



Spring Edition 2023

The Psychiatric Eye

The London Division eNewsletter



'Global Mental Health'

In this issue:

Editorial

Editorial	1
Chair's Message	3
'Mental health and migration: the complexities of providing psychiatric care to a patient you might never see again'	4
'Reflections from Malawi: The vampire lynch mobs'	6
'Bridging Global Mental Health Practice in Egypt and the UK: A Personal Journey'	8
'Brown, British & Broken: The Mental Health of British-Asian People'	10
'Reflections on a global mental health career'	12
'Strikes & Strife in London Psych Service'	14
'Conference Watch: The BNPA 36th Annual Conference'	16
'"Make me a Medic" Careers Fair'	17

Welcome to the Spring 2023 edition of The Psychiatric Eye. In this edition we have received fascinating insights into psychiatry around the world! We are so impressed by the wealth of experience of our psychiatry colleagues at all stages of their careers who have practised mental health across the globe. Thank you for sharing your journeys with us!

Special congratulations to Dr Lindsay Solera-Deuchar on writing the winning article for this edition: "Mental health and migration: the complexities of providing psychiatric care to a patient you might never see again". Dr Solera-Deuchar provides a thought-provoking article from her experience as a regional psychiatrist with Médecins Sans Frontières (MSF) in Mexico and Central America on the challenges of providing psychiatric care for populations on the move, the ethical dilemmas that arise and making risk-benefit calculations.

We also thank the other contributors to this edition. Dr Isabel Mark writes a compelling piece on "Reflections from Malawi: The vampire lynch mobs". Dr Bahar Ibrahim takes us on his personal journey of "Bridging Global Mental Health Practice in Egypt and the UK", whilst Dr Imrana Puttaroo discusses "The Mental Health of British-Asian People". Dr Peter Hughes, our immediate past Chair of the London Division, has written an inspiring and humbling piece of his 20 years expertise in global mental health, and has insights into challenges and rewards in working in this field.

Back in the UK for the RCPsych London Eye section of this newsletter, Dr Ailbhe Brennan discusses the recent junior doctor strikes from a unique psychotherapeutic angle in her article "Strikes & Strife in London Psych Service". In our Conference Watch, Dr Hamilton Morrin makes us contemplate how misinformation can make us alter our views of the world at the 2023 British Neuropsychiatry Association annual conference. We also have an interesting piece from Dr Saima Niaz who played a key role in the "Make Me A Medic" careers fair which encourages state school students to consider a career in medicine and perhaps become our psychiatrists of the future!

The London Division is growing and we thank Karen Morgan for her support in putting the Psychiatric Eye together throughout this time of change. In the next issue we want your articles on **"Creative and play therapies."** Psychiatric healthcare is not limited to medication, talking therapy, and social interventions!



What are your experiences of therapies that are not so widely offered? What interests you about arts therapies such as art, music, dance, drama or writing?

We are looking for opinions and accounts of various therapies, and invite submissions from across the multidisciplinary team, including therapists themselves!

So keep the brilliant contributions coming!

We also welcome expressions of interest in joining the editorial team so do not hesitate to get in touch. Email ThePsychiatricEye@rcpsych.ac.uk for more information.

Once again, many thanks to all our contributors. We hope you enjoy the stimulating reading.

Sonia and Stephanie

**The Psychiatric Eye editorial team are
looking for new members!**

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

For more information, please e-mail:

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Chair's Message

By Dr Suhana Ahmed

Welcome to the Spring Edition of the Psychiatric Eye – The London Division eNewsletter. A big thank you to those of you who have contributed to this edition as well as the London Division Editorial Team.

I hope you enjoy reading the articles in this edition as much as I have. They focus on Global mental Health and cover a breadth of topics within this.

One of the issues raised is the stigma of mental health that still exists within the Asian population, and the impact this has on those of us that identify as British- Asian. Having been born and brought up in the UK but with parents who immigrated from Bangladesh over 50 years ago, I can closely relate to this. I still recall a story of my 19-year-old cousin in Bangladesh having been locked in his room for weeks due to what sounded like a psychotic episode. I witnessed first-hand the stigma that existed within the Bangladeshi community when working as an FY2 in Tower Hamlets – the significant untreated psychosis, reluctance to comply with medication and engaging families explaining the very real nature of mental illness and the need for treatment. Although there is likely to have been some improvement over time, there is still a long way to go in tackling the stigma that may exist within different cultures. In my own line of work as an Old Age Psychiatrist, I still find it astounding at how few people I see in memory clinic from ethnic minority groups, including my own. There is still so much work to be done.

