The PTC Magazine
Registrar
SPECIAL EDITION
What I have learned from my patients
The PTC’s Canada Competition
Guest Editors: Mental Fight Club
From the service-user point of view asking doctors ‘what I have learned from my patients’ signifies not only a shift in perspective but also the need for a shift. For too long mental health has bore the brunt of N.H.S funding cuts and system failings. We often speak of societal stigma and discrimination but neglect to talk about how this seeps into life and everyday interaction on a psychiatric ward – resulting in patients feeling dehumanized and without faith in the very system set up to heal them.

And so, as a service-user led charity, to be invited as guest editors of this special edition of The Registrar – one that explores the fundamental relationship between doctor and patient, we are more than encouraged – we are hopeful.

We are Mental Fight Club. Founded by Sarah & Thomas Tobias as a creative force for positive change, we want to inspire new thinking about how mental health services can be more creative, more healing, and more human for everyone – both for the people who work in services and for the people who use them.

The learning from our flagship project The Dragon Café is the driving influence behind this force and the foundation of our new initiative ReCreate Psychiatry, a collaborative venture between psychiatric professionals and people with lived experience. The aim of this initiative mirrors that of this edition of The Registrar and indeed of it’s competition question ‘what I have learned from my patients?’. In the following pages and through a series of articles we introduce and explore the concept behind ReCreate Psychiatry as well as the importance of asking this question – which is more than wonderfully demonstrated by the winner and entries to the competition.

A shift in perspective acknowledges that a change is needed. Here’s to change. ■
Welcome to this special Summer 2016 edition of the Registrar. This edition is guest edited by Mental Fight Club, a service-user led charity established to encourage social inclusion and the creative exploration of mental illness, recovery and well-being for all. They are the visionaries behind 'The Dragon Cafe', the first mental health cafe in the U.K. It is the weekly project that led to the rise of their new initiative ReCreate Psychiatry - a platform that brings service users and psychiatric professionals together to ask what can we learn from each other. I'd urge you all to read more about it here (https://recreatepsychiatry.com/). It is apt then, that this edition goes on to feature the winner and runners up from our 2015 competition entitled "What I have learned from my patients". These articles are nothing short of incredibly moving and I think we can all take something from them.

Now, I'd like to take this opportunity to update you all on some other matters. In my last "Letter from the Chair", I talked of my disappointment that the junior doctor contract furore raged on. Whilst this situation remains to be resolved, for the moment at least, the impasse appears to have been broken. I'm sure you've all seen the latest terms and conditions (information can be found here - https://www.bma.org.uk/collective-voice/influence/key-negotiations/terms-and-conditions/junior-doctor-contract-negotiations). I'd be interested to hear your views on how they may affect junior psychiatrists and you can do this by e-mailing ptcsupport@rcpsych.ac.uk.

As part of the negotiated settlement, it was decided that the morale review that was set to be led by Prof. Dame Sue Bailey would be discontinued. In its place, the new terms and conditions include some elements that may go to improve the working lives of juniors, such as HEE led work looking at joint applications for training posts. It is unclear whether further work will be undertaken looking more broadly at the morale of junior doctors. However, it has been the view of the PTC for some time that there is much that could be done to improve the working lives of trainees. With this in mind, we have been working for on a project that we are calling "Supported & Valued? A Trainee Led Review into Morale & Training within Psychiatry" which will begin at the RCPsych International Congress at 6pm on Wednesday 29th June. If you're attending Congress (and you really should, the programme is excellent!) and you'd like to contribute to this piece of work then please e-mail congress@rcpsych.ac.uk to reserve your place. Don't worry if you can't make this though, as we shall be having regional events over coming months to enable as many of you as possible to take part.

Continuing with the theme of support, our "Return to Practice" event has been finalised and shall run on 21st November 2016 at the Royal College of Psychiatrists. This is set to be a fantastic day which will cover such topics as maternity and paternity leave, pay, and how to keep up-to-date with clinical work. You can register your interest by e-mailing ptcsupport@rcpsych.ac.uk.

I'd like to end by saying that although the past months have not been the easiest for junior doctors, I hope you can feel at least a little reassured that your concerns are not being ignored. We shall continue to do as much as we can to support the training, recruitment and retention of psychiatrists; and I can assure you that we are well supported by our College with this.

As ever, if you'd like to comment on anything I've mentioned here, or anything else you can contact me through ptcsupport@rcpsych.ac.uk, via Twitter (@RCPsychTrainees) or on our Facebook page (https://www.facebook.com/Psychiatric-Trainees-Committee-186606754737390/)

Enjoy! Matt
Dr Matt Tovey, Chair of the PTC 2015/6, ST6 in Forensic Psychiatry, West Midlands
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Images credited to Liz Gorman, Kevin Mclean and Mental Fight Club
I am not a brilliant “learner”. A shame, when there is such an emphasis on life long learning, and keeping up to date. I try…..it’s just that my memory isn’t what it was. I read an article – enjoy, understand, and reflect. Two weeks down the line, I’d struggle to tell you the “key point”. Sometimes I forget I ever read it.

I am much the same with courses, teaching, training, and e-learning.

