committee members, including Karen Morgan (Division Committee Manager) & Chesnei Monroe (Division Administrator) who have already organised me better than I could have myself.



I am delighted to have taken over as Chair of the London Division having been involved with the Division for a number of years now. I am immensely excited at the next few years and what they will bring. For me, the Division has always brought a sense of belonging, community and support. However, I appreciate that is not what it may represent for everyone and one of my hopes as Chair is to make our work feel relevant and to focus on what you would like us to be. This will be different for different people but now, more than ever before with the pressures we face, is the time to look at what we want for our patients and ourselves. I see the Division as needing to reach out to you, all of you; medical students, foundation doctors, trainees, SAS doctors and consultants.

This leads me on to the theme of this newsletter 'What I wish I'd known'. I wish I had known at the start of my career the power that networks can bring. They serve the purpose of meeting people and developing links but also provide a common aim, a combined vision and a shared outcome. Not only is this more likely to be achievable but the impact it produces is far-reaching and incredibly rewarding. Here's my recent example; this month, I talked at a High Sheriff's event at the College 'The Price we Pay' highlighting the impact that under investment in mental health services has on patients, families, and society – emergency services, judicial system, probation. I highlighted the fact I increasingly find myself apologising to **everyone** – patients, families, staff, emergency services – for not being able to provide the care I wish I could and not being able to help in the way that I should. You would think I'd come away feeling despondent and deflated, I actually emerged feeling the opposite – hopeful and inspired...that there were so many others with a common goal; to fight for those that couldn't. I was humbled by the inspirational people I met that night.

Other networks I've witnessed recently – our amazing London Division #choosepsychiatry committee who ran an online event where over 300 attendees signed up. An event organized by the London PsychSocs highlighting a career in psychiatry including a patient story, a psychiatrist with their one mental health difficulties and panel discussions. Feeling proud would be a massive understatement! Tomorrow, I speak at an event organized by The Careers Office in collaboration with the College, widening participation and access to medicine for sixth form students with over 100 attendees. This is the power of networks.

So, I ask you to have a think about your networks. Do they need renewing? Do you need more? Do you need less? What purpose do they serve for you? Could the London Division help link you in with one? Could the London Division help develop one? And extend this to outside your professional work. One of my strongest networks is a group of mums with successful careers who strongly advocate for this. Finally, a heartfelt thank you for all you do for your patients, their families and each other. Please do reach out if you feel there is something the Division could help you with. Those are the sorts of emails we look forward to!

Best wishes,

Suhana Ahmed - London Division Chair



'What Is Untold About Working Abroad?'

By Dr Sitki Anil Ustun

It was an ordinary morning when I was scrolling around Twitter while having breakfast. My feed was full of comments on a particular article published in Lancet. The article was about why Turkish doctors emigrate.

That article resonated a lot on social media, Twitter especially. Most of the reactions were in the tone of "that is a shame" and "what a disgrace that we are on one of the highly prestigious journals of the world with such a topic." I was somewhat puzzled why this article generated such a reaction because, eventually, it was an opinion article. It might be in a well-reputed journal, well-worded and coherent article. Still, as in the quality of evidence, it was level 5 evidence, not much different than this article in essence.

Traditionally, Turkey has been known as a country of emigration, starting from the early 1960s when a large number of Turkish nationals migrated to western European countries, particularly West Germany. However, what is less spoken about is the motivations, circumstances and underlying psychodynamic mechanisms leading to these decisions. As we know from psychodynamic psychiatry, if something generates a disproportionate response, it triggers something more in us which sticks to the core.

Doctors tend to share their emigration with a picture of themselves at the airport with their suitcases or their flight ticket and passport, with a side note of "Turkey lost a doctor, X country won a doctor." Views on doctors' emigration from Turkey have been sharply dichotomous. While one side has viewed it as a highly-deserved, well-motivated movement to seek and obtain their true value, the other side objects to this by saying doctors who leave their country are traitors because they abandon their fellow compatriots, moreover, betray the investments made by the government to educate them.

When the article is examined, the precarious and oppressive conditions that doctors face propel the motivation for emigration, but when we look beyond the face value, it, in fact, represents a repudiation of primary objects. It provides an illusory sense of both separation and independence. It may also serve to take

revenge on a demanding and controlling parent, as authorities are warned about the adverse consequences of the emigration movement in the long term, as well as freeing oneself from an oppressive relationship.

In this climate of intrapsychic conflict, our hopes and wishes to break free and find our true selves then projected into an external figure, the concept of "working abroad". Western countries then start to represent an idealized parental figure who does justice to the efforts, lets us be our true selves and provides an environment to grow and be independent. These ideas are then reinforced by posts about "ideal" working conditions, fulfilled lives of doctors working abroad and negative news flooding in from the native country.

Immigration from one country to another also involves profound losses. Often one has to give up familiar food, native music, social customs, and even one's own language. The host country indeed offers different-tasting food, new songs, different political concerns, and unfamiliar language, but these cannot fit our psyche the same. Alongside these losses, there is a renewed opportunity for psychic growth and alteration, new channels of self-expression and new identification models, for sure, but one thing is clear. Immigration results in a sudden change from an "average expectable environment" to a strange and unpredictable one, as Hartmann said. The decision to migrate emanates from a complex interplay of intrapsychic and socioeconomic factors. However, it isn't easy to say, when the focus is disproportionately on the socioeconomic factors, how much thinking and consideration goes into a more comprehensive and multidimensional review to make a well-thought decision.

As the journey starts on a very high note of resentment and abandonment, also with an objective to fulfil the true and idealized self by breaking free from an oppressive figure and relationship, returning to the origin country represents a regression which is perceived as a loss and comes with a high cost of a



sense of failure hence shame attached to it. Therefore, many share their idealised self and idealised figure on social media and speak highly of their new lives and host country regardless of the artificiality. However, the wider the gap between the true and idealised self, the bigger the disappointment and psychic pain.