As we approach mid-year, I reflect on the demands placed and morale of those working in the NHS, highlighted by the recent junior dr strikes. In the same breath that I ask for members to engage in the London Division, I am acutely aware of how stretched we all are. There is a real sense of not feeling valued or having our work recognised and appreciated. I personally try to find things that are within my control to change this – saying thank you, asking someone how they are and recognising the positive things my team do on a daily basis. This is how I feel I can make a small difference when so much else is out of my control and I hope it's what you experience too whilst working in the London Division.

This was the basis for the London Division Awards – to recognise the hard work and dedication that so many of you put in every day, to celebrate this and to bring us all together. Nominations are now open and I would encourage you to nominate anyone you think we need to recognise. Don't wait for someone else to do, do it now – it won't take long and imagine the joy when they find out they've been nominated!

Enjoy the good weather which I hope will continue and makes all the difference sometimes.

Please don't hesitate to contact Karen or myself at the Division if you would like to get involved or you think we could help in some way.

Best wishes,

Suhana

Suhana Ahmed - London Division Chair





Mental health and migration: the complexities of providing psychiatric care to a patient you might never see again

By Dr Lindsay Solera-Deuchar

Providing psychiatric care to people permanently residing in one place is challenging enough. But when it comes to providing this for people on the move, a whole new set of challenges arise, and questions are raised about how and whether we can do this safely and ethically. As regional psychiatrist with Médecins Sans Frontières (MSF) in Mexico and Central America, it's been my job over the last year to answer these questions.

MSF has a number of migration projects in this region, and as with many of MSF's projects worldwide, we use the World Health Organization's mhGAP (mental health gap action programme) model to ensure that mental health is a core component of the primary healthcare provided. My role is to train and supervise our projects' doctors in the provision of outpatient psychiatric care based on the mhGAP manual.¹

The key challenge in this context is that we are often not able to provide face-to-face follow-up for patients. In some projects, people spend just a few hours between buses in the location where we are based, and in others, just a few weeks, with little idea of when their asylum process might allow them to move onwards.

Colleagues have asked: "surely, we can't do mhGAP in migration, if the treatment takes much longer than the time the patient is with us? We don't know when they'll be able to get their next supply of medication." In response, I usually point out that the same is true for diabetes, hypertension, and HIV, but we wouldn't dream of not offering treatment for those physical health conditions.

But is it safe to provide psychiatric medication to someone you might not see again? It's a question I have given a lot of thought to. And I have come to the conclusion that, like many things in psychiatry, it's a risk-benefit calculation. In our migration projects, we receive patients who were diagnosed with a psychiatric condition in their country or origin, but their medication got wet or lost when they

were crossing the jungle on their journey. Or others who, through a series of predisposing and precipitating factors during their journey, have developed a depressive illness, a post-traumatic stress disorder, or even a psychotic illness. Migrants in this region are sadly exposed to many dangers, and many people coming to our clinics are survivors of sexual and other types of violence, such as theft, extortion, and kidnapping, among others.

So, there is a clear need for mental health care for many people we see. We always prioritise psychosocial interventions in MSF, as often addressing basic needs and building internal resources in this context can be more helpful than medication. However, for those who are already on pharmacological treatment that is running out, or who have more severe symptoms, sometimes this isn't enough.

What are the risks and benefits of giving psychiatric medication in this context, knowing that we might not see the person again? The risks could include discontinuation symptoms, should they lose or not be able to continue with their medication, side effects (including the small risk of rare, serious side effects) and medication overdoses. The benefits could include an improvement in their mental state, functioning and quality of life, and a reduction in the risk of self-harm and suicide. And of course, there are the risks of not treating somebody with a psychiatric illness, including a worsening of symptoms, deteriorating functioning, and increasing risks to self, and in some cases to others.

In each case, there are individual factors that are relevant. Have they had treatment they have responded to in the past? Do they have a history of self-harm or suicide attempts? What has happened when they haven't received treatment in the past? Do they have somebody with them who could keep hold of the medication and support them in monitoring for side effects? If not, can they manage their own medication? Is there a risk that they could take



their medication in overdose? Do they have a working phone that is likely to continue working when they cross the next border?

If we do decide to offer treatment, and the patient decides to accept, what can we do to minimise the risks and maximise the benefits? This is where our mhGAP “travel medicine kit” comes in. Firstly, to maximise the benefits, assuming the risks of overdose are very low, we give 3 months of medication – if we were to give just one month, the medication would run out just as the medication is beginning to take effect. And as there are very few places offering psychiatric medication on the route, there are no guarantees as to how soon the person will be able to find follow-up.

