

Summer 2026 | Issue 6

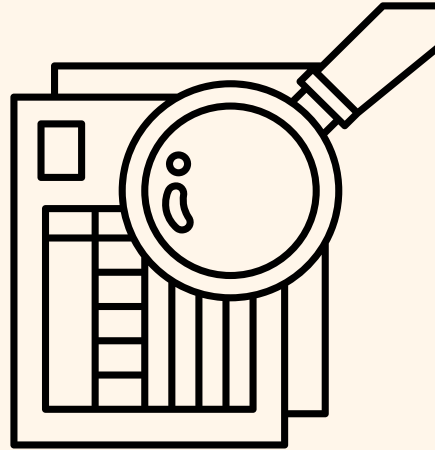
RCPSYCH
NEURODEVELOPMENTAL PSYCHIATRY SIG
NEWSLETTER

Neurodevelopmental Psychiatry - Exploring the Intersections



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NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

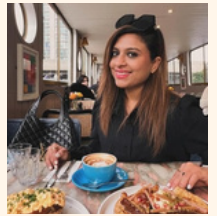


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Editor's Welcome

Dr. Sana Fatima



Issue 6 !

It's always a bit of a pinch-me moment, so I'm keeping the tradition of opening with the *issue number*.

This issue is all about intersections: the overlaps between neurodevelopmental presentations and wider psychiatric practice, and the complexities that emerge at those interfaces.

As our understanding of neurodevelopmental psychiatry continues to evolve, so too does our appreciation of its complexity. We are increasingly recognising that neurodevelopmental differences are neither static nor confined to childhood; they unfold across the lifespan, are shaped by culture and lived experience, and present differently across clinical settings and generations. Perhaps most importantly, we are beginning to better understand their intricate relationship with serious mental illness, not as separate domains, but as intersecting dimensions of human experience. That interface forms one of the central threads running throughout this edition.

We begin with reflections from our Chair, **Dr Jessica Eccles**, who looks back on what has been an exceptionally productive period for the Neurodevelopmental Psychiatry Special Interest Group. Her message celebrates the momentum we have built together while looking ahead with the curiosity, collaboration and ambition that continue to define our community.

I am especially delighted to feature a Spotlight interview with **Dr Subodh Dave, President of the Royal College of Psychiatrists**. Drawing on his experiences as a clinician, academic and leader, he offers a thoughtful and generous reflection on the evolution of neurodevelopmental psychiatry, the challenges that remain, and the opportunities that lie ahead. His perspective reminds us that the future of our specialty depends not only on advances in science, but also on leadership, compassion and a willingness to rethink established ways of working.

The importance of rethinking systems is echoed in **Dr Khurram Sadiq's** compelling exploration of neuroinclusion. Through the lens of the Stop. Stomp. Clap. movement, he argues that genuine inclusion extends far beyond policy statements or reasonable adjustments. It is created through culture, relationships and environments where people are able to belong without masking who they are.

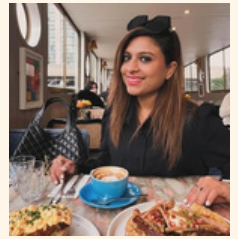
Dr Saima Niaz, Chair of the Transcultural Psychiatry Special Interest Group, extends this discussion by examining how culture, identity and lived experience influence the way neurodivergence is recognised, understood and supported.

I am pleased to welcome back **Sarah Clark**, whose contribution, *Beyond Behaviour: Listening to the Unique Self in Psychiatry*, once again challenges us to look beyond symptoms towards the individual behind the diagnosis. Sarah also returns as our (almost) unofficial in-house artist. Her striking illustrations capture the essence of this edition with remarkable sensitivity, reflecting its themes of complexity, ambiguity and interconnectedness, and reminding us that understanding neurodevelopmental psychiatry often requires us to embrace uncertainty rather than seek overly simplistic answers.



Editor's Welcome

Dr. Sana Fatima



Building on the theme, **Kamran Mahmood's** piece 'Abid's story' - lost in translation explores contemporary perspectives on ADHD which are both thoughtful and thought provoking.

Usama Khan encourages us to look Beyond Labels, questioning how diagnostic language can both illuminate and constrain understanding. **Mariana Galvão** reflects on the lessons neurodivergent patients have taught her through her work in acute psychiatry, offering a thoughtful account of how these experiences have reshaped her clinical practice. **Deepanshi Malik** shares her deeply personal journey of recognising her own neurodivergence at the age of 27, providing an honest reflection on identity, self-understanding and belonging. **Vieri Thonet-Clarke** closes this collection with Not Entirely Whole, a thought-provoking examination of the language, assumptions and meaning embedded within neurodevelopmental assessment reports.

Find early reflections from a project by **Dr. Sherlie Arulanandam** and **Dr. Sana Fatima**: reflections on the first national survey examining the interface between Early Intervention in Psychosis and neurodevelopmental services across England and Wales. We end this issue with an NDP SIG round up of activities, aspirations and engagements.

Taken together, the contributions invite us to think beyond traditional diagnostic boundaries, to listen more closely to lived experience, and to embrace the complexity that lies at the heart of neurodevelopmental psychiatry. If there is a unifying message, it is that progress depends not only on expanding our knowledge, but also on broadening our perspectives.

I hope you enjoy reading this edition as much as we have enjoyed bringing it together. My sincere thanks go to every contributor for sharing their expertise, creativity, curiosity and lived experience. It is the richness and diversity of these voices that continue to make this newsletter not simply a collection of articles, but a reflection of an evolving and deeply collaborative community.

Dr. Sana Fatima

Dr Sana Fatima is a Consultant Psychiatrist in Early Intervention in Psychosis with interests spanning neurodevelopmental psychiatry, serious mental illness, medical education and planetary health. Her work is driven by a fascination with the spaces where these fields intersect, and by a commitment to delivering more integrated and inclusive mental healthcare.

She led a regional Yorkshire and Humber initiative developing a professional support and wellbeing programme for resident doctors and dentists, and played a key role in a national project on neurodiversity in medical education, leading the faculty development workstream. Through this work, she has championed greater recognition of neurodiversity within the medical workforce and advocated for meaningful environmental, educational and cultural change to create more inclusive learning environments.

Dr Fatima is the Communications Lead for the Royal College of Psychiatrists' Neurodevelopmental Psychiatry Special Interest Group and Clinical Lead for Sustainability and Planetary Health at Bradford District Care NHS Foundation Trust.

Update from the Chair Dr Jessica Eccles



As Chair, I want to take this opportunity to reflect on what has been a remarkably active two years for the Neurodevelopmental Psychiatry Special Interest Group, and to look ahead with the same energy that has defined our work so far, and share some professional and personal reflections on embodied intersectionality.

Since our last two AGMs, the SIG has grown its influence considerably, holding well-attended executive committee meetings, strategy days, and a run of flagship conferences. Our December 2024 Winter Conference, "Thinking Differently," featuring neurodivergent speakers, clinicians and researchers, experts by experience, trainees and medical students, and drew warm praise from senior colleagues, including a former Chief Medical Officer and ADHD Taskforce member who described it as "a gem".



Dr Eccles's speaking at RCPsych International Congress 2026 in Liverpool

In June 2025, our joint Conference with the RCGP Neurodiversity SIG, "Innovating Together," was a genuinely historic event, bringing GPs and psychiatrists together to find common ground on meeting demand for neurodevelopmental assessment, and resulted in a press statement subsequently published by the RCGP as a blog. This momentum continued into our January 2026 Winter Conference, "The Elephant in the Room: Neurodivergence in Psychiatry," which set the stage for how mainstream psychiatry approaches neurodevelopmental conditions.

Neurodevelopmental conditions featured strongly at International Congress this Year with sessions including SIG members and chaired by Prof Bowden Jones (Registrar), Adrian James (Former President) and Subodh Dave (President)

S22 Why we need to take neurodevelopment conditions seriously in psychiatry – a new science perspective

Chair: Professor Subodh Dave,
Royal College of Psychiatrists,
London
**Understanding AuDHD – The
interface of Autism and ADHD**
Dr Khurram Sadiq, Oxleas NHS
Foundation Trust, London
**Management of AuDHD –
balancing two realities**
Dr Asif Bachlani, Cygnet
hospital, London
**The tales we tell: the
perception of AuDHD in a
world that learns through
stories**

S58 Neurodivergence and addictive behaviours: a contemporary synthesis

The SIG has featured regularly and prominently in national media, helping to counter stigma and misinformation around ADHD and autism. Coverage has included multiple BBC Radio 4 appearances (All In The Mind, The World Tonight, The Today Programme, Archive Hour), Channel 5 News, BBC Radio 5 Live, the BMJ, The Telegraph, and international outlets including the New York Times. This media work has been complemented by widely accessed podcasts and webinars reaching tens of thousands of clinicians, patients, and families, extending the SIG's evidence-based voice well beyond the group and profession.

Update from the Chair Dr Jessica Eccles



Members of our SIG EXEC have played a direct role in shaping national ADHD policy. Colleagues sat as expert members on the NHS England ADHD Clinical Reference Group throughout the ADHD Taskforce process, contributing to the ground-breaking interim report published in June 2025 and the subsequent blueprint for service reform. This work has continued into the DHSC Independent Review into Mental Health Conditions, ADHD and Autism (the Fonagy Review), to which SIG members have contributed since February 2026. Alongside this, the SIG has supported the development of a cross-college Neurodevelopmental Credential with the Royal Colleges of Paediatrics and Child Health and General Practitioners, and delivered training programmes reaching over a thousand psychiatrists nationally. Please see dates for diary and the further info in the news letter on upcoming Cross College ND Credential, RCPSYCH Autism and ADHD programmes



Academics and clinicians discuss the rise in diagnosed neurodivergence in 62nd Maudsley Debate | King's College London

Academics, clinicians, students, service users and members of the public came together in a packed Wolfson Lecture Theatre at Denmark Hill to debate whether the rise in diagnosed neurodivergence was due to increased awareness...

kcl.ac.uk



SIG Chair and SIG EXEC member Prof Brugha at the 62nd Maudsley Debate - Watch Now!

A Huge Thank You..

None of this would have been possible without the dedication of key colleagues. I want to thank Dr Conor Davidson, our former Autism Champion, for his sustained work Practice raising the profile of autism identification across specialties and his leadership and steering of NATPP. The role of autism champion is currently under review by College.

My thanks also go to Dr Ulrich Müller-Sedgwick, our ADHD Champion, whose leadership on the ADHD Taskforce, national training programmes, and sustained media engagement has been instrumental in advancing the ADHD agenda. I am equally grateful to Dr Sam Tromans, our Academic Secretary, for his careful oversight of the SIG's academic activities and governance throughout this period. Finally, my sincere thanks go to the whole SIG EXEC committee, whose collective effort across conferences, policy engagement, and communications has underpinned Huge thanks also to Dr Sana Fatima, communications lead, and developer of this wonderful newsletter



SIG Chair and SIG EXEC members
Ulrich Muller Sedgwick
Marie Boilson
Conor Davidson
Sana Fatima
Alison Lennox
Raja Mukherjee
Jessica Eccles



Update from the Chair Dr Jessica Eccles



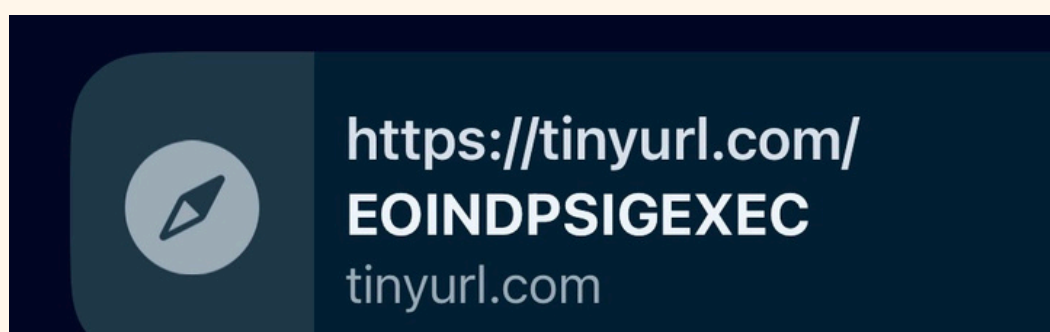
Looking Ahead

Following our strategy day in May 2026, the SIG EXEC will shortly invite expressions of interest from all college membership for executive committee and working group positions for the next two years, in line with our newly drafted Terms of Reference

This is a natural moment to refresh our leadership and welcome new voices as we continue our core mission: ensuring neurodevelopmental psychiatry is recognised as "every psychiatrist's business," and building on our contributions to national policy, training, and public understanding in the years ahead. We hope also to develop a resident doctors 'shadow committee' and strengthen our existing links with other faculties and SIGS.

We are also in the process of developing an email server forum for all psychiatrists interested in neurodevelopmental psychiatry.

Deadline for the EOI is 12th August 2026



Expression of Interest (EOI) Form v1

RCPsych Neurodevelopmental Psychiatry Special Interest Group (NDP-SIG)

Executive Committee & Working Group Positions (September 2026
September 2028)

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JOIN THE NDP SIG EXEC AND WORKING GROUPS NOW! LINK ABOVE

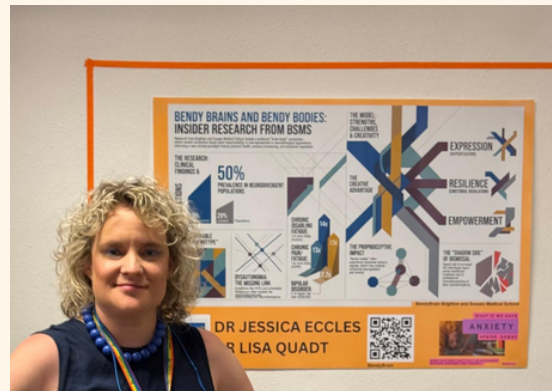
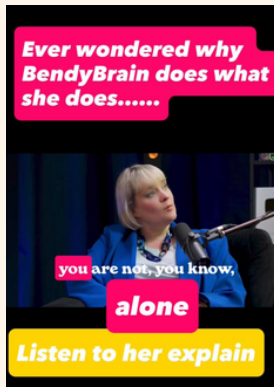
Dr. Jessica Eccles

Dr Jessica Eccles, Chair, is Associate Professor in Brain-Body Medicine at BSMS, a prize winning researcher, she is trained clinically in both liaison and neurodevelopmental psychiatry and works as a Consultant Psychiatrist in the innovative Neurodevelopmental Service at Sussex Partnership NHS Foundation Trust, where she co-leads the worlds first Neurodivergent Brain Body Clinic. She specialises in complex combined neurodevelopmental assessments (ADHD, Autism and Tic Conditions) in those with significant medical and psychiatric co-occurrence. She is multiply neurodivergent (listen to BBC R4 Archive Hour: Trouble Staying Still, The History of ADHD, to hear more about her journey and impact on thinking). She has numerous intersecting brain-body challenges and hopes to encourage curiosity and challenge stereotypes.