But a lot of the story remains unwritten. Many papers in the literature examine the profile of medical professionals emigrating and the reasons behind it. However, what happens after emigration is unclear, and there is a very sparse amount of information in the literature about these people. It is almost as if they disappeared.

What about Western countries? The GMC estimates around 4% (which equated to approximately 4950 doctors) permanently leave the NHS every year, whilst the European average is 3.2%. When doctors in the western countries also leave with similar disappointments by the NHS and government, how is it possible to be sure about how much of these wishes and hopes are going to be fulfilled as well as the room for growth?

I am also a Turkish doctor who has been working and living in the UK for seven years. I, too, received some insights and advice about working abroad, but most of it was unidimensional and in favour of emigration. I do not regret the decision, but I would sooner embark on my journey better equipped than learning almost everything through experience. When I reflect on my journey, what I wish I had known, is the objective, clearer picture of migration with psychological insight into it.

Hope triumphs reliably over experience. So rather than adjusting our ideas of what it is meant to be like, we shift our hopes to a new target on which we can direct our recklessly elevated hopes. That's why the rest will remain unwritten.

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‘What I wish I’d known...’

By Dr Stephanie Charters

John Lennon once said: “Life is what happens when you’re busy making other plans.” As a psychiatrist, I wish I’d known that your working life is what happens when you’re busy making plans for other people.

Juniors see the role of the Consultant Psychiatrist as a goal to aim for - the light at the end of the training tunnel. During training, there is a well-tested support structure, provided by clinical and educational supervisors, peers, senior colleagues and a Training Programme Director.

Like many other colleagues, I followed that quest to become a Consultant Psychiatrist; Senior Clinician; Leader in that all-important Multi-Disciplinary Team.

With great power comes great responsibility, for others. In the role of clinical or educational supervisor to junior colleagues, who look to you for guidance and inspiration. As a clinical leader, providing the vision, whilst absorbing the anxieties of other colleagues in a busy inpatient team. Most importantly of all, as a doctor, meeting acutely mentally unwell people, gaining their trust, and working collaboratively with them as they become well again.

What I wish I’d known...is that whilst focusing on my responsibilities towards these other, extremely important, individuals, I wasn’t nurturing my own needs, ambitions and development. After many years of giving myself wholeheartedly to my work with others, and enjoying that process immensely, I now find myself in need of the same guidance and inspiration. We physicians are not so good at healing - or guiding - ourselves.

What would have stayed the same

Looking back, I wouldn’t have done anything differently where my responsibilities to others were concerned. I am proud of my work with patients and their relatives and carers, with colleagues and with trainees.

If I have one piece of advice on working with others it would be that everything comes down to good communication. And communication is, of course, listening as well as speaking.

Whether it is truly hearing what a patient is trying to convey about their experience of mental illness and its effect on their life.

Or acknowledging their relative’s wish to be involved, whilst being aware of the often complex family dynamics, and ensuring that your primary duty of care is to the patient. Often all that is needed is to provide a safe space to discuss their views or concerns, and to use negotiation to find an approach that works for everyone.

Or recognising a team’s concerns about the acuity on a ward, or the pressure of a large caseload. The anxieties they experience as a result can in turn impact negatively on their ability to support those in their care. The resolution may be as simple as finding time to meet as a group to give individuals an opportunity to express themselves. Reflecting back to them that you understand their concerns. Working collaboratively to devise a team approach to resolve the situation safely.

What might have been different

These are not regrets, nor am I wishing for a better past, but perhaps others might learn from my experiences.

I could have paid more attention to senior colleagues who recommended making time for my own development. I felt that clinical work was so time-consuming, and that I had to prioritise it, making it difficult to find time for myself. To my younger self, I would argue that the patients, and the team I was leading, could definitely have managed without me for a few hours a week to allow me time for reflection, self-directed learning or to attend a conference or two.



In the current climate, NHS workers can spend a lot of time complaining about the status quo - and I am as guilty of this as the next person. There is almost a group therapy effect here. When one person highlights their disagreement with the actions of hospital managers, or bemoans the poor funding or downgrading of services, or the paucity of acute admission beds, it is very easy to fall into groupthink, and agree with their complaints. It would have been better to harness this passion, turn it into action, identify something with the potential to be changed for the better, and encourage others to join me in my aim. These days that would be called a QI project!

Also, I would have made more effort to spend time with colleagues outside the workplace. Psychiatry is a wonderful specialty but can be mentally and physically draining. Sharing experiences with understanding colleagues, who can both sympathise and empathise, is a practice that can be neglected whilst working flat out, attending training, working on-calls and trying to balance this with a home life.

Experiences that have shaped my practice and made me the person I am today

One of the aspects of psychiatry which I love most is the opportunity to meet so many people. Patients, colleagues, trainees, relatives and representatives of agencies outside the NHS. Meeting people from different walks of life and with different viewpoints has definitely shaped my practice, and for the better.

Some individuals stand out:

- A consultant who inspired me when I was a junior, and later became my mentor;
- A nurse who made my job on a busy inpatient ward so much easier (and more fun);
- The many juniors from whom I learnt as much as they did from me;
- A consultant peer who I spent many years working alongside, sharing successes and stresses, in a job that can be very isolating;
- A patient whose illness I was unable to change, whose story was heart-breaking; and
- Another who, after many years 'lost' to psychosis, recovered after only a few weeks of treatment, and was reunited with his long-estranged family.

And my advice...

Every psychiatrist's working life is different. So far, mine has been thoroughly rewarding but, as I approach a self-imposed period of reflection, I would encourage those of you treading a similar path to look after yourselves as well as you undoubtedly care for your patients and colleagues.