We always aim to provide multi-disciplinary telephone follow-up. However, knowing that many people lose their phones, they stop working, or they change numbers, we try to equip them and their carers with everything they need to be able to take care of their mental health and medication. We make sure they have our phone numbers and know what to do in case of side effects or crisis. We offer them leaflets with information on their condition and their medication. We make sure their medications are clearly labelled with our logo so that border authorities allow them to cross with them. We give them a referral form with the key information for another healthcare provider to be able to give them follow-up. We offer a map of the clinics that we are aware of in the region providing psychiatric care, including both MSF and non-MSF providers.

Although it's a small number of patients who we offer medication to following this risk-benefit calculation, we find that many do experience significant improvements in their mental health and functioning, and are very grateful that we were able to help them in this way.

Our hope is that over the coming years, mental health services for people on the move will become even more coordinated and integrated, perhaps with the help of technology to provide electronic patient notes that can be carried securely by the patient. Furthermore, we hope that psychiatric care will become more widely

available, making frequent face-to-face follow-up enroute more easily achievable.

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Reflections from Malawi: The vampire lynch mob

By Dr Isabel Mark

In September 2017, word spread within the communities of Southern Malawi that 'blood-sucking vampires' were amongst them. Locals were describing how vampires disguised as civilians were using chemical and electrical powers to harm and control people, with the motive of 'becoming rich' (1). Panic grew and an outbreak of mass hysteria was reported. By October 2017, mob violence had broken out, with community members attacking those suspected of being vampires, some using fire and stones (2). At least 9 people were killed in the city of Blantyre and surrounding area. Over 140 alleged perpetrators were arrested (1). Those targeted were typically individuals who were viewed as different and not understood by their community, including some with mental illness.

I was based in Southern Malawi at the time, staying in Blantyre and teaching and supervising medical students on their psychiatry placement in Zomba Mental Hospital. I remember how prominent the feelings of confusion, bewilderment and fear were for us all. Many non-governmental organisations and charities had even pulled out of the area (3). The students, the majority of whom were originally from Malawi, mostly reported that they did not believe in vampires, although some did not seem so sure, seemingly afraid of the supernatural element as well as the mobs. More openly apparent was the impact on the patients in Zomba. When presenting clinical cases to me, students described patients presenting with paranoia of vampires, either exacerbating pre-existing psychotic illnesses or triggering a first episode. Some reported stress symptoms, due to their concern about

being targeted by a potential mob. Others presented with fear of being a vampire themselves.

Map of Malawi illustrating the locations of Blantyre and Zomba. Available at: <https://picryl.com/media/malawi-map-50d05f> (no copyright)

In order to process and reflect on what I was witnessing, I started reading how widespread cultural beliefs might lead to an outbreak of this kind. For many communities globally, belief in the supernatural (whether it be the power of vampires, demons, angels, magical rituals or others) is considered the norm, rarely leading to outbreaks of mass violence. Western people often make a distinction between the natural and supernatural worlds, but it is worth noting that for many indigenous groups these entities are felt to be inextricably linked; a symbiotic relationship which is always present in daily life (4). However, it is recognised that an underlying belief in something has potential to develop into a cascade of paranoia and terror, as seen in this case as well as in previously reported episodes of mass hysteria in the African continent (5). Typically affecting individuals who are insecure and suggestible, underlying worries can develop into acute panic on a mass level when reinforced by others (5). People will often present with psychosomatic symptoms (pains, blackouts, convulsions and dissociative trances), although behavioural presentations can also occur (laughing, crying, yelling or even violence) (5). The episode can be prolonged through face-to-face communication or via the mass media, and statements denying the role of the presumed agent (usually supernatural) by those in authority is the best-known strategy to minimise the spread (5).

I spoke to several colleagues, discussing their own analysis of the situation. Some wondered if events were triggered by the psychosocial strain of the local people, as many had very challenging living or financial situations, leading to frustration and perhaps anger. Potentially people were looking for reasons and answers for their troubles, seeking someone or something to blame so that they could take steps to eliminate that person or thing. People they





could not understand or relate to were typically the targets. I reflected on the way that groupthink can be such a powerful phenomenon with a high degree of influence, encouraging and reinforcing thoughts and behaviours to such an extent that it might even lead to mob violence. It highlighted to me how mental health patients faced a whole new level of vulnerability during these times, a fundamental and critical factor when considering patient care and public health strategies.