Doctor/Patient

Dr. Jessica Eccles

Reflections on embodied intersectionality



The patient in doctors clothing

Sometimes, I have this abiding sense that I somehow snuck through
That I have lived when I shouldn't
That I am a patient who has made it to the top of the tree
That I am an outcast that somehow kept their seat at the table
That I am shouting and silent at the same time
That I kept on swimming when I should have drowned
That I was born to defy
Because I leave nothing in reserve

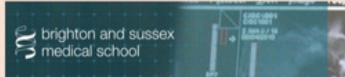
Dr Jessica Eccles, Winter/Spring 2026



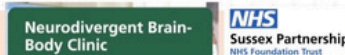
Who am I?

Dr Jessica Eccles (MB ChB, Dip(French), MA, MSc, FRCPsych, PhD, PGCert HE)

Reader in Brain-Body Medicine



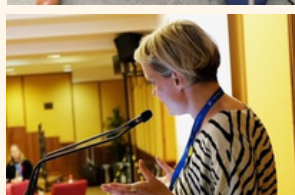
Research areas: Neuroscience, Neurodivergence, Mechanisms of chronic pain and fatigue, Psychiatric and neurodevelopmental features of connective tissue disorders



BendyBrain



[Linktr.ee/BendyBrain](https://linktr.ee/BendyBrain)





Interview with President RCPsych Professor Subodh Dave
Neurodevelopmental Psychiatry at the Heart of Modern Mental Health Care

Professor Subodh Dave



Q2. As President of the Royal College of Psychiatrists, how do you see neurodevelopmental psychiatry fitting into your wider vision for the future of psychiatry?

One of the key themes of my leadership has been bringing people together, breaking down barriers and fostering collaboration.

Traditionally, healthcare systems have often separated mental health from physical health, child services from adult services, developmental disorders from severe mental illness, and clinical practice from academic research. Yet the evidence increasingly tells us that these distinctions can sometimes hinder rather than help patient care.

Neurodevelopmental conditions such as autism, ADHD and intellectual disability should not be viewed as peripheral to psychiatry. They are integral to understanding mental health across the lifespan. Many people with neurodevelopmental conditions experience co-occurring mental illnesses, while many individuals presenting to psychiatric services have previously unrecognised neurodevelopmental needs.

The future of psychiatry must be more integrated. We need services, training pathways and research programmes that recognise the interconnected nature of development, brain health, mental health and physical health. Neurodevelopmental psychiatry has much to contribute to that vision.

Q3. There is growing recognition of the links between neurodevelopmental conditions and severe mental illnesses. How should psychiatry respond?

The relationship between neurodevelopmental conditions and severe mental illnesses represents one of the most important areas of contemporary psychiatric practice and research.

We now understand far more about shared genetic vulnerabilities, overlapping neurobiological pathways and common environmental influences than we did even a decade ago. Conditions such as autism, ADHD, bipolar disorder, psychosis and personality difficulties can intersect in complex ways, requiring nuanced assessment and management.

This means we must move beyond either-or thinking. Neurodevelopmental conditions and severe mental illnesses are neither entirely separate nor entirely the same. They can coexist, interact and influence outcomes throughout life.

Interview with President RCPsych Professor Subodh Dave
Neurodevelopmental Psychiatry at the Heart of Modern Mental Health Care

Professor Subodh Dave



Q5. The current healthcare climate is challenging, with increasing demand, long waiting lists and workforce pressures. What opportunities do you see for neurodevelopmental psychiatry in this context?

The pressures facing healthcare systems are real, but they also create opportunities to rethink how we deliver care.

One important opportunity is moving away from fragmented models towards more integrated systems. Too often, individuals with neurodevelopmental conditions encounter multiple services, repeated assessments and disconnected care pathways.

A more integrated approach could bring together mental health, physical health, education, social care and community resources around the individual rather than expecting individuals to navigate complex systems themselves. Technology, innovation and new models of service delivery may also help us improve access while maintaining quality. However, innovation must always be grounded in evidence and focused on reducing inequities rather than widening them.

Importantly, neurodevelopmental psychiatry reminds us that many mental health difficulties begin early in life. Investing in early identification and intervention is not only clinically beneficial but also economically sensible and socially just.

Q6. Public mental health and prevention have featured strongly in your leadership priorities. How does neurodevelopmental psychiatry contribute to a prevention-focused agenda?

Prevention is one of the most important challenges facing modern healthcare.

Neurodevelopmental psychiatry naturally aligns with a prevention-oriented approach because it encourages us to think developmentally and across the lifespan. Rather than waiting until difficulties become entrenched, we can focus on understanding risk factors, promoting resilience and supporting healthy development from the earliest stages of life.



See Professor Dave's full statement
(text and video)

Professor Subodh Dave

As President, I will be an ambitious champion for Psychiatrists, led by key priorities focussing on:

- Enhancing the impact and influence of Psychiatrists
- Driving optimal patient outcomes
- Supporting a diverse workforce to thrive
- Leading prevention and public mental health
- Implementing future focussed innovation.

Professor Subodh Dave elected as next RCPsych President



Interview with President RCPsych Professor Subodh Dave
Neurodevelopmental Psychiatry at the Heart of Modern Mental Health Care

Professor Subodh Dave



Question 3 continued:

Psychiatrists are uniquely placed to understand these complexities. However, we need to ensure that our workforce is equipped with the skills and confidence to recognise neurodevelopmental presentations, understand differential diagnoses, identify comorbidities and deliver integrated care.

The challenge is not simply diagnostic accuracy. It is ensuring that people receive the right support at the right time, regardless of where they enter the healthcare system

Q4. Workforce development has been a major theme throughout your leadership.

What changes are needed to better equip psychiatrists to support neurodevelopmental populations?

The future workforce must be prepared for the realities of modern psychiatric practice. Increasingly, that means recognising and managing neurodevelopmental conditions across all specialties.

Neurodevelopmental expertise should not reside solely within specialist services. Every psychiatrist should have a core understanding of neurodevelopmental conditions, their assessment, their impact across the lifespan and their interaction with other psychiatric disorders.

This requires investment in training at every stage, from undergraduate education and core psychiatric training through to continuing professional development for established clinicians.

We must also promote multidisciplinary learning. Psychiatrists, psychologists, paediatricians, neurologists, primary care clinicians, allied health professionals and experts by experience all bring valuable perspectives. The most effective services are often those that foster genuine collaboration across professional boundaries.

Supporting the workforce is ultimately about improving patient care. Better training leads to earlier recognition, more accurate assessment and more effective interventions.



Prof. Subodh Dave and Prof. Lade Smith

Interview with President RCPsych Professor Subodh Dave Neurodevelopmental Psychiatry at the Heart of Modern Mental Health Care



Prof. Subodh Dave

This includes supporting maternal health, reducing childhood adversity, addressing health inequalities, promoting educational inclusion and ensuring timely access to assessment and intervention.

Public mental health is not simply about preventing illness. It is about creating environments in which individuals can thrive. For people with neurodevelopmental differences, this means building systems and communities that recognise strengths, accommodate differences and reduce unnecessary barriers.

The earlier we intervene, the greater the potential impact for individuals, families and society.

Q7. Finally, what message would you like to share with members of the Neurodevelopmental Psychiatry Special Interest Group?

I believe neurodevelopmental psychiatry has an increasingly important role in shaping the future of our profession.

Your work challenges us to think beyond traditional boundaries, to embrace complexity and to understand mental health within a broader developmental, biological and social context. These are precisely the perspectives psychiatry needs as we respond to the challenges of the twenty-first century.

As a College, we must continue fostering collaboration across specialties, strengthening research, supporting innovation and developing a workforce that is confident in meeting the needs of neurodivergent individuals throughout their lives.



SUBODH DAVE
IDEAS TO ACTION

Consultant Psychiatrist, Derbyshire Healthcare Foundation Trust; Professor of Psychiatry, University of Greater Manchester; Dean, Royal College of Psychiatrists

As President of the Royal College of Psychiatrists, I will be an ambitious champion for Psychiatrists, led by

KEY PRIORITIES FOCUSING ON

- 01 Enhance the influence and impact of psychiatrists**
at team, organisational and policy levels, ensuring frontline expertise shapes service design and delivery.
- 02 Use the College's influence to drive optimal patient outcomes**
through safe, consistent implementation of evidence-based treatments like Citalopram, Lithium and ECT to narrow the mortality gap for patients with severe mental illness.
- 03 Ensure our workforce is sufficiently staffed, diverse and supported to thrive**
Addressing discrimination and inequity to ensure that psychiatrists at every career stage feel heard and empowered.
- 04 Champion prevention and public mental health**
by promoting early life intervention, secondary and tertiary prevention across the life course.
- 05 Lead cutting-edge innovation**
In applied research, digital technology and funding to improve psychiatrists' working lives.

LET'S INCLUDE, INNOVATE AND IMPLEMENT TOGETHER
www.subodh-dave.com

Core Priorities				
				
Enhance the influence and impact of psychiatrists	Use the College's influence to drive optimal patient outcomes	Champion prevention and public mental health	Ensure our workforce is sufficiently staffed, diverse and supported to thrive	Lead cutting-edge innovation in Psychiatry

<https://www.subodh-dave.com/>

Stomp. Stomp. Clap – The Rhythm that Changes Rooms

Dr. Khurram Sadiq



There is a moment, if you have ever been in the right room at the right time, when something shifts. When a crowd stops being a collection of individuals and becomes a single organism, breathing in together, moving in together, making something that none of them could have made alone.

Brian May knew that moment. He had seen it happen at every Queen concert. He had watched seventy-two thousand people refuse to be passive recipients of a performance and insist, body and voice, on being part of it. And rather than call that a problem, he did what only a certain kind of mind would do.

He wrote the silence in.

Stomp. Stomp. Clap.

No chorus. Just space. Space where the audience was supposed to arrive. He wanted to create something that, once released into the world, would no longer belong to Queen. It would belong to everyone. A football stadium in 1985. A hospital corridor in 1991. A protest in 2024. A conference room at the RCPsych National Residents Conference, full of future psychiatrists, in 2025.

We will, we will rock you.

On the 30th of April 2026, I did not begin with words.

I stood in front of a room full of psychiatry trainees, brilliant, sceptical, confused, exhausted, hopeful and I asked them first to reach back. To find their worst day at work. To feel the weight of it. Stomp. Then another. Another day that had cost them something. Stomp. And then just once to let it go. Clap.

I waited.

The room understood before I had explained anything. Because that is the thing about rhythm it bypasses the thinking mind entirely and speaks directly to something older, something the body already knows. The stomp was grief. The stomp was survival. The clap was, against all odds, defiance.

Stomp. Stomp. Clap.

Seventy-two thousand people gave it back to Brian May at Earls Court. A room of future psychiatrists gave it back to me. Different rooms, different centuries, different everything and yet the same irreducible human truth landing in exactly the same place.

We will, we will rock you.

Not a performance. A conversation. The oldest kind there is.

That was the point. That was the whole argument, enacted before I had spoken a single sentence.

Here is what I have been thinking about ever since.



Stomp. Stomp. Clap – The Rhythm that Changes Rooms

Dr. Khurram Sadiq



Brian May was an astrophysicist. He built his own guitar from a fireplace. He analysed the physics of sound while simultaneously producing some of the most emotionally devastating music of the twentieth century. He existed, comfortably and without apology, in the space between equations and feeling, a space that most institutions would have found deeply inconvenient.

Freddie Mercury, born Farrokh Bulsara in Zanzibar, raised in India, a Parsi Zoroastrian who carried multiple worlds inside him before he ever set foot on a stage had an emotional intensity that in another context might have been labelled dysregulated. Difficult. Too much. On stage at that intensity set a billion people on fire.

Roger Taylor brought the precision of a scientist to a drum kit. Discipline and fire in the same body, a combination that tends to make systems nervous and makes music extraordinary. And John Deacon. The quietest. The observer. The man who barely spoke in interviews, who most people forget was there at all. The introvert who wrote We Are the Champions. Who held the structural foundation upon which all of Freddie's theatre could rest. The one whose silence made the noise possible.

Four human beings. Four different corners of the world. Four different minds, four different ways of processing experience. Their music was outlandish; operatic and absurd and devastating, sometimes all in the same song. It should not have worked. It worked magnificently.

And the reason it worked is not despite their differences.

Now. Look at your ward. Look at your team. Look at your training cohort.

The same diversity is right there. Different minds, different cognitive styles, different ways of attending and processing and making sense of the world. Some of them diagnosed; ADHD, autism, dyslexia, dyspraxia. Many more undiagnosed, carrying their neurodivergence quietly, expending enormous energy every day maintaining the performance of neurotypicality, wondering why they are more exhausted than anyone else seems to be.

Neurodiversity is not a category of patients. It is a fundamental feature of what it means to be human. Approximately fifteen to twenty percent of the global population, one in five of the people in that conference room, one in five of the patients on your wards, one in five of the colleagues you trained alongside. And yet our systems our diagnostic pathways, our training programmes, our examination structures, our ward cultures were not designed with that fifth person in mind. We are not, in many cases, designed to see them at all.

Brian May saw something in the crowd that most people would have missed, he was not insecure, he was a visionary. He saw not noise, but signal. Not disruption, but invitation.

What are we missing?

The greatest rock band in history was, looked at through one lens, a collection of people who had no business being in a room together. An astrophysicist who could not stop analysing. An immigrant who refused to be contained. A scientist-drummer whose discipline burned. An introvert who said almost nothing and built everything.

Stomp. Stomp. Clap – The Rhythm that Changes Rooms
Dr. Khurram Sadiq



If you had handed their CVs to most management consultants in 1970, you would have been told to choose between them.

They chose all of them.