I have, however, found a tried and tested way of learning. The patient directed method, always delivered with skill and flair. There is no curriculum, syllabus, or exam, although the continuous assessment process is rigorous. The feedback can be harsh.

I have learnt many things from my patients: A small boy broke the news about the declassification of Pluto, an elderly gentleman provided inside information on the Freemasons, and a teenage girl demonstrated the perfect “fish plait”. One lesson however, has proved invaluable to me as I progress in my training, as well as nudging me toward a career in psychiatry.

I was on my GP placement. It was a beautiful day, and I was fortunate enough to be based in a practice by the sea. The work was not usually too onerous, however, this lunchtime there were a lot of visits. Four for me, and I’d got off lightly.

Conscious of time, I didn’t bother ringing the patients first as I would usually, I just headed straight out. By my final visit I was hot, flustered and running late.

My patient lived in a sad, grey block of flats, situated in an improbably beautiful communal garden. Getting there involved hiking up the hill, lugging my bag, and clutching my array of printouts. The receptionist had written “abdo pain” and highlighted the multitude of QOF issues needing updating.

I rang the bell and waited. Nothing.
I tried again.
Still nothing.
Her phone rang out.

I convinced myself that her abdominal pain had been a ruptured AAA. I hadn’t triaged my calls, so left her till last, and hence she must be dying inside her flat.
I rang the other buzzers, but everyone was presumably out enjoying the weather.

I then spied an elderly lady sitting in the garden. I introduced myself and begged her to let me in. She huffed a bit, but agreed. I did my trademark “two steps at a time” race up the stairs and banged on the door.

Nothing!

I contemplated my options. Break the door down? Phone the police?
“Well I suppose you’ll be wanting in will you?”
The elderly lady had mysteriously appeared by my side.
“It’s you! You’re okay! Hang on, you did ring for the doctor didn’t you?”

She begrudgingly explained that she had indeed phoned for the doctor, but had requested the senior partner, not “a girl”. And anyway, I had made her late for the bingo.

I experienced a bubbling rage which I managed to contain whilst I examined her abdomen, which of course was entirely normal. I muttered something about those in real need of home visits, and flew to my car. She was somehow able to catch up with me and sit herself in the front seat, “It’s very messy, there’s nowhere for me to sit. Is this your car? I thought GPs were rich!”

I established that she was expecting me to drop her off at the bingo. It seemed easiest just to agree, so I was directed on a circuitous route to the town centre whilst my driving skills were critiqued.

My waiting afternoon patients were disgruntled. I finished late, still with paperwork to complete and my visits to write up.

Two days later, her name was again on the visit list. And she had asked for me personally – of course, I was a pushover. On this occasion I rang her, and was somehow coerced into another visit.

I won’t repeat what happened because it’s basically the same story as before, minus any moments of concern or panic from me. Needless to say, she did not need that visit.

Two days later, she was on the list again. I went. Again.

Several letters, phone calls and visit requests later I cracked. I arranged to see one of the partners to have a chat about “difficult” patients. I presented her at my Balint group. My friends found it hilarious, and we shared tales of our unreasonable patients. I felt better for offloading, and established that most of my peers had their own “lady” who was slowly driving them to distraction.

But then of course it clicked. All those outstanding QOF targets grew new meaning.
I reviewed her notes properly. She had minimal attendances, and was always seen with her husband. There were no mentions of her being difficult. Then I saw the entry; “Bereavement”.

I called round and we talked. She started crying. She took my hand and told me about her husband. About how lonely she was, and how she had never actually made it to the bingo hall because she had no friends to go with. She told me that she felt down most days, and sometimes could not leave the house. She had daily thoughts of ending it all.

She told me she enjoyed my visits, and looked forward to seeing me.

I referred her for some counselling and saw her regularly. She improved over time, and made a bingo friend out of a widow who lived on her floor. She never requested another visit. She told me I’d make a fine psychiatrist.

So I had learnt to always triage my calls. To look carefully at the previous notes. To step back and reflect on the reasons why my patients may prove irritating. To understand that if I feel angry and upset, they likely feel the same, often worse. To never be too quick to label someone as difficult or personality disordered.

I realised she had been teaching me all that time, and I could now confidently say that I had learnt my lesson.
“Can you solve that?”

The patient who had asked me was a quiet loner type, in his thirties but younger still in appearance, exhibiting a range of negative schizophrenia symptoms. He spent much of the day sitting on the front steps of the hospital, smoking. He'd never initiated conversation with me before.

I’d arrived onto the ward that morning with a Rubik's cube in my hands, twisting the sides idly without aim. That's all I knew to do with it. I'd bought it mainly because the smooth gliding motion and reassuring click of each completed move was relaxing. I had been toying with it my entire commute.

I told him that I couldn't. He held out his hand, asking to try it out.

There's something about walking through a ward full of bored young psychotic men while holding a Rubik's cube that makes you popular. I wonder if my patients are so sensitised by lack of stimulation that a multicolour puzzle holds a special mystique to them. They still ask me if I can solve it, and these days I awkwardly tell them that I can, but so can a lot of people. They tell me how they tried so hard as children to solve it, but could only match X number of sides. They tell me the common tale of rearranging the face stickers. I never believe that one.