In terms of my personal response, whilst continuing with my teaching role, I felt it was important to validate and empathise with the concerns of the students and patients. I wanted to reassure everyone as best as I could, being clear that I did not myself believe that vampires existed, trying to reduce the levels of growing panic or anxiety. However, it was important to remain respectful of others' religious and spiritual beliefs, notwithstanding the violence associated with the underlying beliefs in this case. I acknowledged that I was from a different social and cultural background and therefore accepted that my views might not always be welcomed or trusted. Finding the right balance was difficult but crucial.

By October 2017, community leaders had spoken openly in the press, stating that vampires did not exist (1). Acute panic began to fade and the lynch mobs dissipated. By the time I left Malawi, the period of violence appeared to have ended. People seemingly moved on. Although a considerable relief, this could not undo the damage done during those months and the lasting impact it had had.

The experience still sticks with me today.

In April 2020, vampire mob attacks were again reported in Malawi, this time in the North (6).

Thank you to the Scottish Malawi Mental Health Education Project (SMHEP), with whom I worked during my time in Malawi.

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Bridging Global Mental Health Practice in Egypt and the UK: A personal journey

By Dr Baher Ibrahim

Global Mental Health and 'Neo-colonialism'

Global mental health (GMH) is the application of the principles of global health to the field of mental health and illness. Global health, in turn, is 'an area for study, research, and practice that places a priority on improving health and achieving equity for all people worldwide'. GMH is particularly concerned with problems of lack of access to care and human rights abuses of people living with mental illness in low- and middle-income countries (LMIC). LMICs are home to 80% of the world's population but have access to less than 20% of the world's mental health resources.¹

However, the LMIC distinction is unsatisfactory in identifying the jurisdiction of GMH. For example, while I was undertaking an MSc in GMH at King's College London and the London School of Hygiene in Tropical Medicine in 2015/6, I realized that 'LMICs' would not work for the title of my thesis: the majority of my participants were from Taiwan, Hong Kong, and South Korea: all high-income countries. I settled for the geographical term 'East Asia'. Evidently, 'LMICs' is not a comprehensive term for describing the remit of GMH. The terms 'Global South' and 'developing countries' do not fare much better. Going through the various euphemisms for the 'Third World' used in GMH discourse, it is hard not to see colonial overtones, particularly as it is well known that Western humanitarian organizations are most active in the nations formerly colonized by Western states.

Critiques of GMH as 'neo-colonialist' must be engaged with by GMH practitioners. Failure to do so allows agendas motivated by a sense of Western and white guilt to proceed untrammelled, potentially alienating those whom GMH is intended to serve. One such critique is the claim that the provision of pharmaceutical funded scholarships for students from LMICs to study GMH in the Global North is some sort of colonial endeavor, as if the recipients of those scholarships have no agency of their own.² In this article I will outline my own experience of working in GMH in Egypt and the UK, and use my own career trajectory thus far as

an example of South-North knowledge transfer in GMH.

Migration and knowledge production

I graduated from medical school in Alexandria, Egypt in 2011 as the ill-fated 'Arab Spring' was getting underway. The start of the war in Syria led to the arrival of a sizeable and visible Syrian refugee population in Egypt. Though the new Syrian arrivals were the most prominent in the news, Sudanese refugees had been living in Egypt for decades. Interested in learning more about the refugee 'trauma' that was being reported in the media, I volunteered to work with an American University in Cairo-led community mental health project with Sudanese refugees in the Cairo neighborhood of Nasr City. The project aimed to train community members in the delivery of Narrative Exposure Therapy (NET) so that, with supervision, they could deliver structured NET sessions to peers in the community suffering from symptoms of trauma or post-traumatic stress disorder.³ My own research found that the trained lay therapists found the skills they learned helpful and empowering, both for themselves and others.⁴ NET was designed specifically to be delivered by trained laypersons, and it is this model of 'task shifting' that prevails in global health. I contextualized this micro-level work with more meso- and macro-level work at the Mental Health Unit of the World Health Organization's Eastern Mediterranean Regional Office in Cairo and the Cairo office of the medical humanitarian organization Médecins du Monde.

During my fieldwork in Egypt, I found myself asking the question: 'Why trauma?' Why was it 'trauma' in particular that was such a hot topic? I immersed myself in the work of Derek Summerfield and Patrick Bracken, two psychiatrists who have convincingly argued that the focus on trauma reflects Western agendas and priorities that may not necessarily be appropriate for conflict-affected societies outside the West. This is not to say that trauma's effects are not real, but that conceptualizing the effect of conflict on societies as a metaphorical open wound in the individual and collective



psyche should not be the automatic reaction.