Because Brian May, the same mind that sat with a calculator and a piece of fireplace timber and imagined a guitar, understood something that we are still, fifty years later, learning to practise. That the most extraordinary things are not produced by identical minds working in predictable harmony.

They are produced by the collision.

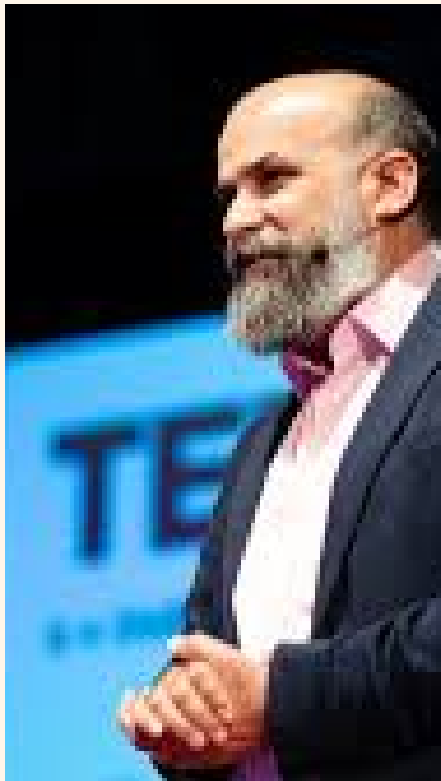
The ADHD mind that cannot sit still but can hold twelve variables in simultaneous tension and find the pattern that everyone else missed. The autistic mind whose emotional intensity is not flat but overwhelming so overwhelming it requires containment, and whose commitment to honesty is, when given the right conditions, one of the most powerful clinical instruments in the room. The dyslexic architect who thinks in three dimensions before others have finished working in two. The introverted registrar who barely speaks in meetings, but who will, given space, write the song that wins.

These are not compensatory strengths. Not triumphs over a condition. These are the strengths of a particular way of being in the world. And if you do not have the eye to see them ; if you are looking, always, for the problem rather than the gift; you will call them disruptive. You will call them too much. You will write a referral letter that describes a child who has memorised the entire London Underground map at four years old, and leave that detail out, because it does not fit the boxes.

We must widen the boxes.

In 1977, Brian May wrote a song with a deliberate silence in it. He left space; audible, felt space, where the audience was supposed to arrive. He was not being naïve about the noise. He heard the noise. He knew the noise was there. He made the decision to call it music.

That is not sentiment. That is vision.



When Order And Anarchy Live Together - Dr Khurram Sadiq



Stomp. Stomp. Clap – The Rhythm that Changes Rooms

Dr. Khurram Sadiq

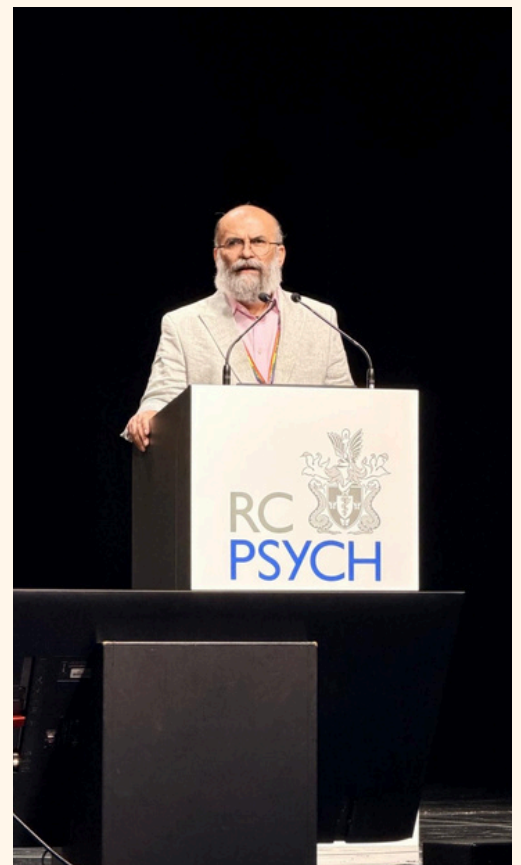


Be the Brian May in the room. Look at the colleague whose ADHD means they cannot sit in the open-plan office but who will be a clinician of extraordinary precision. Look at the patient who has spent forty years being told they are too intense, too rigid, too much and ask: too much for what, exactly? Too much for a system that was never built for them? Or exactly enough for a world that desperately needs people who feel things this deeply and refuse to pretend otherwise? Look for the fork shifting from the right hand to the left. Look for what the referral letter left out. Look for the quiet one in the corner who is holding the whole structure up while everyone else is busy making noise.

Neurodiversity is everywhere. It is in your ward. It is in your team. It is in the history of medicine, in every clinician who looked at the consensus and asked, genuinely, without agenda: but why? It is in Queen's back catalogue and in the silence Brian May left at the centre of a song that has outlived every stadium it was played in.

You just need the eye to see it.

Stomp. Stomp. Clap.



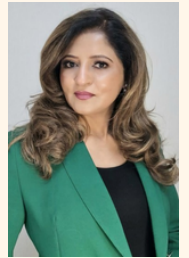
Presenting AuDHD at RCPsych International Congress 2026

Dr. Khurram Sadiq

Dr Khurram Sadiq is a Consultant Neurodevelopmental Psychiatrist his specialism being AuDHD , Honorary Member of the UN Vienna Disability Inclusion Network(DIN) VIC, 7x TEDx speaker, International Speaker, RCPsych Communicator of the Year 2025, SEL Inspirational and Innovative Leader of the year 2025, lead the Oxleas ADHD team to the RCPsych Team of the year 2024 award and author of 'Explaining AuDHD' (Canelo/Penguin Random House, 2025).

Neurodiversity and Transcultural Psychiatry: Seeing the Person Behind the Diagnosis

Dr. Saima Niaz
Chair RCPsych Transcultural Psychiatry SIG



As psychiatrists, we are trained to recognise patterns of illness. However, it is important to consider whether some of these "symptoms" may instead reflect a person's unique neurodevelopmental profile, shaped by cultural and contextual factors.

A young woman from a South Asian family presents with anxiety, exhaustion, and recurrent depression. She has spent years masking her social difficulties, forcing eye contact, and imitating peers to fit in. Her family describes her as shy and overly sensitive, whereas she has always felt different. Autism is considered only in adulthood. Such cases are not uncommon. Cultural expectations significantly shape the recognition and interpretation of autistic traits, often leading to delayed or missed diagnoses, particularly among women and individuals from minority ethnic backgrounds.

The neurodiversity paradigm encourages us to view conditions such as autism and ADHD not only through a medical lens but also as natural variations in human cognition. This perspective does not minimise the significant challenges many individuals face; instead, it shifts the focus towards recognising strengths, reducing stigma, and providing appropriate support.

Transcultural psychiatry adds a critical dimension. Culture shapes how families interpret behaviour, seek help, and engage with mental health services. In some communities, repetitive behaviours may be seen as personality traits rather than neurodevelopmental differences; in others, stigma associated with mental illness may delay assessment.



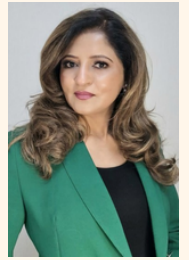
**Representatives from Transcultural and
Neurodevelopmental Psychiatry SIGs in RCPsych IC 2026**



NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Neurodiversity and Transcultural Psychiatry: Seeing the Person Behind the Diagnosis

Dr. Saima Niaz
Chair RCPsych Transcultural Psychiatry SIG



As Arthur Kleinman observed, clinicians must ask not only “What is the diagnosis?” but also “What does this illness mean to this person and their family?”

For trainees, this intersection is particularly relevant. It underscores the importance of approaching each assessment with curiosity rather than preconceived assumptions. A culturally informed, neurodiversity-affirming approach reduces diagnostic bias, enhances therapeutic relationships, and fosters understanding rather than judgment among patients. Evidence indicates that greater acceptance of autistic individuals is associated with better mental health outcomes, whereas stigma and the pressure to camouflage autistic traits are linked to higher levels of anxiety and depression.

Ultimately, both neurodiversity and transcultural psychiatry challenge us to move beyond reliance on checklists and diagnostic categories. They remind us that every patient brings not only neurological characteristics but also a cultural background, a personal narrative, and an identity. As psychiatrists, we should strive to make space for all these dimensions.

Suggested further reading

- de Leeuw A, Happé F, Hoekstra RA. A conceptual framework for understanding the cultural and contextual factors on autism across the globe. Autism Research. 2020.
- Keating CT et al. Cross-cultural variation in experiences of acceptance, camouflaging and mental health difficulties in autism. PLOS ONE. 2024.
- Grummt M. Sociocultural Perspectives on Neurodiversity. Sociology Compass. 2024.



Dr. Saima Niaz with Transcultural Psychiatry SIG team and RCPsych International Congress 2026



Professor Subodh Dave, Dr. Ananta Dave, Dr. Derek Tracey, Dr. Fabida Aria, Dr. Saima Niaz and Dr. Owen Boden James

Dr. Saima Niaz

Consultant Psychiatrist, North London NHS Foundation Trust
Expertise: General Adult, Liaison, Forensic & Perinatal Psychiatry
Numerous research publications
Public Mental Health Leadership Certification, Royal College of Psychiatrists

Chair, Transcultural Psychiatry SIG, Royal College of Psychiatrists
Executive Member – London Division Royal College of Psychiatrists
Life & Executive Member, British Pakistani Psychiatrists Association

Global Advocacy & Peace Work:
Patron & Ambassador of Peace, Universal Peace Federation UK (UPF)

Media & Public Engagement:
Expert Columnist, Global Woman Magazine, Contributor to TV, radio, and print media



Beyond Behaviour: Listening to the Unique Self in Psychiatry

Sarah Clark



For many autistic and neurodivergent people, distress is too often misunderstood by professionals as “behaviour”, or placed under the umbrella term “challenging behaviour”.

What may appear externally as withdrawal, agitation, emotional dysregulation, non-compliance, or “challenging behaviour” may instead represent sensory overwhelm, autistic shutdown, meltdown, burnout, trauma responses, rejection sensitivity dysphoria (RSD), physical pain, or a nervous system pushed beyond capacity.

In my multiple roles as an autistic autism researcher, lived experience autism trainer, and someone with complex physical health conditions who is frequently a patient in hospital — including hypermobile Ehlers-Danlos syndrome (hEDS), Postural Orthostatic Tachycardia Syndrome (POTS), and mast cell activation syndrome (MCAS) — I have experienced first-hand how easily neurodivergent distress can be misunderstood within healthcare systems.

I have also seen how transformative it can be when clinicians move beyond behavioural interpretations and instead ask: What is this person communicating through their distress?

Diagnostic Overshadowing and the Cost of Being Misunderstood

Many autistic adults experience years, or even decades, of misdiagnosis before receiving an autism diagnosis. During this time, distress is frequently conceptualised through psychiatric or behavioural frameworks that do not fully capture the person’s lived experience. For neurodivergent individuals with co-occurring physical health conditions, the situation can become even more complex.

Symptoms such as chronic pain, fatigue, dizziness, gastrointestinal difficulties, sensory hypersensitivity, shutdown, dissociation, communication differences, and emotional overwhelm are often fragmented across services or viewed in isolation within siloed medical specialities. Physical symptoms may be attributed to anxiety. Autistic distress may be interpreted as behavioural disturbance. Trauma responses may be misunderstood as personality pathology or even given the diagnostic label of a personality disorder.

Sadly, it is all too common for late-diagnosed autistic women to have previously been misdiagnosed with Emotionally Unstable Personality Disorder (EUPD), which can have far-reaching, stigmatising, and sometimes devastating consequences.

This process of diagnostic overshadowing can have profound consequences.

Beyond delays in diagnosis and treatment, there is often a deep emotional impact associated with repeatedly feeling unheard, disbelieved, or misunderstood. Many neurodivergent people internalise shame after years of being told that their behaviour is problematic and dysfunctional and that they are “too sensitive”, “attention seeking”, “difficult”, or “overreacting”, when in reality their nervous systems may have been in prolonged states of overwhelm and survival.



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Beyond Behaviour: Understanding Autistic Distress

Traditional psychiatric models can sometimes prioritise observable behaviour over internal experience. However, behaviour alone rarely tells the full story.

An autistic person who stops speaking during crisis may not be refusing to engage, but experiencing shutdown. Someone pacing, covering their ears, or becoming increasingly distressed may be attempting to regulate overwhelming sensory input. Emotional dysregulation may reflect cumulative sensory and nervous system overload rather than deliberate behavioural escalation.

In healthcare, and mental health settings particularly, sensory overwhelm is frequently mistaken for “behavioural disturbance”.

Bright lights, unpredictable environments, noise, unfamiliar routines, time pressures, multiple verbal demands, and lack of psychological safety can all contribute to autistic distress. Yet these environmental contributors are often overlooked, and the person themselves may be blamed for their “behaviour”.

When clinicians move from asking “What is wrong with this person?” to “What has happened to this person?” and “What does this person need to feel safe?”, opportunities for more compassionate and effective care emerge.

Crisis Care, Safety, and Co-Regulation

For many neurodivergent people, feelings of safety are foundational to communication, emotional regulation, and engagement with services.

Unfortunately, mental health crisis care can unintentionally escalate distress when environments are highly sensory, restrictive, fast-paced, or lacking neurodevelopmental understanding.



NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

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Trauma-informed and neuro-affirmative approaches are essential.

Co-regulation, relational safety, predictable communication, sensory accommodations, validation, and allowing processing time can significantly reduce distress and improve engagement. Small adjustments, such as reducing sensory input, adapting communication styles, explaining procedures clearly, or recognising shutdown and burnout, can profoundly alter a person's experience of care.

Importantly, autistic burnout and shutdown are still poorly recognised across many healthcare settings despite their significant impact on functioning and wellbeing. Burnout may present with exhaustion, increased sensory sensitivity, loss of functional skills, emotional dysregulation, and withdrawal — experiences that can easily be misinterpreted as “behavioural” through purely psychiatric lenses if neurodevelopmental understanding is absent.

Reconnecting With the Body: Interoception and Embodiment

Many neurodivergent people experience differences in interoception — the ability to sense and interpret internal bodily signals. This can affect emotional awareness, pain perception, hunger, thirst, anxiety recognition, and nervous system regulation.

For individuals who have spent years masking, surviving, or disconnecting from overwhelming bodily experiences, reconnecting with the body can feel unfamiliar and, at times, unsafe.