One of the wilder reactions I have received is from a patient who had (demonstrably falsely) claimed that he had invented the Rubik's cube. His name was not Ernő Rubik, nor was he Hungarian. It was a delightful delusion, nonetheless, because in his grandiosity he had deemed the cube a puzzle worth being the inventor of; truly a grand thing for such an item to bear your name.

By the time the patient completed the cube, a small crowd had gathered around him. I was glad that nobody had decided to snatch it from his hands in jealousy. Instead, there it was in his hand, complete and uniform: red side, white side, yellow side, blue side, green side, orange side. We clapped. He was unmoved.

"You'll have to teach me that,” I said.

Of course, once you know the method, the magic of “how?” gives way to the thrill of automatism. Doing without thinking. Doing without looking, even. Nowadays, I rarely walk anywhere without the cube in my hands, reconfiguring on autopilot, carelessly bumping into lampposts and tripping over kerbs. I could
never describe it as mentally taxing, but it is mentally satisfying.

We'd sit in the main foyer where he would wait to meet his mother in the evenings, and he took me through the steps, a little each time. He never seemed particularly interested, but he was not bothered by me, either. I, meanwhile, was hooked.

From a psychiatric standpoint, there's nothing to write home about regarding the cube. Case reports describe that the spatial processing involved with solving the cube may trigger seizures in individuals, though this phenomenon is not unique to this particular puzzle. The cube does attract a fanbase of people on the autistic spectrum, some of whom take well to the cube's algorithmic, linear predictability, but no systematic research exists to evidence any link between autism and cube aptitude.

“You start by making a white cross at the bottom”, he told me. And that's how it always is. Inevitable, secure. Then the white face is completed, hidden from view at the bottom, but reliably present. Two layers of colours follow around the sides, before the yellow cross on top, and then specific algorithms depending on what you see. The centre squares never move. White always opposes yellow. Blue versus green. Once you know the path, you can always find home.

I picked up more tips from elsewhere, but without a doubt, my patient had handed me the key to the cube. Long after he had left, I continued solving the cube on the ward. It was no longer magic to me, but it was to others. Now I was the one being asked to teach. I cannot understate how good it feels to connect with patients over something that isn't negotiations over care plans. To incite delight, rather than frustration. To relieve boredom.

To create harmony from disarray. That is the meaning of the cube.

I will never know what the cube meant to the patient, but I have a hunch. Knowing that every piece is drawn to where it belongs is comforting. Knowing that whichever of the 43 quintillion permutations I am faced with, I can still force it back to zero, makes me feel safe. I can fix anything.

Yet as I draw towards home, I always wind down. It is the simplest part of the journey, an anticlimactic sequence, and the same every time. Something else holds me back, too: deep down, I know that a Rubik's cube with uniform sides is the dullest form for it to take. I think others feel the same way; if you leave a fixed cube lying around, it does not stay fixed for long. There is something alluring about all that constrained potential begging to be set loose; something exciting about flux and maelstrom, change and progress.

There is something normal about the abnormal. My patient teaches me still.

I tend towards zero. I savour the final moment, and everything clicks into place. Blue on blue; red on red. I raise my head, checking to see if anyone witnessed me creating normality, and then, before I become uncomfortable with infinity in my hands, I scramble back into chaos.
The police brought her back to the unit. “A white van driver had called us; he’d parked up across the dual carriage way to stop the traffic. She was up on the footbridge, her feet on the wrong side of the railings.” She’d soon be in her third Mental Health Act assessment in as many weeks. The previous two had come about after she’d been found in her room with a bag over her head, a ligature around her neck. Throughout those assessments she’d talked quite positively about her future plans – her new flat to which she’d been taking successful leave and her intention to begin care work at College in the autumn. Still, she’d seemed a little startled when no recommendation was made, “I can just leave then… There’s nothing stopping me walking back to that dual carriageway.” She hadn’t left - she’d stayed - but later reflected this was further evidence we cared little for her wellbeing. The unit staff were weary and talked of “burn out”. They said, “It’s just behaviour” and “She smirked as she recounted her story of the bridge and van and the police” and “This environment just isn’t therapeutic for her anymore - she clearly wants to be back on a Section.” In the previous weeks it had been difficult for us to settle when she was in her bedroom alone, and staff sickness days had swelled. The office had become terse; some keen we should push on working towards discharge, others stating the risks were too great. A second opinion felt that, while the Trust Borderline Pathway supported positive risk taking, it was difficult to apply in this unusual case. She had been passed between a plethora of inpatient services for well over a decade. Her behaviour was escalating; was this a communication that she wasn’t ready to be out on her own? Indeed, she often found it difficult to communicate her needs with words alone. Amongst the medical staff we talked of shared imaginings of the coroner’s court, his voice brittle as he recounted her attempts spitting the words “frequency” and “severity” in his summation.

This was the milieu that circled the third of the Assessments. This time she looked tired, her shoulders rounded and her voice barely audible. “I just want to die…” The AMHP was a still a little reluctant to make the recommendation, indeed the risks weren’t necessarily reduced on the unit as her most serious attempts had previously happened in an inpatient setting. Was another section therapeutic, or simply a locker in which to toss our collective anxieties? Was this a backward step, stripping her again of the responsibility...
we’d been so tentatively feeding back to her? She cried quietly as the AMHP informed her she was back on a Section 3 and as I walked with her from the room, she hissed expletives about my consultant.