My own work in the UK has revealed to me as much. For my PhD thesis, I extensively researched the history of the refugee mental health field and how 'refugee trauma' came to be the construct that it is.⁵ I have recently concluded an oral history project with the Glasgow Medical Humanities Network, in which I have interviewed refugees in Glasgow and explored their narratives of mental health and psychological experiences, and their perspectives on NHS mental health services. My preliminary findings reveal that it is not usually trauma related to past events that consume their everyday lives and affect their mental health – such cases are a minority. Rather, the majority that suffer from poor mental health relate it to their social isolation and their vulnerable legal position. Banned from working, driving, travelling, or registering for university courses, and waiting for years for the Home Office to process their asylum claims, they live a precarious and stressful existence. In other words, the solutions to their psychological problems are socio-political and not psychiatric.

Conclusion

As with the service users of the successful Friendship Bench initiative in Zimbabwe, it is the social connection provided by community volunteers that the refugees I have interviewed in Glasgow found to be most beneficial to their mental health. The knowledge and toolbox of GMH is relevant to refugees in both Cairo and Glasgow precisely because GMH is - or should be - about health inequalities.

But if we are serious about tackling health inequalities, we must go further. In addition to addressing refugees' individual mental suffering, we should not forget that the socio-political conditions that enable their refugeedom also demand intervention, however impossible this may seem.

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Brown, British & Broken: The Mental Health of British-Asian People

By Dr Imrana Puttaroo

I was born in Britain in the early 1990s to Pakistani parents. A lot has changed since then. When I was growing up, Asians on the TV were usually comedic caricatures or sinister terrorists. In 2023, British-Asians are prevalent figures across society and even the Prime Minister is British-Asian. This is progress.

The mental health conversation in Britain has also changed over time. Mental illnesses (especially depression and anxiety) have evolved from being hush-hush topics to trending hashtags. As a psychiatrist, I am thankful for this shift, although public understanding of more complex conditions such as schizophrenia requires a greater amount of time. Nevertheless, this is also progress.

Is it time to talk about the mental health of British-Asians? What happens when these two entities converge? How can the varying experiences of mental health between the different generations of British-Asian immigrants be explained?

I lost my beloved Nani last year; suddenly I had no more living grandparents. Upon reflection, I noted there were stark contrasts between our early-life experiences. For many British-Asians like me, this is where our own relationship with mental health begins.

The term “British-Asian” predominantly refers to people originating from South-Asian countries. The Partition of India in 1947 was one of history’s biggest forced displacements. A post-war, bankrupt Britain swiftly exited India, the “jewel” of its empire. Millions of ordinary citizens fled their homes due to finding themselves on the “wrong side” of the new border, due to their religion. Chaotic, multi-directional mass migration between India and newly created Pakistan was fraught with violence and poverty.

The current population of British-Asians mainly root from post-partition immigration from the Indian subcontinent to Britain, which was most commonly to escape civil war or to seek better economic opportunities.

How did these multiple displacements and upheavals affect people? It is well established that traumatised people are both victims and perpetrators of domestic violence and oppression¹. They experience instability within their interpersonal relationships, emotional dysregulation, and have higher rates of substance misuse¹.

Some compelling animal studies suggest that epigenetic mechanisms can cause an intergenerational transmission of trauma effects from parents to offspring. However, more human studies are needed in this area².

In humans, trauma is more clearly inherited by future generations via psychodynamic mechanisms. When traumatised people have unexpressed anger and rage, a resulting low tolerance for frustration and distress has implications for their parenting capacity. Insecure attachment describes the impaired bonding and connection between parents and children. Children with insecure attachment disorders become adults who develop mental illnesses such as eating disorders, mood disorders and personality disorders. There can also be milder manifestations such as approval-seeking, enmeshment, and issues with self-esteem and identity.

Growing evidence suggests that British-Asian people have higher levels of psychological distress and mental illness compared to the white majority in Britain³. Evidence also indicates that British-Asian communities underutilise mental health services⁴. Why are British-Asians not seeking help?

A large stigma towards mental health conditions exists in Asia, despite the area’s vast ethnic, linguistic, and religious diversity. It is often believed that mental illness is the result of poor parenting, the will of God, punishment for actions in a previous life, or spiritual causes like black magic, karma, and jinns. Mental illness is therefore not necessarily perceived to be a medical issue requiring psychiatric or psychological treatment.



Western culture focuses on individualism. Asian cultures are collectivist and place high value on reputation and tradition. Asian cultures place the needs of the group (family/community) above those of the individual (seen as a representative of their family/community). This can discourage British-Asians from even talking about their mental health and well-being, as they risk stigmatising their families as well as themselves.