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'Why we are important – A focus on therapeutic alliance and person-centred care'

By Dr Bharat Velani

As I reflect on my years as a foundation and core trainee in psychiatry, I realise that there were questions that I often found myself asking, "Am I helping? What is my role in caring for this person? Am I making a difference?".

Life as a junior psychiatrist can feel confined by factors that are driven by service provision such as documentation during ward rounds and clerking-in new admissions. The key management decisions are often made by consultants or registrars. There are, of course, understandable reasons for this. However, it has sometimes left me feeling like a witness to events rather than an active part of the process. At worst, one can be left feeling complicit and ashamed when decisions are made with which one may not feel comfortable. It can cause us to question what it means to be a psychiatrist.

The aim of this article is not to dwell on the negatives, but to seek to inspire and empower psychiatrists in training. In the face of clinical complexity, treatment-resistance, uncertainty and competing agendas in our healthcare system our ability to empathise and our capacity for meaningful reflection can help put the patient back at the centre of the therapeutic framework. Our interpersonal skills and how we conduct ourselves during clinical interactions should be the central hallmark of a quintessential psychiatrist. These skills can be worked on and, importantly, practiced from the very beginning of our training.

There are many avenues by which we can help our patients. Central to a lot of them will be the psychiatrist's role in the therapeutic relationship. During any clinical encounter there are complex psychodynamic factors at play between the caregiver and the person receiving care or their family/carer. Paying attention to these dynamics and developing an understanding of our role in them can help empower us to make a positive impact on peoples' lives.

First believe...

What we say and how we act during a clinical encounter makes a huge difference. Although this seems obvious, I sometimes found myself knowing this but not believing it. There is in fact a wealth of evidence underpinning this statement. For example, secondary analysis of data from the Treatment of Depression Collaborative Research Program suggests that prescriber characteristics may have had more influence on outcome than what was prescribed. We know that tailoring prescribing and management strategies based on patient preference enhances treatment outcomes. There is evidence to suggest that characteristics such as empathy, warmth, openness and sincerity have tangible benefits. It is beyond the scope of this article to review and cite all such evidence.

However, knowing that it exists has helped me to believe that every clinical encounter is important. It has helped me to believe that I am valuable and to rebalance the focus of my attention during training.

Then observe, reflect and learn...

Consultants are a wealth of knowledge. Quizzing them (or allowing them to quiz you!) on diagnostic formulation, psychopathology or medication options is time well spent. However, there is more than one way to learn from our seniors. During ward round, for example, observe the interaction between your consultant and the patient. Pay attention to what each party is trying to communicate. Take note of communication styles and inter-personal dynamics. Notice how the clinical encounter makes you feel. I have found writing reflections increasingly useful as I progress in my training. If a particular encounter makes me feel a certain way, bringing that feeling to Balint groups and discussing it in supervision has helped me learn and grow as a doctor.

As practicing clinicians we are placed in between the person in need of care and the healthcare system that is trying to provide that care. The two often have competing agendas and I believe that understanding



what these are and how they exert their pull is fundamental to training. This can be done by trying to expose yourself to both sides from as early on as possible. From the patient's side, spend time listening to what they are trying to communicate and immerse yourself in stories of lived experience. There are now a wealth of podcasts and resources available that communicate things from the patient's perspective. From the other side, take up roles of responsibility such as junior doctor representatives or BMA local negotiation committee members. Take part in service evaluation and quality improvement projects and work together with non-clinical colleagues.

Why it is important

Personally, this has really helped develop an understanding of the complex psychodynamics at play in every clinical encounter. This awareness has helped me to try to adjust my approach to be more person-centred and hopefully to develop meaningful therapeutic relationships, however brief my part may be in the person's journey.

Chloe Beale, Consultant in Liaison Psychiatry, has recently reflected in a poignant article that it is often "a simple recognition of distress and a desire to help that connection on a human level that so often makes a difference to people." We can all afford people dignity, compassion, and respect. The importance of person-centred medicine and the therapeutic alliance are not novel ideas but the new core trainee curriculum goes a long way to re-focussing our minds on reflective practice and person-centred care. I would urge budding psychiatrists to read it and start to embody some of these principles in their approach to training from the very beginning.

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‘Another round of induction’

By Dr Avani Puri

Starting as a psychiatry core trainee is an exciting and also daunting experience. Having never really considered psychiatry as a career path until my second year of foundation training, I wasn't completely sure what to expect, nor did I realise how steep a learning curve it would prove to be. My first induction was a whirlwind of information, and the first couple of months passed by far more quickly than I could ever have expected!

A year on, sitting in a different hospital, with new faces all around, for another round of induction, I realised just how much I have learnt since that very first day. As a new CT2, here are a few things I would tell my slightly younger self to make the most of embarking on core training...

Use a diary/calendar! It may seem obvious but a core trainee has a range of commitments, including on-calls, psychotherapy, Balint group, teaching, preparation for MRCPsych exams, portfolio – add to this your life outside of work and it can seem quite overwhelming! Setting up a calendar can help to compartmentalise your time, remind you of important dates (e.g. when to apply for an exam, portfolio deadline, etc.), and allow you to better manage your work-life balance.

Take the full allowance of annual and study leave throughout the year – and make use of the study budget. Check with the medical education team how you can utilise the study budget, whether it be for revision resources, specific courses or conferences you would like to attend.

Getting one hour of your clinical supervisor's time each week is invaluable. This is protected time, no matter how busy your day. Discuss with your supervisor how you would like to use this time, for example, completing workplace-based assessments, medication queries, or discussing on-calls. Supervision has made me feel supported, helped me gain a deeper understanding of clinical conundrums, and also feel inspired!

Get to know your whole team, ask what they do and

spend some time shadowing them. Psychiatry is a truly multidisciplinary field. You will learn much from your colleagues – many have years of experience and know the patients well. Furthermore, integrating with the team and developing your professional relationships improves your own wellbeing at work and also enhances patient care.