I bristled with frustration as she ranted. Last week, she said, we were cold and uncaring for keeping her informally and this week we were overbearing, strangling her liberty. But as a careful half-smile crossed my face in an attempt to acknowledge her frustration, I noted our emotional reaction was shared. I was frustrated that for over a decade we had been sectioning her in response to her suicidal acts, perhaps teaching her that suicidal acts were a means to a rescue. Had we been overbearing, repeatedly strangling her ventures to learn the means to rescue herself? And now we’d begun to change the rules - our “parenting” was inconsistent; her startled look at the earlier assessments seemed genuine - suddenly we weren’t offering her rescue, we were indifferent to her suicidal acts, we were cold and uncaring.

The conflicts and anxieties that had splintered through all of us had permeated out from her, such was the intensity with which she experienced them. She couldn’t bear to continue on here, her future a centrifuge of inpatient units, but equally she couldn’t bear to be out there, alone in the quiet of her flat, having to accept that no-one might be thinking of her. It was the same for us; while at times we couldn’t bear to spend time with her such was her anger, there were still other times we couldn’t bear to be separated imagining what might befall her. She too shared our frustration in there being no clear cut answer to what should happen next; for her to live independently we needed to hand the parcel of responsibility back to her. We’d held this parcel for so long, we were scared it may drop as we tentatively passed it back with potentially fatal consequences. This had resulted in us clawing it back in fear. At times she too seemed keen to take the parcel back so she could be free and self-determining, but at others it represented rejection and isolation.

So, to answer the question, I learned that sometimes the conflicts and anxiety we experience about a treatment decision can be a tool to allow us to empathise more profoundly with the conflicts and anxieties our patients themselves experience. And it’s helped me see that in the world of mental health, we are constantly deciding where the responsibility lies between clinician and patient. As patients become more unwell, we justifiably hold a larger share of the responsibility, but it’s not always so easy to give it back.
ReCreate Psychiatry

Leading towards a new model of engagement, healing and care – Learning from anger

ReCreate Psychiatry emerged during two years of the ‘Young Doctor Dialogues’ held at Mental Fight Club’s flagship project The Dragon Café where the often contentious and divisive debate between psychiatrist and service-user was able to happen in a safe and productive way for both parties. Aiming to transform the doctor/patient relationship by suspending the power dynamic currently inherent in the psychiatric encounter, ReCreate Psychiatry facilitates genuine, openhearted, and constructive dialogue between the people who need mental healthcare and the people who provide it. It provides a space for engagement without emphasis on role but on personal experience – instantly creating an alternative setting and atmosphere for doctor/patient interaction focused by mutual experiential learning – and thus allowing for a different, open, and authentic conversation between the two.

As an example of this, and inspired by the dialogue fostered by ReCreate Psychiatry projects ShrinkRadio and the Creative Dialogue Workshops, Dr Khaldoon Ahmed (consultant psychiatrist and Mental Fight Club Trustee) and Seth Hunter (service-user and Dragon Café project manager) met to discuss the concept behind the initiative, its impact and future scope, as well as how the entries to The Registrar’s ‘what I have learned from my patients’ competition demonstrate its need.

Seth: It seems to me part of the aim of ReCreate Psychiatry is developing a future vision of what psychiatry could be by realistically looking at the here and now. It’s an attempt to do something different … a brave

Dr Khaldoon Ahmed and Seth Hunter
In conversation
attempt to have a dialogue in a way that wouldn't ordinarily happen and see what comes out as a result of it. Through our work at The Dragon Café, we see quite a lot of people who have had really difficult – if not damaging - experiences in psychiatric wards and I think because of that what can often happen, if taking the role of the patient, is the “them and us” thing. And so I suppose ReCreate Psychiatry is an attempt to – in a safe, non-defensive way – talk about and tackle some of the trickier issues.

Khaldoon: Yes I would agree. I’m not only involved as a psychiatrist and trustee supporting its development but also as a participant in some of its projects. One of the creative workshops I took part in saw a group of 7 people drawing protest placards and talking about the mental health service they would like to see. So essentially, it’s about ideals. Interestingly, the interaction I had with people who had used mental health services in the group was completely different to the interaction I have on the hospital ward where I work. You didn't have that hierarchical relationship and you could actually speak to people as people. I found it so liberating to not to be seen as "the doctor" or somebody across a divide.

I think that's why and how ReCreate Psychiatry can offer almost a different model for interaction, which isn't based on hierarchy, power, or “I'm the expert and I'm going to tell you what to do”, and actually result in much more of a co-produced relationship. I'm not sure of the word co-produced – perhaps much more collaborative would be better... because when you have the idea that the doctor is going to have all the answers, then that perpetuates the idea that the solution is medical and puts doctors in a certain position. The thinking that they must come up with the solution or must have the solution, when in actuality the person with the problem understands what the problem is in a completely different way to the “so-called experts”. And that's the gap that I think we need to address as one of the focuses of ReCreate Psychiatry.