A further divide exists between the first generation of immigrants and the subsequent generation's prioritisation of mental health. The "Hierarchy of Needs Theory" by American psychologist Abraham Maslow illustrates the concept that people are motivated to fulfil basic physiological, security and safety needs before moving on to more advanced psychological needs.

The first generation of Asian immigrants to Britain had to tend to more basic needs. When a person immigrates, they must learn how to survive in a new country; they experience financial and social instability. The subsequent generations have these needs fulfilled and so can focus on emotional health, esteem and self-actualisation needs in a way their ancestors could never afford to. However, the aforementioned powerful stigma prevents them from seeking help for mental illness.

There are many benefits to being British-Asian and I am proud to belong to this unique, vibrant culture. However, British-Asians experience high levels of mental illness and poor psychological health due to the dichotomy of living in westernised Britain whilst being of Asian origin.

I invite my British-Asian counterparts to strive to recognise and break these cycles. If trauma can pass down through generations, so can healing.

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Reflections on a global mental health career

By Dr Peter Hughes

Global mental health has been my passion for the past 20 years. Working in London has been the ideal complement to this interest as we live in such an incredibly global city. To work in London means we need to know the world and understand the different cultures we see every day in our clinical work here.

My own journey started in one of the nicest, friendliest countries of Malawi where I first volunteered. At that time, the hospitals were places where people went to die from AIDS. Thankfully, the country has moved on a lot since then and Malawi provides an optimism that things can improve.

My global career started through the Royal College of Psychiatrists volunteering scheme. This opened doors for me in the UN and Non-Governmental Agencies. Most of my experience since then has been in humanitarian emergencies around the world.

I will give a few examples of my experiences.

Darfur was probably the most difficult experience in terms of personal comfort, with limited electricity and no running water. I worked with refugees and displaced people whereby many have epilepsy. I learned of the awful situation for refugees stuck without hope in poverty. Yet, one can still see human resilience in celebrations of Eid, make-shift shops and community life. What I have learned is not to define people by their 'trauma' but to support resilience, personal autonomy and self-help as much as possible. People can be refugees but they still have family squabbles, marriages, births and religion. In fact, religion and community are such important forces that balance out the misery of refugee life. One of my reflections is about those people who are still living there after so many years, in terrible circumstances.

Haiti was one of the most influential experiences I have experienced. This was at the extreme level of endurance and suffering following its devastating earthquake on top of grinding poverty. The grief of the people was immense

but I still saw resilience in spite of awful hardships. My job as a Psychiatrist was more often telling people that they were doing just fine in spite of all their grief, homelessness, and stress. I learned to tell people "you are not mad but really strong". I hardly ever used medications during those post-earthquake months but honed my skills in relaxation and psychoeducation that still help me today. What I saw was raw human suffering, grief, pain and effects of stress at the most extreme level. I get asked a lot about my own personal resilience in facing such difficult circumstances. I received the support of colleagues and learned my own strategies. What I did not expect so recently were the strong memories the Turkey-Syria earthquake in February 2023 brought back that echoed so much of the horror of Haiti. The hardest part was not being part of the mental health response but stuck in London.

One of the biggest challenges of this dual career of NHS Psychiatrist and global mental health expert is that of trying to get released from the NHS role to go away. My employers have been extremely supportive in South West London Trust but even with this I have not always been able to be deployed globally when needed.

Working with Ebola in the Sierra Leone was another intense experience and very different to other emergencies. What I did not expect was such an emergency to be in my own country with the Covid-19 pandemic. There was a lot of learning that was used in UK with Covid-19. Psychological First Aid became mainstreamed. This is an approach to working with people in stress using common sense such as meeting basic needs and letting people recover at their own pace.

My global work has changed in more recent years to a public mental health role with lesser contact and more training of health workers. I really miss the clinical side but recognise that this is a more useful utilisation of my skills in capacity building. Capacity building is the terminology for increasing mental health skills and coverage. The mhGAP intervention guide of WHO has been an important tool that can



used in many countries to train Primary care health workers in dealing with mental health. The need to adapt and contextualise cannot be overstated.

I have learned that you cannot easily predict the success of any project. I trained people in Syria with the sound of mortar fire shooting around us. Yet Syria has been one of the most successful projects I have been involved with in rolling out the mhGAP programme.

Another professional development has been a focus on human rights. Human rights awareness is a key part of working globally and something that has relevance to the UK as well as globally.

Global work has reminded me of the importance of psychosocial interventions. The role of the Global Psychiatrist can encompass psychology, social worker, occupational therapy, physical health skills. I have found myself less and less identifying myself as a Psychiatrist but as an MHPSS specialist. MHPSS is the preferred global mental health terminology. MH is mental Health and our familiar Psychiatrist role. PSS refers to psychosocial support. Global mental health has developed my skills in this area of PSS that has not really been a big part of my UK training.