Set up your portfolio as soon as you start, and become familiar with the requirements. Don't be afraid to ask a senior to observe you when assessing a patient in the early days – they were in your place once and can provide constructive feedback! Completing assessments as you go along not only helps as you approach the portfolio deadline, but it also enables you to reflect and deepen your understanding of situations.

Get to know the other trainees – you become each other's therapists! Being in a community post can feel more isolated compared to ward-based posts; induction is a good time to exchange contact details so you can keep in touch.

Check with your local tutor early on about the process of starting psychotherapy cases. This can vary between sites and it is useful to have a rough timeline of when you are going to start and finish – keep in mind there are a minimum number of sessions required for both the short and long case..

You have the privilege of time with your patients, so get to know them and their stories – be curious and compassionate. Don't forget that we are people treating people, so be kind to yourself too and ask for help when you need it.

Trying to understand the human mind is fascinating and complex. So above all, when starting this journey, don't forget to have fun!

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‘What I wish I’d known...’

By Dr George Coates

In the 1995 rap song "I Wish" [1] Skee-Lo laments how he longs to be a little bit taller, that he was a (basket-) baller, and that he could obtain attractive women, if I'm going to paraphrase slightly. I believe that Skee-Lo has hit immediately on my idea that this question can be taken in two different ways.

One of the ways in which this question can be taken has, for me, a clear answer, but also a clear response. "I wish I knew everything, clinically, professionally, metaphysically". If this were the case would work not be a dream? Imagine the look on everyone's faces as you correctly diagnose Stendhal syndrome [2] as yet another patient experiences tachycardia, fainting, confusion and hallucinations at your magnificence. One could clear A&E and fill the local HBPOs in an afternoon, much to the annoyance of your colleague who is on call that evening. For me, the beauty of this job is that the moment at which I believe I am starting to understand it, fate conspires against me and a harsh reminder is delivered as an American patient uses brand names for every day medications, making me feel like I don't speak my own language. Every day is for learning, and I'd have to find another profession if it wasn't.

Let's rub the lamp again and see if we can land on something less idealistic this time! The other way in which this question can be answered is to ground one's answer in one's experiences. I have often found training to be a lonely experience. As a trainee you meet like ships passing in the night, wearily handing over the phone at ever-more-detailed handovers when all you want to do is make the long trip home, inhale any sustenance that is in your fridge, and sleep, to then wake up and do it all again the next day. Alongside this, you must tick many boxes which will be checked by a faceless review sometime in June, and then the number after your letters gets increased by one. At certain points your letters even change. This may be a cynical view of it all, but I can't say that I haven't felt like this at times. However, what I wish that I'd known is that there are people out there who take a real interest in you, and in a professional way, care about you. For some this may be obvious but it took me a

long time to realise it, and to accept it.

My most important moments of development and growth have come from those moments when supervisors, peers, and other colleagues have reached out and crossed that invisible line somewhere between supervision and mentorship. Those conversations have been the hardest, the most reflective, and at times the most dismissed, but they are the people who can realise that what they've said isn't the easiest to hear, but they knew where they were going with it, and I had to work it out. Earlier in my career I would have dismissed these approaches as misunderstandings, malicious negative feedback, or clueless individuals who didn't see what I was doing the rest of the time that I wasn't with them. The reality couldn't have been further from that, and these were people exposing their own vulnerabilities so that I might accept mine. I remember being affronted when asked why my mini-PAT didn't match the ludicrously high average, and trying to reason my way out of that situation by proving how it was mathematically improbable for the average to be that high. I'm fortunate that my mentor was brave enough to challenge me and then reach out for discussion and support, and I was much more careful who I asked to do my next mini-PAT.

To build on my wish, I suppose that I wish that I could also have the courage to seek this raw and brutal feedback out myself, and to be able to contain it in a productive way, but alas I think that is too much to ask. I wish I'd known that the system that sets us up for overwhelmingly positive feedback isn't helpful at all. It isn't our fault that we are in this system, however that doesn't mean you have to conform, and I say that to both sides of the assessment. Be brave enough to challenge and to be challenged. I do wonder whether these relationships would have been different if I was a little bit taller though.



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ST6 General Adult Psychiatry

‘What I wish I’d known about qualitative research’

By Dr Dan Siddiqui

Research. A fundamental part of science and a bedrock of clinical medicine. As for psychiatry, research continues to play an evolving role with cutting edge abilities to unravel and propel this specialty in the world of modern medicine.

Yet, research is generally not a major part of the medical school experience or journey to becoming a doctor. Getting involved in research often relies on the ambitious medical student to navigate their way of their own volition, or following ones deep personal interest, or making headway through networking at wider medical events, or pursuing a consultant supervisor. All these avenues place the onus on the student. It may reflect the reluctance and limited participation of many doctors in research as they focus on day-to-day clinical medicine whilst climbing the career ladder in their respective specialties. It may also reflect the barriers and challenges around research, its opportunities, and access to ground-breaking research in this country. It is likely an interplay of various factors. What I have realised as a psychiatrist, is that this umbrella term ‘research’ means different things to different people. Personally, trying to step into the world of research brought me hesitancy, questions, and the thought that intellectual academia lay beyond me. These reservations along with worry about time commitments, quickly caused a rebound effect,

pushing me towards focusing on postgraduate exams, day-to-day practice, developing clinical psychiatry, and working towards that goal of becoming a consultant – the expert specialist in my chosen field.