Seth: Yes, I think for me - if I don the patient hat, having quite profound mental health issues for most of my adult life - one of the most maddening things is that feeling of not being listened to. Or as some of my early experiences were with psychiatry - being listened to but at the same time you can almost hear the whirrs of the cogs going round in the doctor's brains: they were listening to you to tick off the symptoms that they were kind of waiting to spill out of your mouth. So it wasn't a very authentic being listened to. To be fair to the doctors they were probably under a lot of pressure to come up with a diagnosis and move on to the next patient, but I did find that really madding.

Khaldoon: That is such an important point, and that I think is where ReCreate Psychiatry can have an impact on how mental healthcare is delivered because this checking of the symptoms and ticking the boxes and appearing to be listening when you're not listening is a big fault in the system. And it's not necessarily to do with time pressure, I think it's to do with the models that we have and the frames of our understanding. So basically a person's experience can be reduced down to symptoms and I think that's an issue with the medical model - which I'm quite critical of as a doctor and as a psychiatrist but a number of my colleagues are much more comfortable with it, or perhaps I would say, haven't had the training or the opportunities for reflection on the issues it can create. And I think the issues it can create is the sort of situation which you're describing - that a person is describing their experience but the other person is thinking that "ah ok OCD, anxiety, psychosis, bipolar personality disorder" or whatever, whereas what the person really wants and needs is real listening.
If only we could come to some sort of position where you have that listening happening but also the doctor can actually say one of the most powerful tools we have is classification and that could be helpful as well - to try and work out what the problem is, to get the right medication, to get the right sort of therapeutic input, and to get the right sort of care package.

Seth: Absolutely, and I think for myself on a very personal level - like one of the assailant sort of features of my illness if you want to use that word - is the varying degrees of paranoia, and when I first came into contact with psychiatric services it was very much looked at as a feature of my illness and there wasn't any real curiosity about it. But since then I've been part of a group psychotherapy process so there is a lot of curiosity about it - really looking beneath it - and it is only through the years of sifting through stuff that I realised my paranoia is to do with childhood trauma, compounded by bereavement, sexuality, addiction. I mean it's multi-layered my paranoia, so if you're just rocking up to a psychiatric service and they hear the word paranoid and they know that you have erratic mood swings, they are quite quickly going to diagnose you as perhaps bipolar as is what happened to me. It becomes about trying to find the right pill and it is missing a whole treasure trove of experience. It can be quite de-humanising and that's where some of the anger comes from because when you’re mentally unwell you already feel quite far from human anyway and it's almost as though the system reinforces that you are a cluster of symptoms rather than a curious creative human. I think that's where quite a lot of my rage came from really. And I think that happens to a lot of people. I think a lot of people that end up with adult acute psychiatric distresses often have very troubled childhoods and I think it can often manifest later on in all sorts of weird and wonderful symptoms. I guess I always sort of feel as if maybe part of the frustration is that perhaps there is more need for talking therapy that isn't currently affordable on the NHS, or isn't there. I've been lucky that I have had that longer-term stuff.

My personal involvement in ReCreate Psychiatry has also been helpful. It's hugely healing to me. When I think back all those years when I was on a psychiatric ward feeling very unwell - very very unwell, very scared, very angry, very misunderstood - and here I am now having a very frank and honest conversation with a consultant psychiatrist. I've come a long way in terms of my own personal development and that in itself is very healing. But I'm one of the lucky ones because most people who end up in a psychiatric ward won't go on this journey. They might end up just being in and out of the sort of misery wheel of revolving door services.

Khaldoon: Thinking about this from the training perspective - training psychiatrists - we don't have enough of the conversations that you and I are having now, or have happened at The Dragon Café and as a result of the ReCreate Psychiatry projects. Whenever I get involved in these events and hear the conversations happening between doctors and people who have used services, I’m left feeling that a lot more people - a lot more doctors - need to have this experience… to really see things and to understand that what is perceived to be the other side isn't actually the other side. And I guess this is one of the reasons why ReCreate Psychiatry is very important and the very reason we’ve been invited to guest edit this special edition of The Registrar. As an initiative, we are completely supportive of learning from patients so a genuine listening can happen and so that psychiatrists feel that actually it's a part of their
job to be doing so rather than if they have a spare minute.

As a psychiatrist I sometimes feel that I have to make extra time for the listening because the priority is something else - like trying to get somebody out of hospital as soon as possible because the bed is needed for instance and because of the pressures on services. So in some ways the system makes you feel that listening is a luxury when actually it's the complete opposite - listening is essential part of what you're doing - and I think that can get lost.

However looking at the entries for the competition, it seems as though that isn’t necessarily the case. What I read are extremely sensitive accounts - very reflective - from junior doctors - and it's really impressive that people are saying that they have learnt much more from their interaction with their patients than from all the textbooks that we've read. All of this gives really a lot of hope for the future of psychiatry I think.

Seth: Definitely and I think that's a major reason why I wanted to be involved in the initiative ReCreate Psychiatry. Young psychiatrists are the future of mental health provision of course - a major major player in it - so that if we can have honest and frank conversations now and encourage real sort of nuance reflection for the next generation - it means the medical model has still got a place but is not the dominant model. It's not the only way of thinking of things and I think that's very very encouraging.