My most recent deployment was to Afghanistan. Here was where I could really use my skills of having been London Division Chair. It was a great experience but marred by the Taliban now banning Afghani women from working in the NGOs and UN organisations. This was a really depressing turn of events and I am really not sure whether my role helped or hindered the work.

The important lessons for me from working globally has been to be humble and learn from

others. The UK system may not be transferrable to other countries, and much can be learned from elsewhere that can be used in the NHS. I have learned the importance of understanding culture, family, resilience and not being trauma-focussed. The approach must be public mental health focussed. I believe I have become a better Psychiatrist with my global experience for UK NHS work. I have learned of the heroes who work tirelessly in so many countries for the mentally ill, sometimes with no regular salary, going far and beyond their jobs to help those in need. The daily reality for many is the absolute poverty, domestic violence, loss of human rights and discrimination faced. We see many of these similar issues in London and we must celebrate the same heroes we have here.

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Former Chair—London Division



Strikes & Strife in London Psychiatric Services

By Dr Ailbhe Brennan

How much is a doctor worth?

This was the question posed to the public on one of many placards adorning the London picket line on Monday 13th March. Due to the effects of pay erosion, as a last resort, the highest ever number of BMA members have voted for industrial action [1]. I wanted to reflect how we as doctors cope with being complicit in the nationwide disruption and mayhem.

The concept of healthcare workers striking is an example of a psychological grey area where conflicting views thrive; the perfect breeding ground for developing psychological defences. On one hand, we receive praise and support in our pursuit of better pay and conditions. On the other hand, we work in a vocational career, and striking means turning our backs on those in need.

Splitting, first described by Freud, is an ego mechanism of defence employed when we cannot tolerate conflicting emotions. We seek refuge in absolutes and categorise the person or idea as entirely good or entirely bad. We label things as black or white and cannot tolerate shades of grey.

In this article, I will give some examples of the harmful effects of splitting. Perhaps, by keeping this defence mechanism in mind, we may resist the urge to fall into unhelpful thought patterns.

Multidisciplinary working is so integral to our functioning as one 'NHS ecosystem'. I am concerned that current healthcare strikes threaten unity among colleagues. During strikes there can be expectations for remaining members of the MDT to plug the gaps. It's a natural reaction to feel disgruntled at this increased workload, and resulting guilt at feelings of irritation. Another concern is that these strikes risk draining the supply of public

sympathy, which may threaten the success of future strikes in other professions.

We can see these frustrations being played out daily in healthcare environments across the capital. Instead of grappling with the intangible idea that we are under-resourced, it can be too easy to target frustrations to our less abstract, closer at-hand colleagues. It is easier to believe that our team or service is faultless and that it is 'others' who are falling short. Easier still, is to assign criticism to other groups – eschewing guilt by refusing to blame any specific individual, but castigating specific roles, departments or specialties. When this happens we fuel a split rather than spend psychological energy to ease a rift.

Even within our community of doctors, splits are rife. I wonder if it's a way of coping with the difficult decision to strike. Again, I see division and vilification. From my cursory search of social media, ever a divisive force, I found my attention drawn to discussions of opportunities for strikes to fail. A recurring theme in these discussions was the identification of a particular subgroup of doctors as the 'weak link'. Appetite for joining the picket line among international medical graduates can be variable, with reasons such as financial strain and visa rejection fears contributing to this trend [2]. Again, we see black and white thinking, and a culture of us and them.

I worry that the tendency to see our colleagues as hazards serves only one function; to fuel discontent and drive us apart, ultimately undermining the effectiveness of healthcare strikes. We could benefit from withholding judgement until we have walked a mile in each other's scrubs.



As we weather the storm of strike action it is all the more important to be aware of these defences and understand how easily they can sweep in. Let's find a way to move forward with industrial action without drifting apart from each other.

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[1] British Medical Association. <https://www.bma.org.uk/our-campaigns/junior-doctor-campaigns/pay/pay-restoration>

[2] British Medical Association. <https://www.bma.org.uk/news-and-opinion/enough-is-enough-imgs-must-be-involved-in-pay-restoration-campaign>

Author Details:



Dr Ailbhe Brennan MRCPsych

SAS Doctor



Conference Watch: The BNPA 36th Annual Conference

By Dr Hamilton Morrin

As a trainee, I often find myself having to tactically plan months in advance which conferences merit the rigmarole of requesting study leave. Location and speaker line-up are perhaps the most important factors affecting the likelihood of one's decision to attend, though the impact of catering quality should not be underestimated. I'm pleased to say that in all of these areas (and more) the 2023 British Neuropsychiatry Association Annual Conference met and surpassed my expectations.