Yet embodiment practices such as yoga, mindfulness, breathwork, grounding, and nervous system-informed approaches may offer important opportunities for self-understanding and regulation when approached safely and compassionately.

Rather than viewing emotional regulation purely as a cognitive process, psychiatry may benefit from increasingly recognising the role of the body, sensory systems, trauma, interoceptive awareness, and autonomic nervous system functioning in mental health and wellbeing.

Towards More Integrated and Human-Centred Care

Psychiatry cannot afford to continue overlooking physical health in neurodivergent populations.

Emerging research increasingly highlights associations between autism, ADHD, connective tissue disorders, autonomic dysfunction, immune differences, chronic pain, and gastrointestinal conditions. Despite this, services often remain siloed and fragmented, leaving individuals navigating multiple specialists and services that rarely communicate effectively with one another.



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Interdisciplinary collaboration is therefore vital.

Equally important is listening to lived experience. Neurodivergent individuals are experts in their own sensory, emotional, and bodily experiences. When clinicians listen beyond behaviour and seek to understand the unique person in front of them, healthcare becomes not only more effective, but also more human and personalised.

For many neurodivergent people, receiving a diagnosis is not about acquiring a label. It is about finally understanding a lifetime of experiences through a lens of compassion rather than deficit.

Sometimes the most important clinical question is not: “How do we manage this behaviour?”

But rather: “What does this person need in order to feel safe, understood, and able to thrive?”

Ultimately, moving beyond behaviour means recognising the whole person: their nervous system, sensory world, physical health, trauma history, communication style, strengths, needs, and humanity.



A La Folie by Sarah Clark

Sarah Clark

Sarah is a Patient Expert in the EDS International Consortium (Psychiatric Working Group) and a Postgraduate Researcher on diagnostic delays in Autism and HEDS. With an MSc in Clinical and Developmental Neuropsychology, Sarah is an award-winning EDI advocate, EBE Autism Trainer, author, and photographer. Her work captures the intersection of health, trauma, and healing, using photography to explore the power of embodiment practices in resilience and self-discovery.



Lost in Translation: ADHD Across Cultures

Dr. Kamran Mehmood

Abid, a sixteen-year-old boy from Karachi, Pakistan, was the kind of student teachers never quite knew what to make of. Quiet and reserved, he moved through school with a gentleness that made him easy to be overlooked. He preferred the edges of classrooms, quieter corners of playgrounds, and the company of a few close friends rather than large groups. Teachers often described him as being “in his own world,” that familiar phrase adults use when a child seems present in body but elsewhere in mind.

Yet academically, Abid was clearly not unintelligent. During his GCSE years, he excelled in subjects that genuinely interested him. Biology fascinated him. Chemistry made intuitive sense. He wrote thoughtful essays, demonstrated strong comprehension, and performed well in most of his classes.

But Mathematics and Physics were a different story. There, his performance collapsed. He did not ask questions. He seemed distracted. He rarely showed visible interest. This inconsistency baffled the people around him.

At a parent-teacher meeting, the vice principal of institute, who also taught Physics, was blunt. How could a student perform so well in some subjects and so poorly in his? How could someone achieve high grades elsewhere yet fail Physics and Mathematics unless something questionable explained the discrepancy? The implication was clear: perhaps Abid had cheated in the subjects where he had done well.

The vice principal also had a nickname for him: freelancer. Not because Abid freelanced, of course, but because he appeared detached, uncommitted, unwilling to properly engage. In the vice principal's eyes, he was simply a boy who did not care.

But what the vice principal saw was forty minutes a day. He did not see the rest.

He did not see the student who could spend hours immersed in biology, following ideas with deep concentration, only to feel overwhelming resistance when trying to begin a Physics assignment or solve an algebra equation. He did not see what teachers often miss in quieter students: the internal lag of processing information just slowly enough that, by the time understanding arrived, the lesson had already moved on. He did not see the paralysis of wanting to ask a question but realizing the class was already discussing the next concept, making the question feel embarrassing.

So Abid stayed silent. And silence, in classrooms, is often misread. Teachers interpreted it as disinterest.

Another teacher had once described him as *daanwa-dol* - an Urdu word used to describe someone unsettled, unsure, unreliable, or restless. The labels accumulated: careless, inattentive, disinterested, non-serious, bright but doesn't apply himself. At home he was called 'La-parwah' - which translates to careless. These are phrases generations of South Asian students know intimately.



Lost in Translation: ADHD Across Cultures
Dr. Kamran Mehmood



At home, the pattern continued. Assignments were left until the last minute. Sometimes forgotten entirely. Books were misplaced. Plans were made enthusiastically and then abandoned. Tasks were started with energy but left unfinished. Small impulsive purchases became routine. Following through on intentions felt harder than it should have.

Social situations were another quiet struggle. Abid often came across as awkward or distant, not because he disliked people, but because social interaction required effort he could not always explain.

No one saw a pattern. Or if they did, they did not know what to call it.

Instead, adults did what adults often do when behaviour does not make immediate sense: they moralized it. Forgetfulness became laziness. Disorganization became carelessness. Silence became disinterest. Poor follow-through became non-seriousness or, in the vice principal's words, freelancing.

Forgotten homework did not prompt curiosity. It prompted punishment. Sometimes verbal humiliation in front of classmates. Sometimes physical punishment, common enough in many schools to feel routine rather than remarkable. Shame was meant to correct behaviour. Instead, it deepened the problem, because shame does not improve executive functioning; it worsens it.

The tragedy in stories like Abid's is not that one student struggled. Many children struggle. The tragedy is how quickly struggle becomes identity. When a child hears "careless" enough times, it stops sounding like feedback and starts sounding like truth.

When teachers repeatedly describe a student as inattentive, lazy, non-serious, or difficult, those descriptions do not remain in classrooms. They become part of how that child understands himself. This is perhaps one of the harshest consequences of undiagnosed neurodevelopmental conditions - not merely academic difficulty, but the slow construction of shame as identity.

Not every child like Abid has ADHD. That is important to say. Academic struggles are multifactorial. They can emerge from anxiety, depression, trauma, family stress, poor teaching, learning disabilities, or any number of other causes.

But ADHD remains widely misunderstood in Pakistan, particularly in the ways that matter most. Many people still imagine ADHD as a hyperactive child who cannot sit still. In doing so, the quieter children are missed. The intelligent but inconsistent ones. The children who hyperfocus on subjects they love while appearing incapable of starting tasks they find overwhelming. The students whose internal chaos remains invisible because it does not disrupt the classroom. And because these children do not fit familiar stereotypes, they are often judged rather than understood.



Many subcontinent classrooms can be especially unforgiving toward this kind of difference. Large class sizes, limited teacher training, minimal psychological support, and a deep cultural emphasis on discipline, obedience, and academic performance can make invisible struggles easy to misread. Public correction remains normalized. Mental health literacy is uneven at best. Within such systems, invisible struggles are easily mistaken for moral failings.

A child who forgets assignments looks irresponsible. A student who zones out looks disrespectful. Someone who performs brilliantly in one area but fails in another looks suspicious. From the outside, inconsistency can resemble choice. But neurodivergence is often inconsistent by nature. Attention can shift dramatically depending on interest. Executive dysfunction can make seemingly simple tasks feel disproportionately difficult. Without awareness, adults judge children by what they cannot do instead of asking why. And those judgments can damage self-confidence for decades.

Abid's story is not unusual. That is precisely the problem. There are many adults in Pakistan carrying similar memories. Some were diagnosed later. Many never were. But diagnosis is not the only issue. Recognition, curiosity, and compassion matter.

A teacher seeing poor performance should ask why before assigning character judgments. A parent seeing inconsistency should consider struggle before assuming laziness. Because for some children, the difference between being understood and being mislabelled shapes an entire life.

Abid was not the only one to endure the shame. And unless awareness of neurodivergence changes among teachers, schools, and parents, he will not be the last.



Dr. Kamran Mehmood
presenting his
work in RCPsych
International
Congress 2026

Dr. Kamran Mehmood

Dr Mehmood is a General Adult Psychiatry ST6 trainee and will be taking up a Consultant post in an Assertive Outreach Team (AOT) this August. His clinical and academic interests include neurodevelopmental disorders, transcultural psychiatry, and advancing equality, diversity, and inclusion (EDI) in mental healthcare. He is passionate about improving equitable access to mental health services and enhancing care for individuals with complex needs across diverse populations.

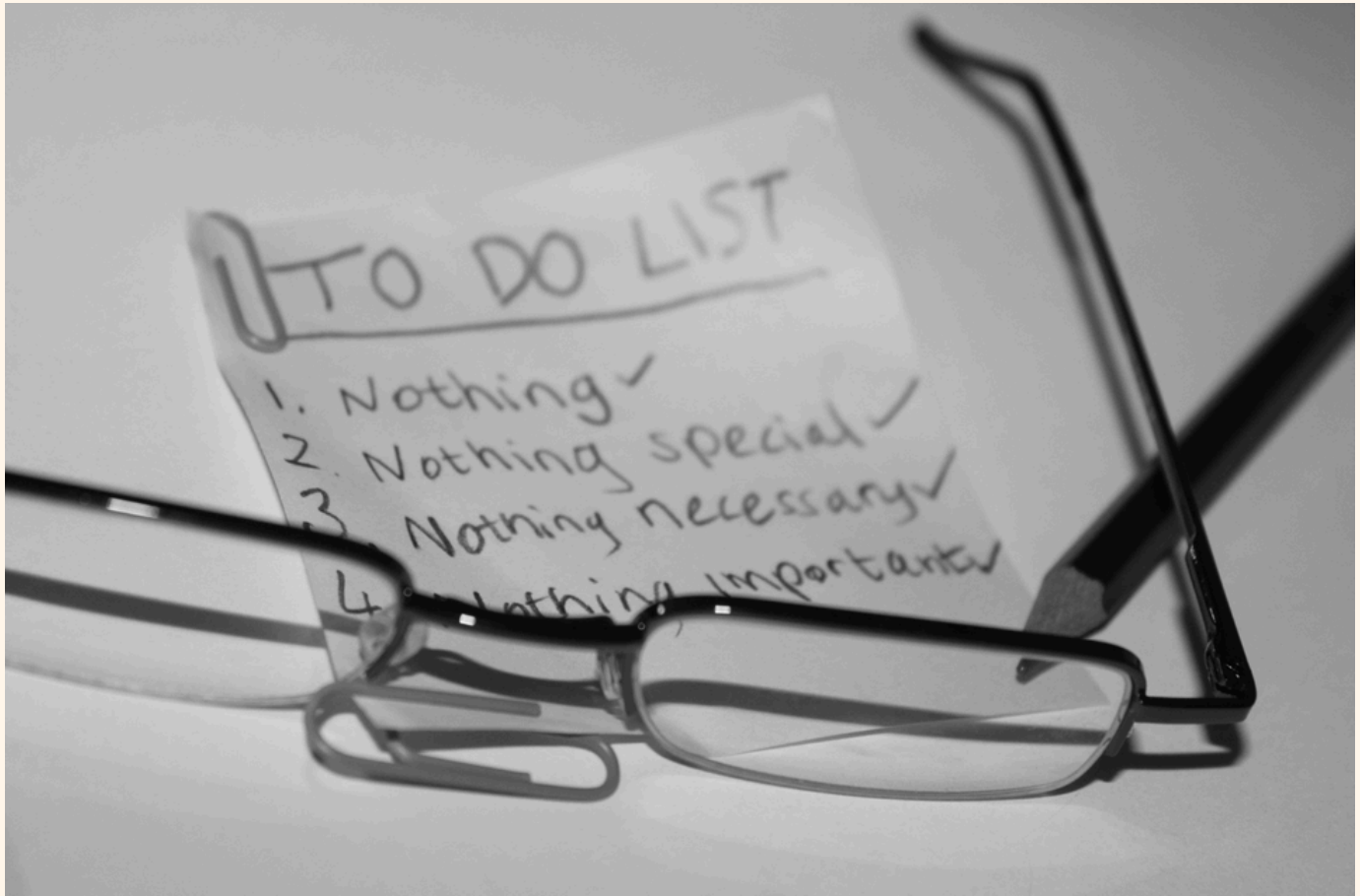
Outside of work, enjoys travelling and is an avid cricket enthusiast.



Shutter - Stories

The To-Do List

Sarah Clark

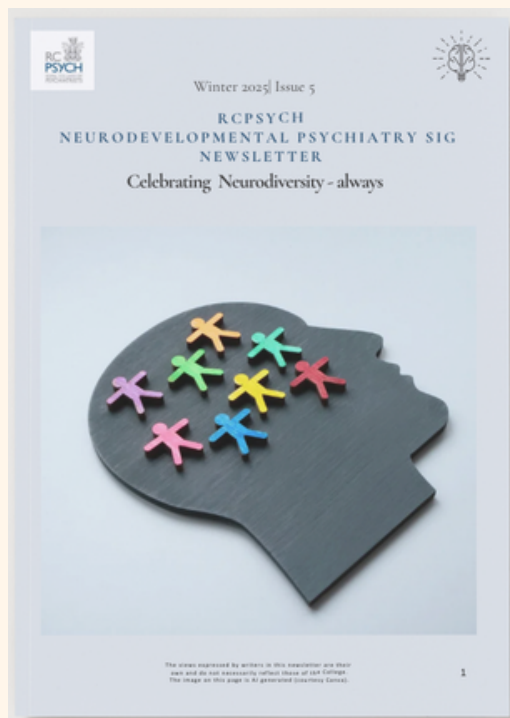


To-do list by Sarah Clark

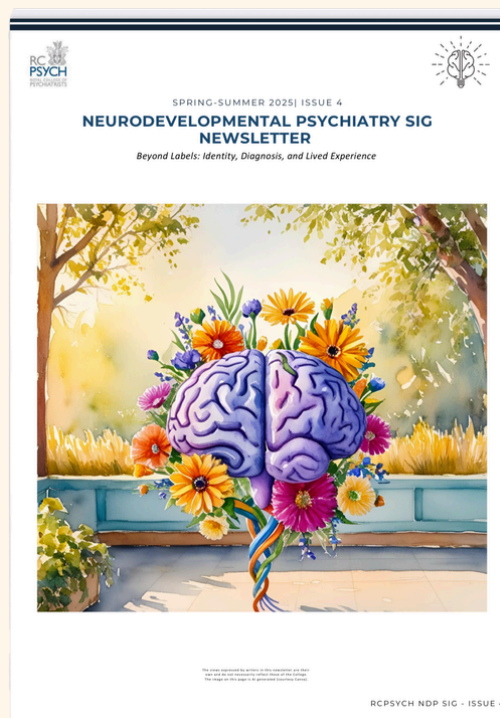
For years, I measured my worth by what I achieved. Recovery began when I realised that rest is not the absence of productivity; it is a necessity. In a world that celebrates busyness, choosing rest can feel almost rebellious. For people living with chronic illness, disability, or neurodivergence, an apparently empty day is rarely empty at all. Behind every unchecked task lies a series of invisible calculations: spoons-math! Constantly calculating the impact of every activity on your pain, fatigue, sensory load, cognitive capacity, executive function, and survival. When every action carries a cost, “nothing” is rarely nothing. Sometimes rest is not avoidance - it is strategy. Perhaps the most radical item on any to-do list is giving ourselves permission to simply ‘be’. Some days, doing ‘nothing important’ is, in fact, the most important thing on the list! After all, it’s often the time when I have the most important sudden insights and realisations on things I’m working on.