Before I came here today I spent a good hour reading through entries and I was blown away by the sensitivity - blown away. Something I forget as a patient is that the psychiatrist has to deal with life and death scenarios quite a lot. I often feel like criticizing psychiatry for being quite risk adverse and for not being very creative or bold. You go onto your average ward and it's all about locking doors and you know making sure that things can't be used to strangle yourself and the like, and its dehumanizing. But reflecting on this, I realise that ReCreate Psychiatry has helped me to understand that the system is set up for only the psychiatrist to hold ultimate responsibility for their patient and that’s a problem. One of the things that has been quite important for me to realise in my own recovery now that I'm no longer in crisis, is that I am actually responsible for my physical, mental, and spiritual wellbeing, and my psychiatrist and therapist and people like that in my life collaborate with me to stay well. It's really important for me that I don't try to handover my responsibilities like I used to do. But it has been 15 years of recovery to get to that stage and I'm not saying when you first walk in to the ward when you're unwell that it's going to be like that. What I am saying is ReCreate Psychiatry to me is a way of furthering that a more genuine recovery is possible because of it's emphasis on listening and collaboration. I'm pretty sure - touch wood - that I will never go back to hospital and I think that's because I now work really well as a patient with my mental health providers and that's because I genuinely feel listened to. That's really really healing and empowering.

Khaldoon: The idea of genuine collaboration is really interesting as for too long there has been a "them and us" struggle between doctors and service-users. One of the participants of the Protest Placard Workshop made an amazing one that said 'there is no them and us - there is only us' which is a really liberating concept. And this sort of thinking is one of the guiding principles of ReCreate Psychiatry.

So often people are in defensive positions, and very often psychiatrists are defensive. I'll give you an example of my experience today: there's a patient on the ward very unwell - very psychotic. Before she came into the hospital, she was extremely chaotic at home -
said some awful things to her parents, which resulted in her being evicted from her house. In the run up to her admission she had been up to accident and emergency a few times. She wasn't admitted and then got worse and her parents were left to deal with very serious behavioural disturbances. I met her mother today who was so traumatized by all of that experience that she was very angry with the whole system but because I'm the doctor I became a symbol of that system so therefore she was very angry at me. And in that situation sometimes you do take it personally. We saw some of this in The Dragon Cafe when people talked about traumatic events that they had experienced in hospital, being enforcedly injected, or distressed caused by detention and how that resulted in them feeling very angry towards the mental health system but also specifically psychiatrists because that's what psychiatrists represent for people – a symbol of a failing system.

It's very hard actually as a psychiatrist to deal with that level of anger. You're put in a difficult situation because you're supposed to be the one helping somebody but then also you're at the brunt of their anger and that's why you do have this "them and us" situation in mental health. I think that's so damaging to both sides. Having said that, ReCreate Psychiatry for me is actually a way to move forward by having these micro-discussions - discussions on a micro level like the placards. You're not going to be able to change the power dynamic, which in a way is enshrined in law because the Mental Health Act requires two medical recommendations to detain somebody. You're not going to change that concrete power differential but by opening up these conversations you see that the 'them' are patients - ordinary people and human beings - and for the patients and their families who see 'the other' in the psychiatrist they may also see that doctors are trying their best and struggling in a under resourced system … and are quite frankly people who are often burning out because of the pressures they are under.

Seth: Absolutely. I do sometimes feel that some of the sheer anguish is caused by funding decisions made at a much higher level that people on the ground are then left to deal with. I really do feel for psychiatric nurses and psychiatrists on these woefully inadequate wards that they know are inadequate - in often out-dated buildings not really fit for purpose. But it is what we’ve got and I suppose it's what we’ve got to make the best of. For me I guess ReCreate Psychiatry is a bit of a revolution of heart as well - not just for psychiatrists but I think also for patients. It's a two-way thing and I think we can all do with being a bit more compassionate to one another because all of us are struggling under a difficult time at the moment. Nothing is easy - it's all under funded and unfortunately frontline workers pick up the brunt of it. And then patients project their anger that really belongs higher onto frontline workers and it becomes a Catch 22. I do think this sort of unbridled anger can be incredibly poisonous. I had to learn to let mine go to get well really - to recover.

Khaldoon: But I also think anger is a justified response. I think that if somebody hasn't been listened to or serious things have gone wrong because something could have been done and wasn't done - it will create anger and is therefore justifiable. I think people working in the system need to take responsibility as well - and they can’t absolve themselves of responsibility because they are in responsible positions. But how will they discriminate between the anger that is justified and is not justified? And how can they learn from the anger and the criticism? I think the only way is through authentic real dialogue and application.

Seth: Which is what ReCreate Psychiatry is an attempt to start off isn't it? Some of the
workshops were an attempt to facilitate that authentic conversation wouldn’t you say?

Khaldoon: Yeah I think it is a conversation - like our conversation now. All too often however it isn’t a conversation but a stand off or a debate where things are shut down because people are blinkered by their own models. I think as doctors and psychiatrists we sometimes retreat into the lens that we have - the psychiatric lens and that’s only how we view things. Psychiatrists are highly trained individuals - with a huge amount of expertise, but that can become a blinker in itself as well.