Taking place at the Royal College of Physicians, attendees of The BNPA 36th Annual Conference were a stone's throw away from Regent's Park, and I can't help but feel a mild tinge of envy when I compare our own college's proximity to greenery. The schedule for both days was packed with a phenomenal line-up of experts from a range of disciplines, and it was a joy to see neurologists, psychiatrists, psychologists, and individuals with lived experience coming together to challenge the notion of Cartesian dualism, one panel discussion at a time.

The overarching theme for this year's conference was "Our perception of the world and its effect on health". With the rise of credible AI-generated images (see Pope Francis in his stylish puffer jacket), it is easy to see how misinformation can alter our views of the world, and so it was particularly interesting to hear Professor Sander van der Linden describe how he and his colleagues have developed The Bad News Game, a brief interactive intervention in which individuals are able to create their own 'fake news', thereby becoming inoculated against misinformation.

Another crowd favourite was no doubt the talk delivered by aerospace psychiatrist (RCPsych formal training pathway pending) Dr Charles H. Dukes who shared fascinating details regarding NASA's behavioural health and performance services for long duration space missions. Whilst I'm still not entirely sure how he was allowed to disclose the details of NASA's selection process psychometric evaluations, it was certainly amusing to watch rows of consultants mentally score themselves to determine if they would make the cut.

The quality of poster abstracts was excellent, though as one of those fortunate enough to have delivered a rapid-fire oral abstract presentation at the conference I am admittedly biased. I can't think of another conference where, in the space of 15 minutes, attendees can hear about: whether Julius Caesar had a brain disorder impacting his judgement; the clinical relevance of serum versus CSF NMDAR autoantibodies when associated exclusively with psychiatric features; and the value of distressing dreams as a predictor for dementia.

Needless to say, I very much enjoyed attending this year's conference which was brilliantly organised and smoothly run by members of the BNPA committee, and I would highly recommend attending next year's conference to any trainees (psychiatry or otherwise) keen on hearing world-class speakers discuss topics that are quite literally 'out of this world'.

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“Make me a Medic” - Careers Fair

By Dr Saima Niaz

The Education Team at Chelsea and Westminster NHS Foundation Trust recently held the “Make Me A Medic” course in April. The purpose of this outreach event was to provide Year 12 students in state schools with information about careers in Medicine, and to encourage them to consider a career in this field.



As a part of the event, the organisers held a speciality careers fair, where each medical speciality was represented at a stall, and students could go around and ask specialists about their roles. I was asked to represent the London Division of the Royal College of Psychiatrists to assist with this event, and to help promote Psychiatry. Part of this role was to run a stall at the fair.



The Psychiatry stall was highly popular among the students, with many showing a keen interest in learning more about Psychiatry. Students were attracted to the colourful “Choose Psychiatry” promotional items sent by the Careers Manager at the College.



The organisers were pleasantly surprised by the level of interest generated by the Psychiatry stall. Many students were enthusiastic about exploring the various subspecialties of Psychiatry and asked insightful questions about the role,

patient interactions, workload, on-call duties, and how to deal with challenging situations.



The level of interest and enthusiasm displayed by the students was truly impressive. They showed a positive attitude towards Psychiatry and were eager to learn more about pursuing a career in this field. This event provided an excellent opportunity to provide students with valuable insight into choosing Psychiatry as a career. Overall, the event was a great success and helped inspire and encourage the next generation of medical professionals.



This was an amazing experience and opportunity to be an advocate for Psychiatry, and to help the decision-making process for young people and inspire them to be a psychiatrist.

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London Division Awards 2023

Nominations are now open

Categories:-

- Medical Student
- Foundation Doctor
- Core Trainee
- Higher Trainee
- Patient/Carer
- Psychiatrist
- SAS Doctor
- Team
- Educator

Nominations close 26 May 2023

Please see our [website](#) for nomination forms and more information

Save The Date - Upcoming London Events

London Division Awards—28 June 2023

Leadership Event with RCPsych LMC—20 September 2023

Training for Trainees Event—26 September 2023

Medical Student/Foundation Doctors Reception—4 October 2023

London Division Autumn Conference—9 November 2023

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

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Winning Article

Congratulations to Dr Lindsay Solera-Deuchar winner of Best Article for their submission:

'Mental health and migration: the complexities of providing psychiatric care to a patient you might never see again'

Read all about it on page 4!

Disclaimer

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