Pre-view

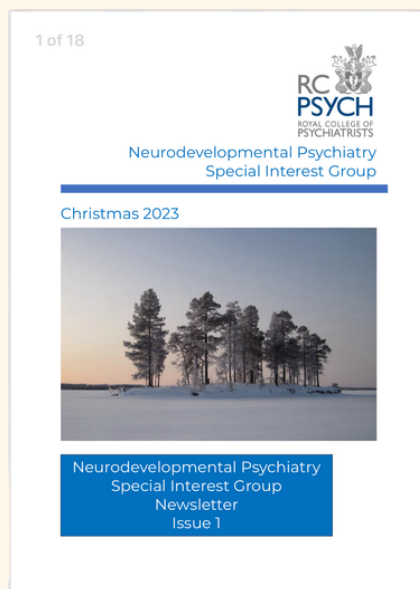
Our newsletters so far



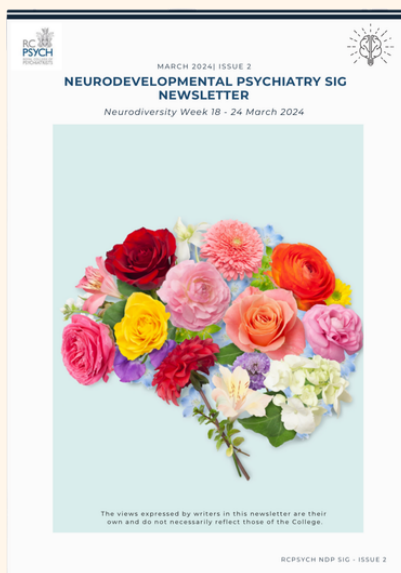
Issue 5 : Winter 2025



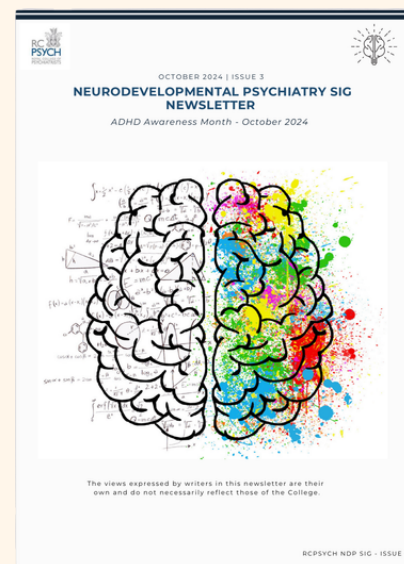
Issue 4 : Spring- Summer 2025



Issue 1 : Winter 2023



Issue 2 : Spring Summer 2024



Issue 3 : Autumn-Winter 2024

Snap shots of our 5 previous editions - find them on the RCPsych Neurodevelopmental Psychiatry SIG page - linked below



National Autism and ADHD Training Programme for Psychiatrists (NATPP)

Elen Cook

Autistic people experience higher rates of mental health difficulties and are often supported across a range of psychiatric services. However, many psychiatrists have limited access to specialist autism training beyond core requirements. To address this gap and support professional development, a National Autism Training Programme for Psychiatrists will be delivered for a second time.

This national programme aims to strengthen capability, improve patient outcomes, and support a clear professional development pathway in autism and neurodiversity.

The NATPP is designed for:

- Consultant Psychiatrists
- SAS Psychiatrists
- Resident Doctors in Higher Training

This course is funded by NHS England and is available to eligible learners working in England. Learners in Wales, Scotland, and Northern Ireland are welcome to submit an EOI - we hope to be able to accommodate learners if funding can be sourced.

The course will begin in September 2026. To be notified when the programme is open for applications please complete this expression of interest form: [Expression of Interest \(EOI\) National Autism Training Programme for Psychiatrists - Fill in form](#)

For more information about the programme or to apply to be a mentor, contact: keisha.byfield@rcpsych.ac.uk



[National Autism Training Programme for Psychiatrists | NHS England | Workforce, training and education](#)



RCPsych ADHD Foundation Course

Sherlie Arulanandam

This course aims to educate general adult psychiatrists about the nature, assessment and management of adult ADHD.

While ADHD has long been studied and discussed in the context of childhood, there is mounting evidence that its symptoms often continue into adulthood, where more individuals are now being diagnosed and navigating its impact. Adult ADHD is frequently comorbid with other disorders: neurodevelopmental disorders, mood disorders, anxiety disorders, personality disorders, alcohol and substance disorders. It is, therefore, important for general adult psychiatrists to be able to diagnose ADHD in this population and differentiate it from other disorders.

The aim of the foundation course is to help general adult psychiatrists gain a better understanding of adult ADHD and learn about diagnosis and support. It seeks to support psychiatrists to be able to recognise and respond to the needs of people with adult ADHD by successfully combining pharmacological and psychosocial interventions whilst taking into account the wider support requirements for people with ADHD and their social network.

The programme will commence in autumn 2026, featuring a live online event in November and supported by an eLearning module, which delegates can access from September 2026.

Adult ADHD Foundation Course 2026

04
NOV

Virtual event
Online

[More information](#) ➔

Adult ADHD Foundation Course 2026



ADHD in women : Beyond the Label, Across the Lifespan

Dr. Usamah Khan



This article is educational and not a substitute for local clinical guidelines. Service developments should be implemented in line with local policies, commissioning arrangements, and clinical governance structures.

ADHD in women is frequently under-recognised and under-treated, not because it is uncommon, but because it is often internalised and shaped by gendered expectations around behaviour, organisation, and emotional containment (Young et al., 2020). Rather than presenting with overt disruptive hyperactivity, many women describe an inattentive profile with emotional dysregulation, perfectionistic coping, and chronic overwhelm, frequently misattributed to “stress,” anxiety, or personality factors (Quinn & Madhoo, 2014; Kooij et al., 2024).

The “masking paradox”: high functioning, high cost

A common clinical trajectory is compensation until collapse; academic or workplace functioning is maintained through high effort, anxiety-driven over-preparation, rigid routines, and self-criticism, while impairment accumulates privately in the form of exhaustion, burnout, and low self-esteem (Young et al., 2020). Over time, this may contribute to diagnostic delay and repeated experiences of demoralisation—“I’m capable, so why can’t I cope?”—which then becomes fertile ground for comorbid anxiety and depression (Faraone et al., 2021).

Hormones are not a footnote — they can be the clinical story

Across the lifespan, ADHD symptom expression and medication response may be influenced by hormonal fluctuation, particularly during puberty, menstrual cycling, pregnancy/postpartum, and perimenopause/menopause (AADPA, 2024; Findeis & Strauß, 2025). Oestrogen is described as enhancing dopaminergic transmission and potentially stimulant responsiveness, while oestrogen decline (e.g., late luteal phase, perimenopause/menopause) may worsen attention and emotional regulation and may transiently resemble “treatment resistance” (Findeis & Strauß, 2025). Evidence from experimental work also suggests stimulant effects can differ by menstrual phase (Justice & de Wit, 1999).

Clinical takeaway: when a patient reports a sudden drop in medication benefit, first check for hormonal context (cycle phase, postpartum transition, perimenopause) before escalating doses or switching treatments (AADPA, 2024; Findeis & Strauß, 2025).

Assessment: a female-informed checklist is recommended

In addition to the standard adult ADHD pillars (developmental history, onset in childhood, multi-setting impairment, and functional impact), a women-focused assessment benefits from explicitly documenting hormonal and reproductive factors (Kooij et al., 2024; AADPA, 2024).



Practical items to include:

- menstrual/cycle pattern, PMDD or premenstrual symptom exacerbation (de Jong et al., 2023; Dorani et al., 2021)
- pregnancy/postpartum status (or plans), breastfeeding considerations (AADPA, 2024; NICE, 2018)
- perimenopause/menopause symptoms and HRT status where relevant (Berkshire Healthcare NHS Trust, 2023)
- key functional outcomes: organisation, emotional regulation, relationship functioning, and occupational stability (Young et al., 2020)

Comorbidity and risk: what to screen deliberately

Women with ADHD show high rates of internalising disorders, particularly anxiety and depression, and these may represent downstream effects of chronic impairment, shame, rejection sensitivity, and repeated “near misses” rather than independent primary mood pathology (Young et al., 2020; Faraone et al., 2021). Emotion dysregulation and borderline-like features may reflect the impact of executive dysfunction and chronic invalidation rather than fixed personality disorder (Quinn & Madhoo, 2014; Kooij et al., 2024). Hormone-linked mood symptoms may also be prominent, including PMDD-like presentations (Dorani et al., 2021).

Clinical pearl: where mood symptoms appear reactive to life-long organisational and attentional difficulties, treating ADHD (with psychoeducation and appropriate medication) may lead to meaningful improvement in emotional symptoms (Faraone et al., 2021).

Management: phase-sensitive, function-focused care

Guideline-based pharmacological approaches remain broadly similar, but the lived clinical reality for many women is that efficacy can vary with hormonal phase and life stage (AADPA, 2024; NICE, 2018). Where symptom deterioration is reliably premenstrual, careful and individualised approaches (including structured monitoring and, where appropriate, planned dose adjustment strategies) have been explored (de Jong et al., 2023). In perimenopause/menopause, clinicians should be encouraged to reassess ADHD symptoms and functional targets and consider interdisciplinary discussion where hormone-related change appears central (Berkshire Healthcare NHS Trust, 2023; Findeis & Strauß, 2025).

Non-pharmacological interventions remain essential, particularly for internalised ADHD profiles: psychoeducation, coaching/CBT strategies for executive dysfunction, skills for emotion regulation, and support around sleep and routine scaffolding (Young et al., 2020; AADPA, 2024). Qualitative work also supports the value of female-specific groups as a context for reducing shame and improving self-understanding and coping (de Jong et al., 2024).

ADHD in women : Beyond the Label, Across the Lifespan

Dr. Usamah Khan



Clinical Pearls (for quick reading)

- Consider ADHD in women presenting with chronic overwhelm, emotional dysregulation, perfectionistic coping, and late-onset “burnout,” even when they appear high functioning (Young et al., 2020; Quinn & Madhoo, 2014).
- Hormonal transitions (late luteal, postpartum, perimenopause/menopause) can worsen symptoms and alter perceived medication benefit—review hormonal context before changing medication (AADPA, 2024; Findeis & Strauß, 2025).
- Screen deliberately for anxiety/depression, PMDD-like symptoms, and emotion dysregulation; interpret “borderline-like” features carefully within the ADHD context (Dorani et al., 2021; Faraone et al., 2021; Kooij et al., 2024).
- Keep management function-focused (sleep, routines, relationships, work functioning) rather than relying only on symptom checklists (Young et al., 2020).

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Dr. Usamah Khan

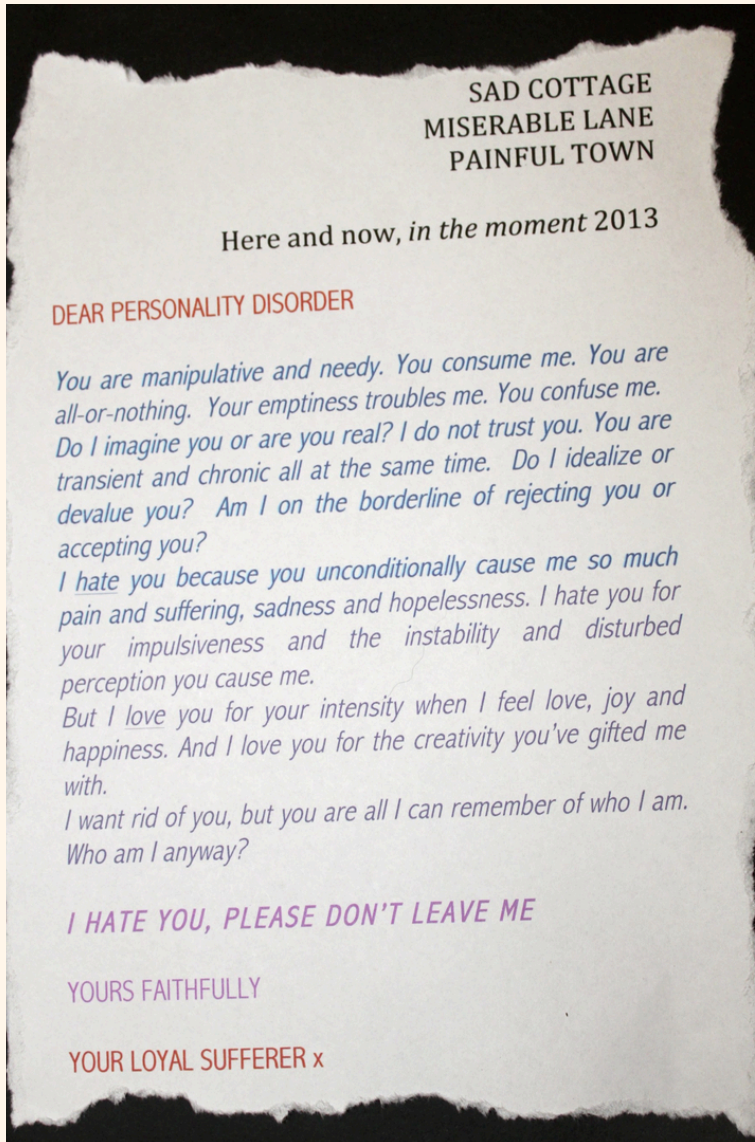
Dr Usamah Khan is a psychiatry trainee with clinical and academic interests in public mental health, neurodevelopmental psychiatry, medical education, and culturally informed mental health care. He has contributed to academic writing on psychiatry in Pakistan and South Asia, including work on early intervention in psychosis, geriatric psychiatry, and national mental health systems. Alongside his clinical work, he is interested in reflective writing, poetry, and the role of narrative in mental health.