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ReCreate Psychiatry is an exploratory platform enabling medical and psychiatric trainees of all levels to better understand and collaborate with people who have lived experience of mental illness. Delivered by Mental Fight Club, it is supported by a network of psychiatrists keen to champion mutual learning and break out of the predominant roles of ‘expert’ and ‘patient’. For more information, and to join the dialogue, please email amneet@mentalfightclub.com.
thought I was an empathic, caring doctor. Other psychiatrists told me so, my workplace-based assessments evidenced this, and I had passed my membership exams to the Royal College of Psychiatrists. Funnily enough, throughout my training I had never asked my patients how caring they thought I was, how collaborative I appeared, and in what ways I could improve. It was only when sitting in a public dialogue at The Dragon Café with a patient who I had happened to meet years earlier, that I heard feedback about my relationship with patients - she had left the consultation with a change of medication but had not felt heard. I had lacked insight into my relationship with patients and how they experienced our interactions.

Over the last 18 months, my practice of and beliefs about psychiatry and how we educate and train healthcare professionals has radically changed. The reason for this is my involvement in ReCreate Psychiatry.

My first experience of ReCreate Psychiatry was walking into The Dragon Café to take part in the Anxiety Dialogues that were being held over the summer of 2014. I was immediately disarmed, signing up as a patron and had no idea what to expect. I was unable to tell who was a service user and who was a healthcare professional. Who should I talk to? Should I tell people I was a psychiatrist and if I do how will they react? This feeling of being outside of the hospital setting, outside of my comfort zone and not being surrounded by other healthcare professionals was anxiety provoking and I

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Written by Dr Catherine Louise Murphy
ST6 General Adult Psychiatry
discussed this frankly at that first meeting. I have been a regular at The Dragon Cafe since then. After my first evening, I returned the following week to engage in a dialogue about being detained under the mental health act. I realised that in those two evenings I had probably learnt more about the role of psychiatrists and my own identity as a psychiatrist than at any other time during my training.

I have been challenged during these dialogues but, overwhelmingly, my impression was that the patrons of The Dragon Cafe were interested in my opinion, even if they disagreed with it. There was a mutual appreciation of getting stuck in and discussing the difficulties and rewards of being a provider and user of mental health services. I have heard experiences and stories at The Dragon Cafe and during the ShrinkRadio sessions that have made me ashamed to be a part of a system where people can be treated so unfairly at best and inhumanely at worst. However, I have also heard patrons discuss encounters with mental health professionals who they feel have helped them enormously. A lot of the time I have just had to listen, not jump to defend psychiatry or my own practice but listen carefully to another’s perspective, take it on board and use it to change my relationships with patients. However most of the time at The Dragon Cafe I have just chatted about films, music or the coffee. I have even danced. There has always been a sense of working together and respecting each other at The Dragon Cafe, which has made it extremely important to me.

From these dialogues, ReCreate Psychiatry grew - an idea and then a movement where the practice of psychiatry could be transformed. ReCreate Psychiatry is a place where voices are equal and where expertise is not defined by your profession. It is a place where people with experience of mental illness are involved in the education and training of psychiatrists and other mental healthcare professionals, in the assessment process for these professionals and in the design and implementation of services. It steps away from tokenism and the ‘tick-box exercise’ of service user involvement, which I have experienced in the NHS - where service user involvement is seen either as an afterthought or a hindrance.

What have I learnt so far?

I have learnt that I still have a long way to go. I frequently don’t live up to my own ideals of being a caring psychiatrist and I can think of a myriad of excuses for this including workload and tiredness. However, I know I can do better and the small things count: a friendly introduction, an explanation, an apology. I reflect more on the difficult interactions and how I could do things differently.

I have learnt that I am not the expert. The more I know the more uncertain I am. My patients surprise me, they teach me and help me in many ways (including my patient who brings me weekly updates on psychosis research).

It is illuminating to work, discuss or share experiences with people who have who had experience of mental illness outside of clinical settings. This allows me to hear people’s journeys of recovery and their views and opinions on what really helped them. This helps me provide better care.

Do not underestimate the power imbalance. It is large and frightening. Our relationships with our patients are different from other healthcare professionals; we have the power to restrict their freedom, to label them as sane or insane, and to influence their access to social support.

Listening is not the same as being heard. We may think we are listening however often we are not hearing what our patients are trying to tell us. Our patients frequently feel misunderstood and disrespected. We have to have humane interactions with our patients. ReCreate Psychiatry is the first step in this process.
At our recent launch of Shrink Radio held at The Dragon Café, I commented that my own experience on this journey had been somewhat akin to a horse suddenly losing its blinkers. Studying medicine is rather like being on a racetrack. One is propelled forward, as a racehorse is, in amongst the competition and the excitement, with the way forward clearly defined and delineated. Any deviation from the track is generally not desired, with blinkers helping to keep one focused and prevent gaze in other directions. In this way, the threat of the horse (or medic perhaps?) questioning its route and doing something different, or even potentially bolting is minimised.

Being part of ReCreate Psychiatry has been a chance to stop, take stock and think, to intermittently come off the track, and widen my perspective. Of late, questions of identity - my own, and that of the system in which I work, have been at the forefront of my mind. The conversations we have had together during our Shrink Radio/ReCreate Psychiatry sessions have allowed a space in which a deeper exploration of these thoughts can occur, with other perspectives and voices also heard and considered within the same room.