Now I find myself, on the cusp of completing training and becoming a consultant, with the feeling of little research experience in real terms, along with resounding apprehension. Yes, as part of my core and higher psychiatry training, I have presented at journal clubs, evaluated papers, appraised articles, conducted literature reviews, collected and critiqued data, passed the statistics module of the Royal College of Psychiatrists’ membership exam, read journals, many of which I have an active subscription to, but nonetheless, I find myself a novice in the big wide world of research. As part of my special interest during higher training, I embarked on an under-discussed area in psychiatry of learning disability; sex and relationships. Little did I know an opportunity may arise for turning this work into a piece of research.

Having assembled, offered and delivered a series of twelve-week programmes on sex and relationships with a trainee clinical psychologist colleague and peer, to groups of adults with learning disability, we found ourselves wondering how our project really went down. How well was it executed? Did people enjoy it?



Did we pitch it at the right level? What did they learn? Was it useful?

After asking each other these questions back and forth, we quickly realised we did not have all the answers. We suggested devising a simple survey to gather thoughts and feedback from participants. Following some brainstorming, this idea translated into an adapted easy read invitation to take part in a video interview with accompanying comprehensive yet relevant information around its purpose. Ethical consideration and guidance on consent was sought from both the professional hub and expert-by-experience body.

Qualitative research has received increasing attention in health care. Where traditional quantitative methods are deductive and analyse trends, qualitative research seeks to establish the understanding of phenomena through description, meaning and experiences.(1) After reading about the two broad methodologies within qualitative research, we were inclined towards the phenomenological approach. Phenomenology endeavours to understand the subjective lived experiences of individuals, while grounded theory evaluates phenomena and constructs theory through discovery of patterns in the analysis of data.(2)

Aiming for no more than a total of eight subjects for the study, we invited all attendees of our sex and relationships course to go through the easy read pack with them, allowing a 'cooling off' period for them to decide if they wanted to continue with the interview process and beyond.

We had decided to proceed with Interpretative Phenomenological Analysis (IPA) as our chosen method of inquiry. IPA declares a commitment for collaboration by encouraging exploration of experiential meanings through interpretive work between the researcher and participant.(3)

We attended an IPA focus group at the Institute of Psychiatry, Psychology and Neuroscience at King's College London, where we felt lost and overwhelmed. With students from various institutions presenting

parts of their research and sharing experiences, we found ourselves surrounded by what felt like a sea of qualitative data, waves of themes, and boats of researchers boldly negotiating these waters. It was here we made some practical sense of qualitative research, the processes, realities, challenges and joys. We found out that even four participants is a worthwhile number in the world of qualitative research. Four? Really? Is that enough to be considered proper research?

After interviewing six participants, we generated verbatim transcripts, and launched ourselves into themes and analysis. This is where we stand today. Finding our way in the world of 'double hermeneutics', a key underpinning of phenomenological analysis, where the researcher strives to make sense of the participant making sense of the world. This is best achieved through reflexivity, a process of becoming aware, being mindful and shining light on how the researcher's own thoughts, perceptions, attitudes, and beliefs influence the interpretation of the participant's world, and consequently the outcome of qualitative research.

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‘Taking a relating space’

By Dr Camilla Fadel

I recently paused for thought after overhearing a psychiatrist say “I am not here to manage relationships”. Having moved from working as a psychiatrist to become a relationship therapist, this line was sure to pique my interest. My role now certainly is to manage relationships, but I would say that working in mental health, it always has been. This was not the first time I have been curious about a seeming reluctance to consider relationships in depth as part of mental healthcare and exploring this felt fitting for this issue of the Psychiatric Eye. I will start with why we may pull back from discussing relationships before moving on to how mental health can be positively impacted by taking a little more space for relationships. I conclude by considering what core tenets are needed for supporting relationships within mental healthcare.

1. Why mental health professionals may not want to look at relationships

A psychotherapy colleague noted a meeting where there was complete shutdown. No-one wanted to talk anymore about the patient, the air was thick and risk management was key. In searching for an immediate solution all curiosity was slowly squashed from the room. This response can be automatic when an area is complicated and uncertain. Mental health and relationships are both of those things and there is every reason to wish to simplify things by separating the two and focussing on the immediate problem in front of us. This is only added to by high standards, believing we ‘should already know’ and then perhaps making ourselves vulnerable by admitting we don’t always know the answer and being curious. I have encountered this dynamic both as a clinical educator and therapist. I believe the first thing here is to note that this dynamic occurs, and then to attempt to give more room to thinking about relationships.

2. How is mental health impacted when we take a larger relating space

In a counter to looking for an immediate solution, the value of taking time to consider relationships in more depth is recognised as imperative across the whole of mental health. Many therapy disciplines - including

Interpersonal therapy, Dynamic Interpersonal Therapy, Systemic Therapy and Dialectic Behavioural Therapy - all focus on the direct overlap between mental health and social connection and/or the key role in supporting people around interpersonal conflict.

Supporting relationships means considering not only the patient in front of you but also the wider relating group. Carers and relatives can be more susceptible to mental illness due to a myriad of factors, including their caring responsibilities and having a relative who is unwell. Relational management, therefore, can be seen as a proactive and sustaining action to futureproof the mental health of those around the patient.

3. What core tenets can support relationships

Relationship focus in psychiatry could be improved in three ways; modelling the value of relationships, communicating about relationships more, and looking out for relationships at work.

i) Modelling the value of relationships

This can be achieved by demonstrating excellent interpersonal skills in consultations with patients. Language might be adapted to include ‘I feel’ or ‘I heard’ rather than ‘you are’ or ‘you said’ and avoiding absolutes such as ‘always’ and ‘never’. Boundaries can be set by making clear plans, noting limits, and suggesting alternate approaches. This creates a base for systemic questioning and encouraging more curiosity when things feel stuck, including considering how mental health may be directly linked to social context.