Shutter - Stories

'Dear personality disorder'

Sarah Clark



Dear Personality Disorder by Sarah Clark

In 2013, I wrote a letter addressed to what I believed was "my personality disorder." At the time, my understanding of myself was largely shaped by the diagnostic constructs offered by professionals. I accepted the explanation that my 'difficulties' were rooted in a construed and constructed 'disordered' personality, and I tried to make sense of my experiences through that diagnostic lens, trusting the professionals as 'the experts'. Looking back now, I see myself as someone who was desperately searching for answers, understanding, and compassion, yet harmfully constrained by a stigmatizing framework that never truly captured the complexity of what I was actually living through.

More than a decade later, in my mid-thirties, I was formally diagnosed with autism and Complex PTSD, as well as hypermobile Ehlers-Danlos syndrome. Those diagnoses did not change who I was, but they transformed how I understood myself and my self-compassion. Experiences and differences once interpreted as symptoms of a flawed personality began to make sense as the understandable consequences of neurodivergence, trauma, sensory overwhelm, and years of navigating a world that often felt confusing and exhausting. I sometimes wish I could go back and sit alongside my younger self as she wrote that letter. I wish I could tell her that she was never broken, never difficult, and never the personality disorder diagnosis she had been given. Most of all, I wish she knew then what I know now: that understanding ourselves through a lens of compassion can be far more powerful than understanding ourselves through a lens of pathology.



From Diagnosis to Formulation: What Neurodivergent Patients Taught Me in Acute Psychiatry

Dr Mariana Galvao de Oliveira

Early in my psychiatric practice, I often understood agitation, emotional instability and behavioural disturbance through familiar diagnostic frameworks - psychosis, mood disorder, or personality-related pathology.

These frameworks remain essential within acute psychiatry, particularly for risk assessment, communication and treatment planning. Yet over time, I encountered patients whose presentations resisted these explanations and challenged my assumptions about behaviour, distress and psychiatric formulation.

Working within an acute adult psychiatry ward has increasingly shaped how I understand neurodivergence in crisis presentations.

Through both clinical experience and engagement with neurodevelopmental theory, my thinking has gradually shifted from a predominantly diagnosis-led approach towards a more formulation-driven and mechanism-based understanding.

One patient, whose presentation reflected patterns I have subsequently recognised across several neurodivergent admissions, remains particularly memorable.

She was a young woman with autism, ADHD and mild learning disability, known to services through multiple crisis-related admissions. During admission she presented with marked emotional dysregulation, impulsivity, behavioural escalation, perceptual disturbances and episodes of aggression. Her presentation appeared diagnostically complex and, at first glance, could reasonably have been conceptualised through several psychiatric frameworks, including mania, psychosis or emotionally unstable personality disorder.

Like many clinicians working in acute settings, my initial task was to identify risk, stabilise distress and determine the most appropriate diagnostic formulation. Yet as the admission progressed, the clinical picture became increasingly difficult to reconcile with any single diagnosis.

Her distress appeared highly sensitive to environmental and interpersonal context. Behavioural escalation often followed increased stimulation, disruption of routine or perceived demands. What initially appeared as behavioural disturbance or psychiatric deterioration seemed closely linked to overwhelm rather than to a primary mood or psychotic disorder.

This observation prompted reflection

Acute wards are inherently stimulating environments. Noise, unpredictability, frequent interpersonal contact and rapid transitions are often unavoidable features of inpatient care. While these settings provide safety and containment, I began to recognise a paradox within acute psychiatry: the very environments designed to reduce risk may simultaneously intensify distress for some neurodivergent individuals.



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For this patient, reduction in environmental demands was associated with improved behavioural stability. This invited a different interpretation of her presentation, one less focused on symptom categories and more attentive to underlying mechanisms.

I found myself increasingly considering how sensory processing differences and cognitive overload might contribute to crisis presentations.

**From Diagnosis to Formulation: What Neurodivergent Patients
Taught Me in Acute Psychiatry**

Dr Mariana Galvao de Oliveira

When behaviour falls outside these expectations, it may be experienced as deliberate, oppositional or “non-compliant.” Social psychology describes a related phenomenon through the fundamental attribution error, the tendency to attribute behaviour to personal characteristics while underestimating contextual factors. Reflecting on my own practice, I recognise that earlier formulations may at times have been influenced by such assumptions.

This recognition has been uncomfortable but important.

Neurodivergent patients have repeatedly challenged me to tolerate greater uncertainty in formulation and to question assumptions regarding intentionality and control. Behaviours initially interpreted as defiance, manipulation or deterioration may sometimes reflect executive overload, sensory distress or difficulties processing interpersonal demands.

Many of these reflections resonate with neurodivergent accounts describing overwhelm, misunderstanding and the exhausting pressure to have distress interpreted through conventional psychiatric frameworks.

A broader question has also emerged from these experiences. Do psychiatric training and diagnostic descriptions, historically derived largely from neurotypical presentations, adequately prepare clinicians to recognise how distress may manifest across neurodivergent individuals?



AI generated image depicting : ‘a busy corridor - NHS’



From Diagnosis to Formulation: What Neurodivergent Patients Taught Me in Acute Psychiatry

Dr Mariana Galvao de Oliveira

This question reminds me of developments within dermatology, where diagnostic descriptions historically based upon lighter skin tones reduced recognition of illness in people with darker skin. While not directly comparable, the analogy illustrates how reliance upon a single normative model may limit diagnostic confidence and accuracy across diverse populations. Might something similar occur in psychiatry?

If training is largely grounded in neurotypical presentations, clinicians may understandably feel less confident recognising how emotion, distress or perceptual experiences manifest within neurodivergent populations. This remains an area requiring further research and discussion. What I have learned through these encounters is not that diagnosis is unhelpful, nor that neurodevelopmental explanations account for all psychiatric difficulty.

Rather, I have learned the importance of remaining curious about mechanisms and cautious about assumptions.

For me, neurodivergent patients have not simply expanded diagnostic knowledge. They have challenged how I think about behaviour, distress and psychiatric understanding itself. And perhaps this has been the most valuable lesson of all.

Suggested reading

- Milton D. The double empathy problem (2012)
- Corrigan PW et al. An attribution model of public discrimination (2003)
- Ross L. The intuitive psychologist and his shortcomings (1977)
- Cage E et al. Autism acceptance and mental health (2019)

Dr Mariana Galvao de Oliveira

Mariana Galvao de Oliveira, Trust Grade Doctor in Psychiatry, South London and Maudsley NHS Foundation Trust; MSc Clinical Neurodevelopmental Sciences (candidate), King's College London



How I Realised I Might Be Neurodivergent at 27

Deepanshi Malik



I realised I might be neurodivergent at the age of 27.

Growing up, I always felt like I didn't quite fit in. But no one really pointed it out as something different. Instead, it was described in other ways—being “too sensitive”, “too shy”, “not confident enough”, or having “low self-esteem”. These labels followed me, but they never fully explained what I was experiencing.

I was born and brought up in India, and like many others, I worked towards getting into medical school. That period took time, and it affected my mental health deeply. I struggled to regulate myself, but no one around me noticed—or perhaps didn't have the tools to notice. Even I didn't question it in a different way.

Medical school came, and with it, a new environment—but the same underlying experience. The shy girl who never quite made friends in school was now in medical school, still unaware that there might be something fundamentally different about how she experienced the world. I didn't form friendships easily. I found myself being pulled into social circles rather than naturally belonging to them, often staying under the wings of roommates rather than building connections of my own.

Despite everything, I made it through medical school. But the struggles didn't disappear. They continued—in friendships, in relationships, and in how I understood myself.

After graduation, I began preparing for the PLAB exams. That journey came with its own setbacks—failures, retries, and emotional turbulence. My mental health deteriorated again, and I found myself unable to cope at times. Yet, even then, it was still seen through familiar lenses: stress, anxiety, lack of confidence. No one, including me, considered that something deeper might be underlying it.

It wasn't until late 2024, during my observership in Child and Adolescent Mental Health Services in the UK, that something shifted.

Working with autistic girls, I began to notice something I couldn't ignore—I saw myself in their stories.

The quietness. The compliance. The way they appeared “fine” on the outside while their internal world felt overwhelming. The way distress didn't always look like disruption, but instead like withdrawal, shutdown, or being labelled as “too much” when it did surface.

For the first time, I wasn't just empathising as a doctor—I was relating as someone who had lived something similar.

How I Realised I Might Be Neurodivergent at 27

Deepanshi Malik



A childhood photograph of Deepanshi with her cuddly toy.

That was when the dots began to connect.

By mid-2025, I felt certain enough to seek answers. I read extensively about autism in women, particularly how it often goes unrecognised. I completed self-assessments, reflected on my life, and started to reframe my experiences through a different lens.

Eventually, after starting work in the NHS, I was able to seek a referral. I am now on the waiting list for an adult autism assessment.

I don't share this story to recount a journey for its own sake, but to highlight something important: how easily autism in women can be missed.

Much of what we recognise as "typical" autism is still based on a narrow profile. When presentations differ—when individuals are quiet, compliant, masking, or internalising distress—it is often overlooked. Instead, these experiences are reframed as anxiety, depression, low self-esteem, or personality traits, without questioning what might lie underneath.

Realising that I might be autistic at 27 didn't feel like discovering something new. It felt like finally having a language for everything that had always been there.

For the first time, my experiences made sense—not as flaws, but as differences.

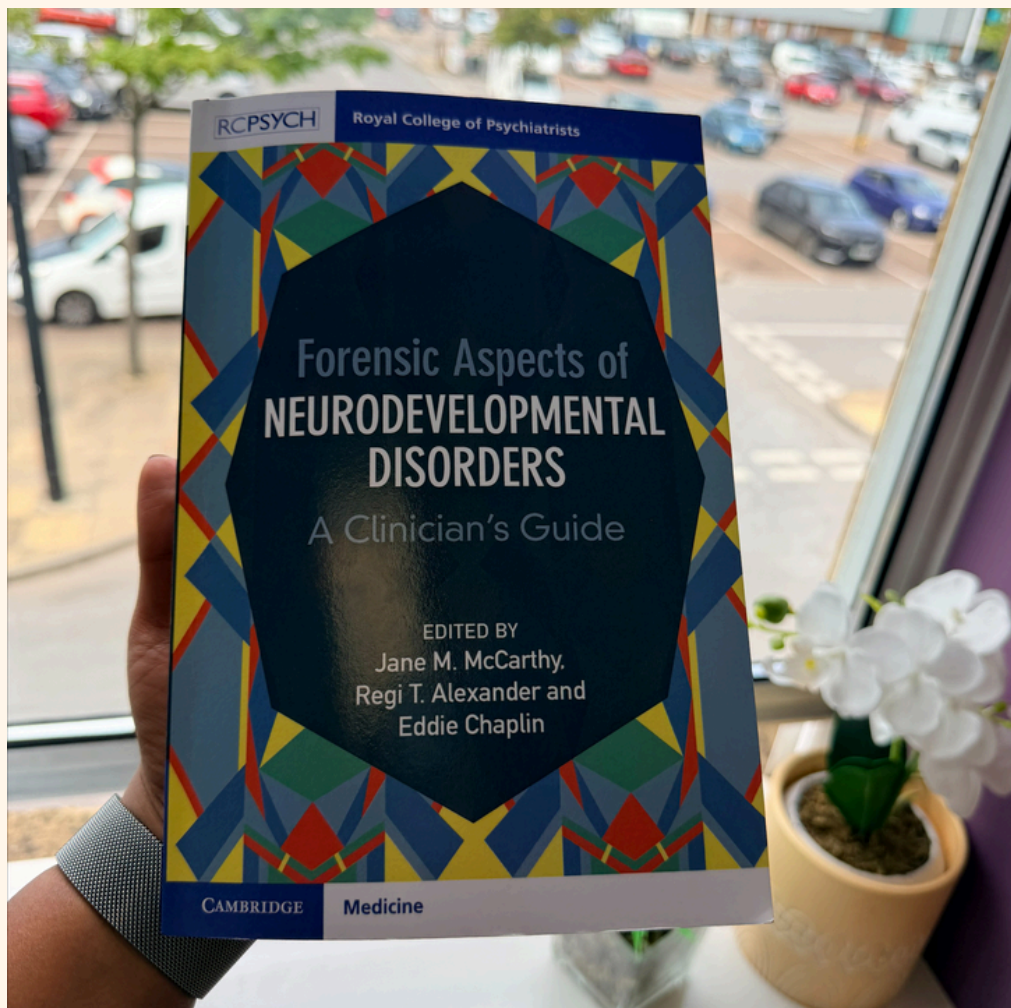
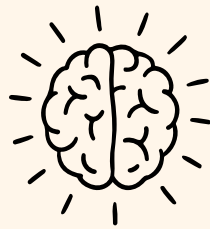
And for the first time, I could begin to understand myself with clarity, rather than confusion.

Dr Deepanshi Malik

Dr. Deepanshi Malik is a CT1-equivalent Trust Grade Doctor in psychiatry at Oxleas NHS Foundation Trust. After graduating from medical school in India, she joined the NHS in October 2025. Psychiatry has been a longstanding passion, predating her medical training, and she has a particular interest in neurodevelopmental psychiatry. As someone who identifies as neurodivergent, she values the perspective that lived experience brings to compassionate, person-centred clinical practice.

RCPsych Neurodevelopmental Psychiatry SIG - reads

Sana Fatima



Forensic Aspects of Neurodevelopmental Disorders - a clinician's guide

I purchased a copy of *Forensic Aspects of Neurodevelopmental Disorders* from the Cambridge University Press stand at the RCPsych International Congress, and I just had to share how much I enjoyed reading it.

What particularly stood out to me was its focus on the unique challenges faced by individuals with neurodevelopmental disorders at the intersection of mental health services and the criminal justice system. The book thoughtfully explores the complexities of assessment, treatment, care, and risk management across these overlapping settings while providing practical, evidence-informed guidance for clinicians working across these interfaces.

If you get the chance to read it, I'd love to hear your thoughts.



Not Entirely Whole

A reflection on clinical reports in neurodevelopmental assessment

Dr Vieri Thonet-Clarke



Seen in clinic.

Accompanied by parent.

History obtained.

You begin, as you must,
with what can be written,
in the way you have been trained.

Developmental milestones:

Delayed / variable / within
expected range.

Education:

Currently attending / struggling /
truant.

No space to rearrange.

Social communication:

Differences noted.

It is a language
that knows how to proceed.

No mention
of the morning it took
two hours to leave the house.

No space
for negotiation over:
Socks, seams, sounds.

No code
for the exhaustion
of the struggle to seem "fine" until
3 p.m.

Risk: Low.

A truth -
in the way that certain truths are.

You document strengths.

And try to be specific.

But good verbal ability
offers little reliability
in conveying
the cost of speaking.

Engaged well, rapport established
does not show
what happened after -
the time to recover,
and recharge,
and move on.

Impression:

Consistent with -

Features of -

In the context of -

The sentences close
with careful uncertainty.

And still,

- between the lines -

there is a version of the story
that does not fit the margins.

Plan:

Follow-up.

Support.

Recommendations.

You save the document.

Close the laptop.

Accurate.

Complete.

Yet not,
entirely whole.

Author's note: This is a hybrid piece combining poetry and reflective commentary, exploring the interface between clinical documentation and lived experience within neurodevelopmental assessment.

The piece reflects on how structured report-writing, while essential for clarity and consistency, may not always fully capture the variability, effort, and context that shape individual experience. It aims to offer a perspective that may resonate with clinicians working within neurodevelopmental psychiatry.

Not Entirely Whole

A reflection on clinical reports in neurodevelopmental assessment

Dr Vieri Thonet-Clarke



Clinical reports are a central component of neurodevelopmental assessment. They serve multiple functions: communicating diagnostic impressions, informing intervention, supporting access to services, and providing a record that is both clinically and legally robust.

To fulfil these roles, reports rely on structured language – concise, standardised, and defensible. This often necessitates summarising complex, longitudinal experiences into discrete categories such as “history”, “presentation”, “risk”, and “plan”

This piece reflects on what may be lost in that process. While reports aim to be comprehensive, they are inherently selective. They prioritise information that is clinically relevant and externally verifiable, which can mean that more diffuse, context-dependent, or effort-based experiences may be underrepresented.

For example, descriptors such as “engages well” or “low risk” are meaningful within a clinical framework but may not fully capture variability across settings or the cumulative impact of daily demands. Similarly, the emphasis on observable behaviour can overshadow internal experiences that are less easily articulated or measured.

The intention here is not to critique report writing, but to highlight the interpretive gap that can exist between documentation and lived experience. Recognising this gap may support clinicians in supplementing formal reports with collaborative discussions, clearer contextualisation, and, where appropriate, language that reflects both strengths and challenges in a more nuanced way.

Ultimately, reports are one part of a broader clinical narrative, rather than the whole.



Dr Vieri Thonet-Clarke

Dr Vieri Thonet-Clarke is a CT3 Psychiatry Trainee at Humber Teaching NHS Foundation Trust, currently undertaking a placement in forensic psychiatry. He graduated from Imperial College London in 2018 and was awarded MRCPsych in 2025. He is also an Honorary Lecturer at Hull York Medical School. Alongside his clinical work, he has interests in medical education, child and adolescent mental health, and neurodevelopmental psychiatry."

'Neurodivergent'

Nayab Farikhullah

I learn the world like a second
language—
a language with no grammar,
and no written rules.

It speaks in opposites:
right and wrong,
good and bad,
black and white,
darkness and light.

And I try—
God, I try—
to be truthful,
to be kind,
to be the person
it tells me I should be.

To be good.
To be careful.
To say the right thing
in the right way
at the right time.

To be someone
they don't have to correct.

But the rules change.

Without a warning.
Without any explanation.

And somehow
I am wrong again—

too direct,
too honest,

blunt,
rude,
not normal.

My worth is measured
in eye contact,
in the firmness of a handshake,
in a smile that must arrive
at the right moment—
or not at all.

Everyone else seems to know
when to look,
when to nod,
when to fall into the rhythm.

And I stand outside it—

scared,
nervous,
uncertain,
watching,
trying to understand.

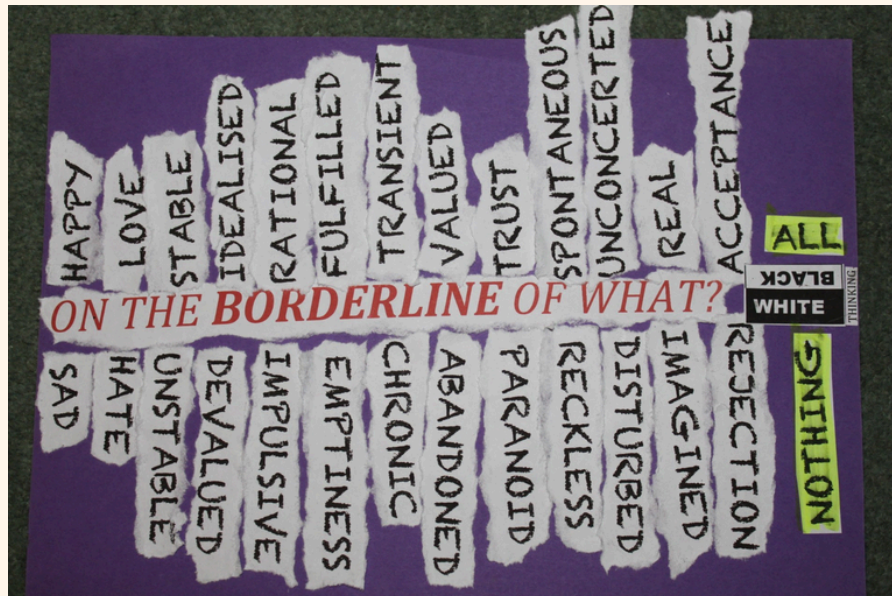


AI generated image depicting 'Neurodiversity'- open to interpretation

Shutter - Stories

Borderline of what

Sarah Clark



'On the borderline of what' by Sarah Clark

Created years before I received my autism and Complex PTSD diagnoses, this collage reflects my attempt to make sense of the label “personality disorder” that had come to dominate how professionals understood me - and, ultimately, how I came to understand myself. At the time, my identity was filtered through a diagnostic framework that encouraged me to view my experiences as evidence of pathology rather than as meaningful responses to my life circumstances.

The words surrounding the title represent a dialectical black-and-white interpretation of the diagnostic criteria associated with Emotionally unstable personality disorder (EUPD). Yet many of these words - happiness, loneliness, sadness, trust, rejection, impulsivity, empathy, vulnerability, and abandonment - are not ‘symptoms’ of illness; they are fundamental aspects of the human condition. The collage questions where the boundary lies between pathology and humanity, and whether complex emotional experiences become pathologised simply because they are intense, visible, or difficult for others (professionals) to understand within neuro-normative standards.

Looking back, I find myself returning to the question posed by the artwork: “On the borderline of what?”

Was I on the borderline of a disorder, or on the borderline of being understood? Was I inherently disordered, or was I an autistic person living within a disordered healthcare system, experiencing trauma, sensory overwhelm, and unmet support needs in a world and system that lacked the language to recognise them?

At the time, I accepted the diagnosis as an explanation for my difficulties because it was the explanation offered to me by professionals. Today, with the benefit of hindsight and the clarity brought by subsequent diagnoses of autism and Complex PTSD, alongside my professional and academic knowledge, I see these experiences through a very different lens - one shaped by neurodivergence, trauma, chronic misunderstanding, and survival rather than personality pathology.

This image is both a challenge to the power and constructs of diagnostic nosology and labels and a reminder that no diagnosis should eclipse the complexity, individuality, and humanity of the person beneath it. Labels may describe aspects of our experience, but they can never fully capture the richness, contradictions, strengths, struggles, and uniqueness that make each of us uniquely human.



NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER

Understanding the Interface Between Early Intervention in Psychosis and Neurodevelopmental Services: Reflections and rationale for a National Survey Across England and Wales



Sana Fatima & Sherlie Arulanandam

Though formal write up is still pending, we thought it will be good to share our thoughts and reflections on what got us thinking about this project

This project was conceived to explore how Early Intervention in Psychosis (EIP) services and neurodevelopmental services work together to meet the needs of individuals with co-occurring psychosis and neurodevelopmental conditions. Through a national survey of clinicians across England and Wales, we sought to map current service provision, identify variations in practice, understand barriers to collaborative working, and highlight examples of innovation that may inform future service development.

The project was born from both academic curiosity and our shared clinical experiences as two Early Intervention in Psychosis psychiatrists with an interest in neurodevelopmental psychiatry. Working within EIP services, we were increasingly encountering service users whose presentations could not be adequately understood through a singular psychosis-focused lens. Many entered our services with established diagnoses of autism or ADHD, while others displayed significant neurodevelopmental traits that had never previously been recognised or formally assessed.

These clinical encounters repeatedly highlighted the complexity of working at the interface between psychosis and neurodevelopmental conditions. We found ourselves reflecting on how unusual beliefs, sensory experiences, social withdrawal, rigid thinking, literal interpretations, communication differences, and difficulties with social understanding could be interpreted very differently depending on the clinical framework being used.

Distinguishing psychotic phenomena from neurodevelopmental characteristics is not always straightforward, and these distinctions have important implications for diagnosis, formulation, risk assessment, treatment planning, and long-term engagement.

Through conversations and collaborations we gathered how these challenges extend beyond individual diagnostic uncertainty and reflected broader service-level issues. EIP teams were managing substantial neurodevelopmental complexity without timely access to specialist neurodevelopmental expertise. Long waiting times for autism and ADHD assessments, inconsistent referral pathways, and considerable regional variation in service provision often resulted in uncertainty about where responsibility for assessment and ongoing care should lie. Too often, service users with overlapping needs appeared to fall between organisational boundaries, despite requiring coordinated, multidisciplinary care.

We also recognised that many of the interventions routinely delivered within EIP services may not always be optimally adapted for neurodivergent individuals. Psychological therapies, family interventions, group programmes, and vocational support frequently require modifications to accommodate communication differences, sensory sensitivities, executive functioning difficulties, and alternative styles of information processing. While individual clinicians and teams were often making these adaptations, there was little understanding of how consistently this occurred across services or whether clinicians felt adequately supported to do so.

NEURODEVELOPMENTAL PSYCHIATRY SIG NEWSLETTER



Understanding the Interface Between Early Intervention in Psychosis and Neurodevelopmental Services: Reflections and rationale for a National Survey Across England and Wales

Sana Fatima & Sherlie Arulanandam

Although these issues were regularly discussed within local teams and professional networks, there was not only a dearth of research and data in this domain but also wider heterogeneity in terms of how EIP and neurodevelopmental services across the England and Wales currently interface.

We therefore recognised the need for a systematic exploration of current practice.

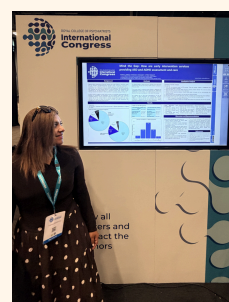
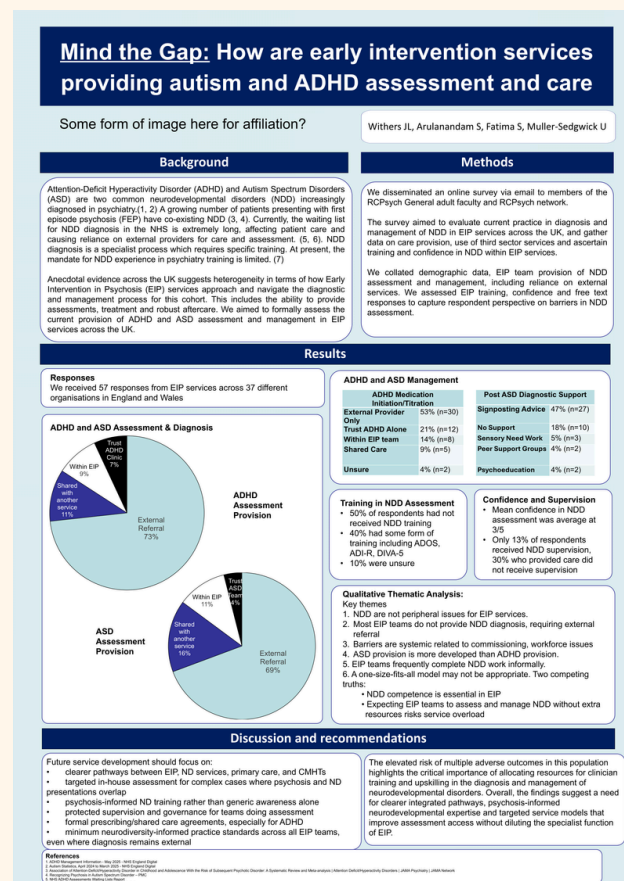
Through this survey, we wanted to understand how EIP services support individuals with co-occurring neurodevelopmental conditions, what formal pathways exist between services, how clinicians access specialist assessment and consultation, what barriers prevent effective joint working, what training and resources are available, and where examples of effective and innovative practice can be found.

For us, this project represents more than a service evaluation. It reflects a commitment to ensuring that mental health services evolve alongside our growing understanding of the relationship between neurodevelopmental conditions and psychosis.

Increasingly, research demonstrates that neurodevelopmental disorders are common among individuals presenting with first-episode psychosis and influence clinical presentation, engagement, treatment response, and outcomes. Yet service models have often developed separately, with relatively little guidance on how these overlapping needs should be managed in practice.

We undertook this project because we believe that diagnostic complexity should never become a barrier to receiving timely, compassionate, and person-centred care.

We hope this work will contribute to the development of more integrated, equitable, and neurodevelopmentally informed models of care that better reflect the realities of contemporary clinical practice and improve outcomes for the people and families we serve.