Remembering to ask how carers are managing and how they navigate the relationship with a patient is important and can indicate when to signpost carers to mental health support for themselves, as well as providing essential information regarding relationship dynamics



ii) Communicating about relationships

We consider reasonable adjustments in vulnerable populations such as those with dementia or an intellectual disability, yet relational adjustments are relevant across mental health care. Formulating a relational handover of what may help an individual in communicating, setting boundaries, and noting relational risk factors may be involved in their distress can be significant. Names or dates can often be lost yet are potential triggers when someone may have incurred a relational loss including bereavements, separations, and pregnancy loss.

iii) Looking out for relationships at work

Taking a team perspective can be helpful to check how a group may be experiencing working with an individual and with one another. As healthcare professionals often deny their own vulnerability and can lose sight of the boundary between work and home life, individual 'social check-ins' can help to protect against burnout.

In relationship therapy, the concept called 'love languages' has been described. These are five areas that can build connection between people; acts of service, gifts, verbal affirmation, touch, and quality time. These concepts can also be brought into our work to consider ways to build connection, not only with patients but also with mental health teams, such as how to support one another in a given task, providing appreciative feedback, and planning social events.

If I were to respond to the psychiatrist who prompted me to write this article, I would in part agree with them. Relationship management is not just their role - it is everyone's. If a village supports a child, it is a village that supports an individual with a mental illness - and

every relationship matters. Taking time to explore relationships has numerous benefits and is imperative to anyone working in mental health.

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“Youth mental health awareness in a musical in London ”

By Dr Mihai Pop

In the UK mental health awareness has been on the rise in the last decade or so and many TV shows are commonly portraying mental health issues amongst young people. This can be done in various shapes and forms, however depicting them in the world of musical theatre could be seen as challenging but quite unique. The difference here is that it is delivered to a live audience which can make for a rather unrefined conveyance of the information.

I was invited by one of my very good friends to London’s Noel Coward Theatre to see the Broadway hit Dear Evan Hansen. I have to be honest, I just could not find the time to read a bit more about the story before the show and so I allowed for the element of surprise to take over my experience.

The musical does not begin with music but with noise. The audience is thrown into the roar of the internet: a cacophony of car insurance ads, cat videos, scattered shards of emails and text messages and social media status updates. And then, all at once: silence. On stage, in front of a laptop, it’s Evan, a 17-year-old boy in his bedroom, alone, writing a letter to himself as part of an assignment from his psychotherapist. ‘Dear Evan Hansen, Today is going to be a good day and here’s why ...’ [1-2]. The thought behind the letter is that “positive outlook yields positive experience” [1]. Evan suffers from social anxiety and he feels invisible amongst his classmates on his first day of school. That is when he decides to continue writing the letter but on a different tone... “Dear Evan Hansen, I wish that everything was different. I wish that I was a part of something. I wish that anything I said mattered, to anyone.... would anybody even notice if I disappeared tomorrow?” [1-2]. He prints the letter in the library but then another boy, Connor Murphy, a very troubled young man, picks up the letter, goes home with it and kills himself. Through a series of events Evan finds himself cast as Connor’s only friend and becomes the centre of ‘The Connor Project’, which uses social media to raise awareness of teenage suicide.

As an International Medical Graduate who has now been working a bit over 3 years in the field of

psychiatry in the UK, I find it fascinating to see the level of youth mental health awareness amongst new generations. Having studied Medicine in a developing country which sees mental health issues at the bottom of the list when it comes to public health issues, I am impressed, hopeful and so happy to see that the stigmatization of such an important topic can be soon eradicated. It was a truly magnificent experience. Even though the subject can evoke certain emotions in people, I feel like the musical delivered the message in a rather soft way – through music. The anthem of the show, ‘You Will Be Found’, is beautifully making its way into school choirs. It demonstrates the desire for children today to know that they are not alone, that mental health struggles are important and so is asking for help.

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'Then and Now'

By Dr Harold Behr

I am eighty one years old now, so my retrospectoscope has a long-distance focus.

In the 1960's, during my early post-graduate training experience in South Africa, I was steeped in the world of hospital-based psychiatry. The head of department was a keen geneticist and phenomenologist and I, as a novice, diligently followed his line. Physical therapies and pharmacotherapy were the be-all and end-all of my therapeutic repertoire. Psychotherapy was a murky pool in which there was a polarisation between behaviourism and psychoanalysis. Insofar as I was prepared to wet my feet in these waters, I chose to associate with the behaviourists. Their clear-headedness and rationality appealed to me more than the woolly thinking (as I saw it) of the psychoanalysts. So my cautionary word to trainees is, learn from your teachers but listen to your inner voice at the same time. I wish I had done more of the latter.

My tendency to adopt the theories and methods of my teachers followed me through the next decade or so. In the 1970's I worked at the Maudsley, a teaching hospital renowned for its intellectual rigour. There, I was influenced by the doyens of organic psychiatry but my ardour for diagnosis and classification began to cool when I came into closer contact, through supervision, for example, with psychiatrists of a more psychoanalytic persuasion. I gradually learnt that there is no 'one size fits all' for psychiatrists. Who you are temperamentally and by inclination, should determine your choice of sub-specialty and professional orientation as much as your exposure to the leading figures of the day.

In the 1970's I became a child psychiatrist and gravitated towards a psychotherapeutic and group-centred approach to psychiatry. Here too, there is a 'yesterday' and a 'today'. The emphasis which I had earlier accorded to treatment of the group as a whole was overtaken by my individualistic instincts. I learnt most of what I know working in a zone where the individual was the primary focus of my treatment, albeit in the context of relationships and the community. I wish, therefore, that I had spent more time in conversation with patients and proportionately less

time trying to understand and reconcile different theoretical viewpoints.