Poster presentation in RCPsych IC 2026
Dr Sana Fatima, Dr Sherlie Arulanandam



RCPsych IC 2026
Dr Sherlie Arulanandam, Dr Sana Fatima, Dr Asif Bachlani, Dr Khurram Sadiq, Dr Nadia Liaquat, Dr Saima Niaz, Dr Javeria Aftaab, Dr Salah Bashir

NDP SIG Round Up Activities and Engagements



The landscape of UK neurodevelopmental psychiatry has undergone a profound shift, driven by unprecedented referral backlogs, emerging clinical models, and major legislative changes. With over 700,000 individuals in England awaiting autism and attention-deficit/hyperactivity disorder (ADHD) assessments, the clinical, academic, and policy activities of the Royal College of Psychiatrists (Neurodevelopmental Psychiatry Special Interest Group Executive Committee represent a response to this evolving landscape. Since our last newsletter, committee members have pioneered transdiagnostic research, established national clinical training frameworks, and engaged in critical policy and advocacy work.

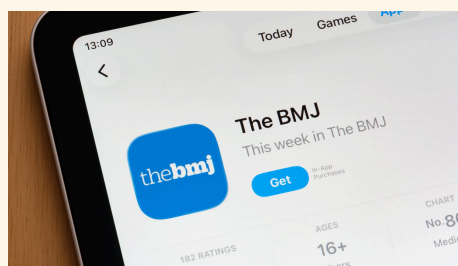


Dr Eccles and **Prof Brugha** contributed to the 62nd Maudsley Debate: This prestigious debate brought together prominent academics and clinical practitioners to interrogate the evolving prevalence of neurodivergence. Convening at the Wolfson Lecture Theatre, Denmark Hill, a multi-disciplinary audience including clinicians, researchers, and experts by experience examined the drivers of surging diagnostic rates. The debate scrutinized whether this trend reflects a genuine rise in public awareness or the belated clinical recognition of populations historically excluded from psychiatric assessment frameworks and was chaired by prominent Autism Researcher Professor Francesca Happé. A video is available on line, and the arguments were summarized in a BMJ Article.



RCPsych Neurodevelopmental Psychiatry Strategy Meeting May 2026

The strategic direction of the NDP SIG leadership team has been defined by a concerted effort to integrate neurodevelopmental science into mainstream psychiatric practice, and also to bridging historical divisions between mental and physical healthcare, evidenced by the **Chair, ADHD Champion** and **Autism Champion**, other esteemed colleagues and experts by experience authoring the BJPSYCH editorial, **'The Elephant in the Room: Neurodivergence in Psychiatry.'**



MAUDSLEY DEBATE

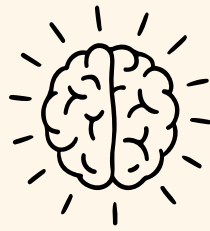
Autism and ADHD: does the global rise in diagnosed neurodivergence reflect increased awareness of undiagnosed cases?

Diagnoses of autism and other neurodivergence are rising. **Jessica Eccles** and **Elizabeth Weir** say that the trend is real—and that claims of “overdiagnosis” and insistence on exact case numbers are unhelpful. But **Alastair Santhouse** and **Traolach Brugha** argue that more factors are at play, not least a widening of already vague definitions

Jessica Eccles,¹ Elizabeth Weir,² Alastair Santhouse,³ Traolach Brugha⁴



NDP SIG Round Up Activities and Engagements



Dr. Ulrich Müller-Sedgwick, the college's ADHD Champion, has led regional and national policy initiatives designed to reform adult ADHD and autism service delivery. Operating as a consultant psychiatrist and lead clinician for Health & Care Jersey, Dr. Müller-Sedgwick began leading the implementation of the Neuroinclusive Jersey Strategy in March 2026, establishing a whole-island model for multi-agency neurodiversity support. Both he and the Dr Eccles are members of the Clinical Reference Group of the Independent ADHD Taskforce, and SIG EXEC members have contributed to the Independent Prevalence review. In the academic sphere, Dr. Müller-Sedgwick has addressed the contentious debate surrounding ADHD diagnostic rates, co-authoring a high-profile editorial in BJPsych in 2026 titled "ADHD (over)diagnosis: Fiction, fashion and failure," which provided an evidence-based response to public and political narratives of overdiagnosis. His clinical trials oversight includes serving on the Trial Steering Committee for the University of Birmingham's SNAPPER trial and collaborating on the King's College London ART-CARMA study. The ART-CARMA study utilizes remote monitoring and wearable technologies to track real-world cardiovascular risks and medication adherence in adults with ADHD.



RCPsych NDP SIG Conference Jan 2026 - London, - Jenny Bryden, Jessica Eccles, Alison Lennox, Sana Fatima, Sam Tromans, Ulrich Muller Sedgwick, Hussien Elkholy



Dr. Conor Davidson, the past RCPsych Autism Champion, who concluded his formal four-year tenure in December 2025. Dr. Davidson's final blog post, "Reflections on the last four years," cataloged systematic improvements in national training pathways. In February 2026, Dr. Davidson provided expert commentary to The Guardian on a landmark BMJ study showing rapidly narrowing male-to-female ratios in adult autism diagnoses. He emphasized that autism in girls is frequently missed during childhood, leading to inappropriate psychiatric diagnoses of mood and personality disorders in adulthood, and advocated for gender-informed diagnostic frameworks.

Dr. Sam Tromans, serving as the SIG's Academic Secretary and Associate Professor at the University of Leicester, has focused on epidemiology and also Dr. Tromans has also engaged in critical legislative analysis, co-authoring a high-profile professional and carer consensus statement in BJPsych in early 2026 examining the proposed Mental Health Bill (2025) and its implications for autistic individuals and those with learning disabilities.

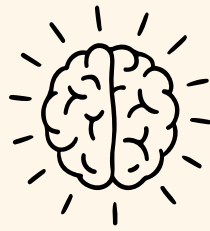


**NDP SIG Conference, Jan 2026
Alison Lennox, Sana Fatima**

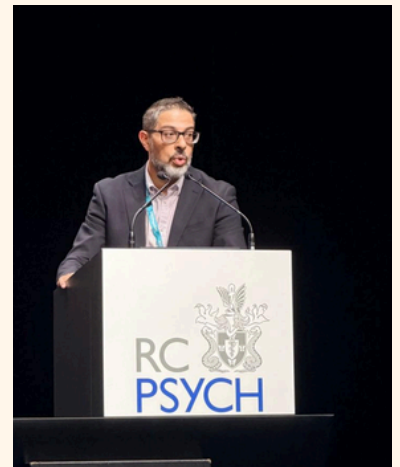
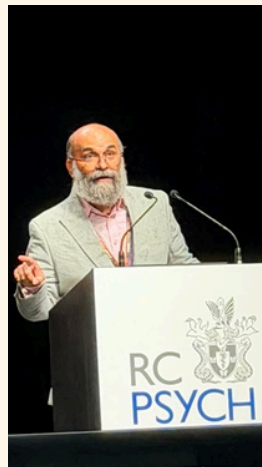
Dr. Alison Lennox has worked hard to demystify complex adult assessments. Her public engagement has expanded through a series of highly accessed media appearances, including "Misdiagnosis in Autism" on the Hidden 20% Podcast, which addressed the clinical misattribution of borderline personality disorder in autistic women. Her clinical training contributions include delivering specialist education to the RCPsych Quality Networks including work on crisis teams and autism, and contributed to the Women's Statement. **Dr. Sana Fatima**, the Digital Communications Lead, has driven the SIG's digital outreach and professional education. Communications lead Dr Fatima, has worked hard to heighten the profile of the SIGs work. Academically, Dr. Fatima co-authored a nationwide survey published in BJPsych Open in 2026, titled "Mind the Gap," which evaluated current clinical practices, diagnostic confidence, and training gaps regarding neurodevelopmental disorders within UK Early Intervention Psychosis (EIP) services. The study highlighted a critical reliance on external diagnostic services and moderate baseline clinician confidence, advocating for urgent resource allocation to upskill EIP clinical staff.



NDP SIG Round Up Activities and Engagements



The financial operations of the SIG are supported by **Dr. Hussien Elkholy**, the Financial Officer. Dr. Elkholy's clinical and academic interests lie at the intersection of adult neurodevelopmental disorders, addiction, women's mental health, and epidemiological trends. Dr Elkholy convened a session on Neurodevelopmental Conditions, gaming, eating, Chemsex and AI, chaired by Prof. Owen Bowden Jones and featuring four graduates of integrated academic training in Psychiatry! Fellow speakers included Core Resident of Year, **Dr Stephen Naulls**, and HST **Dr Hamilton Morrin**.

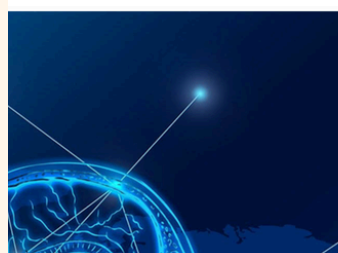


There was strong representation of Neurodevelopmental Psychiatry at International Congress in Liverpool, and many discussions on the topic, with high profile attendees such as Past President **Adrian James**, **Dr. Khurrum Sadiq**, **Dr. Asif Bachlini** and **Dr Dheeraj Chaudary**

In forensic and intellectual disability frameworks, **Dr. Ken Courtenay**, the Forensic Faculty Representative, has driven clinical standards for highly complex patient groups. Dr Courtenay has recently been elected to the Academic Faculty EXEC. As the NHS England National Clinical Director for the Learning Disability & Autism Programme, Dr. Courtenay led a major breakout session at the national DEMEC conference in December 2025, showcasing the National Autism Training Programme for Psychiatrists, designed and delivered by members of the NDP SIG and colleagues.



Adult ADHD Foundation Course 2026


[< back to events](#)

04 NOV Online event

Timings 9.30am – 4.50pm

Location Virtual event, Online

**REGISTER INTEREST NOW FOR THE NEXT COHORT
OF NATPP and RCPSYCH ADHD FOUNDATION
COURSE**

NDP SIG Round Up Activities and Engagements



The Adult Autism Community of Practice (CoP) is led by **Dr. Jenny Bryden**, Under Dr. Bryden's leadership, the CoP has hosted quarterly forums designed to share best practices in adult autism diagnostics, clinical masking, and post-diagnostic support. Dr. Bryden has also contributed to high-level clinical-ethical debates, publishing correspondence in BJPsych regarding the implications of assisted dying legislation on vulnerable psychiatric populations, emphasizing the societal pressures and self-stigma experienced by neurodivergent individuals and those with severe enduring mental illnesses. **Dr. Marie Boilson**, the Scotland and Ireland co-representative, has focused on addressing the clinical barriers facing neurodivergent young adults transitioning between child and adult mental health services. This regional representation is bolstered by **Anna McGovern**, the Northern Ireland representative.



Dr. Beth Ranjit, serving as the Wales Representative on the NDP SIG executive committee, has focused her clinical and academic activities on the implementation of "No Wrong Door" care pathways, designed to prevent the exclusion of neurodivergent patients from general adult mental health settings. Through this integration of clinical practice and capacity law, Dr. Ranjit has actively campaigned for legislative reforms that protect the legal rights and physical safety of neurodivergent inpatients across Welsh and English psychiatric services.

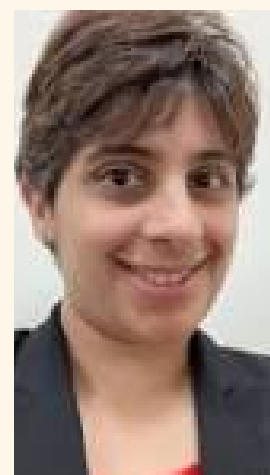
Dr. Bhatika Perera, Chair of the ID in ADHD Community of Practice, Associate Professor at UCL. Dr. Perera's academic contributions also include a longitudinal cohort study published in BJPsych Open in May 2026 and as the Research Lead for NHS Practitioner Health, Dr. Perera has investigated the prevalence of ADHD and autistic traits among medical professionals seeking mental health support.



Strong representation at RCPSych IC
2026



Dr. Bhatika Perera



Dr Beth Ranjit



The Evolving Pharmacological Landscape for Paediatric and Adult ADHD

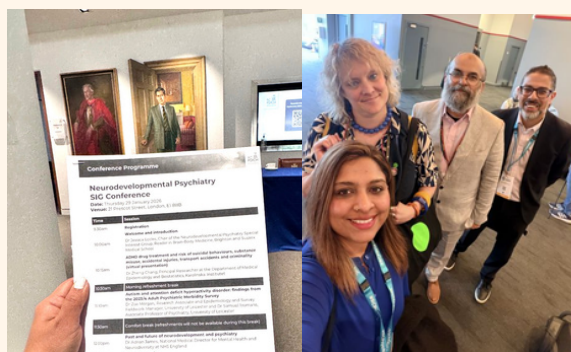
Article May 2026

CNS Drugs

Guilherme Fusetto Veronesi · Fabio Tarantino · Daniele Pirolo · Samuele Cortese

While attention-deficit/hyperactivity disorder (ADHD) medications, particularly stimulants, are among the most effective treatments in psychiatry, there remains a need for novel alternatives, as not all individuals with ADHD respond to or tolerate currently available medications. We aimed to provide an up-to-date overview of

Professor Samuele Cortese, NIHR Research Professor and Professor of Child and Adolescent Psychiatry at the University of Southampton, has directed extensive clinical and academic efforts towards research that systematically evaluates the evidence base for ADHD and its treatment. He was invited to present critical evidence demonstrating the long-term safety and efficacy of ADHD medications, bridging the gap between clinical research and national health policy. This session, featuring talks from **Professor Anita Thapar**, Dr Eccles and **Prof Hugo Critchley**, was chaired by **Prof Adrian James**, Past President of RCPSYCH.



**A very successful
Spring/Summer**

Professor Terry Brugha, serving as Professor of Psychiatry and Clinical Epidemiology at the University of Leicester and Consultant Psychiatrist in Leicester, continues to lead national research in adult autism epidemiology and Schedules for Clinical Assessment in Neuropsychiatry (SCAN). Past finance officer **Professor Raja Mukherjee** has driven national efforts to establish the UK's first linked longitudinal database for Fetal Alcohol Spectrum Disorder (FASD) and is preparing the FASD position statement for the College.

We look forward to an action packed next year for the NDP SIG



RCPSych Neurodevelopmental Psychiatry Conference
9th October 2026 - Online

The Neurodevelopmental Psychiatry Special Interest Group invites you to join the upcoming conference which will be held online on 9th October 2026.

REGISTER NOW



Neurodevelopmental Psychiatry SIG Autumn Conference

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