My passage through the profession was mirrored in what I chose to read. At first, I was eager to mug up textbooks and papers which argued for a scientific take on psychiatry. I spent many hours poring over multi-author articles bristling with statistical data, charts, diagrams and acronyms, rounded off with long lists of recent references. All of these gave ballast to the writing but only served to convince me that in the long run I was not cut out to be a scientist. In contrast, writings which presented anecdotal evidence and emphasised the uniqueness of the individual stayed more in my mind and gave me more to think about than scientifically orientated papers which focused, often with disappointingly tentative conclusions, on diagnostic entities which seemed to be planted in shifting sands.

Today, my readings in retirement consist mainly of history, biography and a wide scatter of fiction. A few psychiatric journals and two or three of the great textbooks, in which many passages have been carefully underlined by me, still lie on my shelves, gathering dust. My overall wish is that I had followed the advice of that old rogue, Polonius in 'Hamlet', earlier than I did: 'To thine own self be true, and it must follow, as the night the day, thou canst not then be false to any man.'

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'Rhythm & The Blues: How Kendrick Lamar is redefining Hip Hop's relationship with mental health'

By Dr Nataly Gibson

'Mr Morale & the Big Steppers' is the fifth studio album released by Kendrick Lamar in May 2022 (1). As a Psychiatrist, hearing a (ridiculously) famous Black rapper talk intimately about going to therapy, attachment, childhood abuse, generational trauma, and gender identity, I was moved to tears. As a scholar of Hip Hop since I had ears, I rejoiced in this album. There is nothing quite like it, and I hope this is a sign for things to come. As soon as I heard the lyrics, "I went and got me a therapist" in the first song, 'United in Grief', my ears pricked up, and they stayed that way the whole 78 minutes. If that wasn't enough, the album is interspersed with narration from a Freud-like character/therapist (with an accent to boot), offering soundbites such as, "this is how we conceptualise the human condition".

A few of the songs stood out for me.

The song 'Father Time' introduces Kendrick's self-confessed 'Daddy issues', recounting the "tough love, bottled up...neat, no chaser" and how he was taught that, "men should never show feelings, being sensitive never helped". Kendrick opens up about the difficulties in children's relationships with their fathers; something more commonly described from a female perspective in the stereotypical 'Daddy issues' trope.

'Auntie Diaries' discusses gender identity. With lyrics such as "My Auntie is a man now...I think I'm old enough to understand now", Kendrick talks about how he took pride in his Uncle's transition. He recalls a time when his cousin, who is also transgender, was called out negatively by a religious leader and how he defended her. Elsewhere, Kendrick takes a stance against the homophobic 'f-word' (a term he admits to previously using as a thoughtless slur), and how the aforementioned experiences with his family have made him more mindful of the word's hurtful nature. A song like this is unprecedented and a bold statement from an artist whose Hip Hop audience is likely accustomed to the use of homophobic and transphobic lyrics.

'Mother I Sober' is an extremely powerful song, talking about generational trauma in Black communities: "I pray our children don't inherit me and feelings I attract;

a conversation not being addressed in Black families; the devastation haunting generations and humanity". He goes on to talk about this abuse and how other rappers "bury the pain in chains and tattoos". He implores the listener to not to judge these people on how they cope and likens it to PTSD. Near the end of the song Kendrick makes a series of statements 'setting free' these feelings: "As I set free all you abusers, this is transformation!", is Kendrick almost giving anyone who feels this, permission to address their trauma, face it, and start to heal in some way. At the end of the song is an emotional quote from his partner and child thanking him for breaking the generational curse – "I bare my soul, and now we're free".

I have only talked about three of the nineteen songs on this incredible album. Even if you are not usually a listener of Hip Hop, I would encourage you to listen to it as a mental health professional. This album is a war cry against the toxic structures that prevent people from acknowledging their trauma and seeking help. It is especially poignant for young Black men, and I can only hope this is the beginning of some sort of societal shift.

I hope Kendrick sets them free.

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[1] Mr. Morale & the Big Steppers by Kendrick Lamar (May 13th 2022). Released by PGLang, Top Dawg Entertainment (TDE), Aftermath Entertainment and Interscope Records.

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‘Lessons from the Benchmarking Report for Learning Disabilities Services in London’

By Professor Angela Hassiotis

Benchmarking, in its broadest application, not only compares health indicators, but is also a tool which utilises “voluntary and active collaboration among several organisations to create a spirit of competition and to apply best practices”(1). Therefore, a key feature of benchmarking is its integration within an ongoing strategy of quality improvement. Benchmarking can be useful in driving changes in services and developing and sharing good practice. Other by-products of benchmarking are setting priorities for population health, contributing to local implementation of the NHS Long Term Plan goals, and improving patient safety.

The NHS Benchmarking Network acts as a platform for a large number of health providers who provide a wide range of data about health workforce and services across a number of population groups. The NHS Benchmarking Network includes several sectors and publishes data on systems, commissioning of care, acute care, community services and mental health. The mental health sector issues a number of dashboards about the performance of services across the lifespan. The available materials have a specific domain about London-based services, but this does not include any data about learning disability services. There is a separate publication on learning disability which is based on a smaller number of health providers in England as not all Trusts submit evidence about services for people with learning disability. The most recent report published in 2021 has a data cut-off of 2020.

There are limitations of the benchmarking report, not least data prior to the COVID-19 pandemic and the low number of respondents from London. The data can be submitted only by health providers and as this is not a mandatory submission, there is likely underreporting of both challenges but also successes. Why focus on London? There are multiple reasons. It is one of the most diverse cities globally, with 41% of its population from BME groups. There is significant social disparity, lack of affordable housing, and staffing shortages. Whilst there are several positives, such as the high uptake of health checks and the multidisciplinary

nature of community learning disability services, there are many more issues that are cause for concern and require targeted attention. The large number of secure inpatient beds, the increased number of people from BME groups who are inpatients, low staffing levels, unstable accommodation, long inpatient stays, and long delays from assessment to treatment must be addressed. There is evidence that the policies around Transforming Care(2) have not succeeded as anticipated; it is unlikely that there is a single reason as to why this is the case, and a properly staffed and skilled workforce would be needed to maintain people with intellectual disability who display behaviours that challenge in their own communities. The cultural competence of the community learning disability services needs to be explored, followed by development of more effective ways in which to manage liaison with and engagement of service users and their families. The funding gap must be levelled up. There are often difficulties in commissioning tailored accommodation for very complex cases in London, and many of those require bespoke care packages. Not only has the investment in learning disability and autism services in London been lower than in 2014; it will be further eroded in real terms given soaring inflation and the expected economic downturn.

We have not really seen the benchmarking report on learning disability being utilised as intended. However, it is timely to place it as part of the commissioning agenda for new services that are being initiated within several London boroughs. People with learning disability in the capital deserve properly funded high quality services.

For further information see: NHS Benchmarking Network <https://www.nhsbenchmarking.nhs.uk/>



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‘How to find hope in hopeless times...’

By Dr Alzbeta Karlikova

"In the midst of winter, I found there was, within me, an invincible summer." — Albert Camus

Acutely aware, that hope may be one of most powerful therapeutic aspects of the doctor-patient relationship (1,2), as well as, out of all the people, Napoleon’s quote that a leader is a dealer in hope, it was clear to me, that going into medicine and psychiatry especially, we are in the business of hope. Hope that does not overpromise or sugar-coat the painful reality, but that steadfastly shines in the darkness. And the darker it would get, the more it would shine...

At first, it seemed easy to find. It was in the little things – smiles, connections, new drug charts, successful leave from the ward, new training opportunities, gentle encouragements of ‘keep going at it, you’ll get there’...

However, through the years, the heat of an endless conveyor belt of patients, demands, and ever-changing reality, kept testing the systems. Hope became rarer to come by, but not impossible. Then COVID-19 hit. Overnight, the line between patients and staff blurred – the fact that we were all potential patients became more palpable.

In the silence of our streets, we could suddenly hear the painful stories buried deeply in the daily hustle and bustle of our lives, stories of inequality, and structural discrimination along lines of race and gender. As months went by, the hope became paper-thin. As did the hope there was somehow a way to return to the innocence of our past. We find ourselves living in a fearful and deeply troubled world, restless with war, raging mother Earth, and a cost of living crisis.

On the day of deciding to write a contribution about hope, our service found itself stricken by the grief of losing one of our colleagues - general manager and friend to so many, Olu Oyerinde. And for the first time I wished I really knew how to find hope in hopeless times.

Olu was a person who had ‘a kind of magic’. The invisible touch of loving kindness, an apparently limitless resource, despite the adversities of his own life. Even when seriously ill, from his hospital bed, he kept recruiting to CAMHS and keeping his colleagues in mind, even those he never met. He deeply cared for everyone else around him up until the end.



Olu did not only leave behind his grieving family, friends and colleagues, but also a legacy of hope. Somehow, he embodied the hope we so desperately need to keep in touch with in these uncertain and testing times.

Hope, that things will be better if we keep trying, that what hurts today may heal tomorrow. Hope that lies in a deep understanding that the true wealth of this profession lies within us and who we are to each other; patients or staff. That no matter how big the distance between us may be, whether it be religion, race or mental illness, we have the incredible ability to be the bridge that can connect us all. Hope that if we keep showing up every day, the hope Olu showed will never die, as it will keep living in thousands of little seedlings, sown in every person he came across, whether it be the young people he looked after or us, his colleagues.

How was he doing it? After all, he was living in the same world as we did. Hearing accounts of generosity, warmth and an endless desire to leave the world a better place than how he found it, his life is a poignant reminder, that maybe hope is not something to be found. Hope is a choice. A brave choice we can make every day. For those we look after and for ourselves.

Olu chose it. Every day. And so should we.

On behalf on our team, with gratitude for the endless invincible summer you brought to so many and to us, thank you, Olu.

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In Loving Memory of Dr Olu Oyerinde



Exhibition at RCPsych – “We Are Not Alone”: Legacies of Eugenics



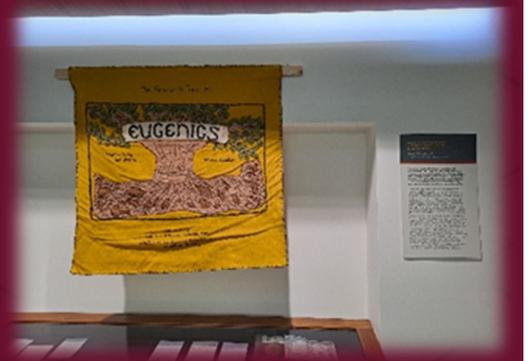
The College is currently hosting an exhibition exploring the history and legacies of the eugenics movement.

The exhibition was created by Professor Marius Turda and was first hosted at the Wiener Library in London. Since then it has travelled to Romania, Poland and Sweden, and in April 2023 will be visiting Harvard University.



The History of Psychiatry Special Interest Group has worked with Professor Turda to add a panel discussing the RCPsych and its members' involvement with eugenics, in the hope that by exploring and accepting our history, we can better challenge systemic inequality and prejudice in healthcare today.

The exhibition will remain in the College until 24th February 2023 and we hope members will visit. You can also watch the accompanying webinar '[Confronting Eugenics and its Legacies in Psychiatry](#)', which is available freely on demand.



Find more information on the [RCPsych website](#).

Fiona Watson | Library and Archives Manager | Royal College of Psychiatrists



Save The Date - Upcoming London Events

London Division Autumn Conference 15 November 2022

Please visit the [London Division events page](#) for more information.

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Winning Article

Congratulations to Dr Harold Behr, winner of Best Article for their submission:

'Then and Now'

Read all about it on page 16!

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.