Key to this process of exploration, is that some of these other voices have been those of the people who have travelled the system, as patients, as users of it, as those who have been both helped, yet also sadly at times traumatised by it. What has it been for me to simply sit with these fellow human beings, without an agenda, without the unequal power balance in full force? For me, it has been about levelling the playing field, losing the hierarchy and beginning to understand what our current mental health system means for different people, depending on their involvement with it. We have considered in some depth the varied experiences of those who work in the mental health system, those who describe having ‘survived’ it...
and those who neither work in it nor use it, yet have control over aspects of its functioning. The discussions have challenged my own identity, one built up through the last 10 years of moving through the medical system, and at times this has been uncomfortable, though much appreciated and welcomed.

What happens to the horse that loses its blinkers? What are the opportunities afforded, what new perspectives open up, and what does this mean in terms of one's desire to change a system for the better? These are some of the questions that have been inspired in me, now that the metaphorical mask is off.

Much of the ReCreate Psychiatry experience has been about this process of taking off the mask, and allowing for a very humanising and normalising sharing to happen between people. It has been for me about coming back to what it is to be human, and echoes much of my current training in the Open Dialogue approach. I am reminded of Professor Jaakko Seikkula’s paper entitled ‘Healing Elements of Therapeutic Conversation: Dialogue as an Embodiment of Love’1 where he comments: ‘The drama of the process lies not in some brilliant intervention by the professional, but in the emotional exchange among network members, including the professionals, who together construct or restore a caring personal community.’

ReCreate Psychiatry is for me, an effort to restore this compassionate sense of community, where our mutual dialogue becomes the basis for inspiring change within a system that could perhaps easily be regarded as sick. Is it in fact the system itself that is ‘psychotic’? A photograph of a young doctor bowed down in a moment of distress outside an A&E department did the rounds on social media sites recently and we must ask ourselves why. Websites encouraging doctors to seek alternative careers are opening up with rapid membership from thousands of disillusioned and desperate staff, terrified by the on-going chaos in our services, often described as at breaking point in the media. We must, I believe, consider whether in fact, it is our system that is also wounded, and think hard together on how we might change this for the better, from the inside, for staff and users of it alike.

Is it perhaps not time that we take off the masks we have been taught to wear, in order that we may become our more authentic psychiatrist selves? What is it that binds us to these identities we have so carefully constructed around us? To the letters we slavishly write after our names, as if ‘Dr’ were not enough? And what happens when we are stripped of these shields, of these powers, such that we are simply ‘being with’ rather than ‘doing to’? What other power may be generated, what healing may happen if we allow this new space to open up?

ReCreate Psychiatry has provided me with alternative tracks to explore, and allowed me time amongst people that I respect and greatly admire, to consider some of these questions I have and most importantly to think about what kind of doctor I may be in the future.

I believe that now is the time to do this, to stop, remove our blinkers and look around. To truly listen, to see, to sense, and to ultimately have the courage to step off the one-track racecourse and into a new realm. To ReCreate Psychiatry.

References:
From the beginning of my involvement with The Dragon Café, something Sarah said has stuck with me. She told me that in any and every interaction with someone with mental health distress or illness or crisis, we can either nudge them toward feeling and getting better, or we can nudge them back toward their despair and into their illness. As a junior psychiatrist who was already exhausted by the demands and expectations of senior colleagues, sick patients, and the system we work in, this came to me two fold. First, I thought, oh gosh, more pressure to be perpetually receptive, warm and encouraging, even when or more accurately especially when, I am exhausted and stressed. I imagined myself on-call in the middle of the night, tired and trying to manage four or five different and competing tasks for people each with their own urgency, risk and emotional demand. The other side of this coin though is the important part. It is that with every interaction, your ability to muster gentleness and kindness in what may be the most difficult of situations does make a difference. You might not notice it at the time, you might not be able to recognise or appreciate it, but it is there and it matters. And so, what I do, does matter.

I have found that ReCreate Psychiatry and its dialogues sessions have done two things towards reinforcing this. The neutral power balance that is fostered in The Dragon Cafe has given me hope of a meaningful sharing of experience and a sense of solidarity. It is a movement...
that is developing a culture of working together and collaborating to improve our parallel experiences. It has also been a place where I have been able to hear first hand that good practice, not only bad, has an impact. This has encouraged me.

There are practical ways my psychiatric practice may have improved or ways that I wish to improve systems that aren't conducive to the actual care we are able to provide. But alongside this, despite it, and above all else ReCreate Psychiatry has helped give me the emotional strength to continue working compassionately in a system and environment that for the most part does not palpably appreciate you or the work you do.

I have learnt that ‘a nudge forward’ is a crucial concept to me, if I want to be a part of a healthy mental health system. However large or small the organisation, it has to be able to foster this principle and work towards it. A failure to maintain warmth and gentleness and patience and tolerance is both ubiquitous and understandable in mental health staff in our NHS today. Not only do I sometimes feel it in myself but I see it - I see it in un-appreciated nurses and doctors every day who are treated badly by the system and go on to treat others without understanding and compassion in return. Don’t get me wrong, we still do our job, do our medicine, do our caring, tick the boxes, and manage risk, but there is no possible box to capture this particular and most important aspect of our work. It is subjective, it is a feeling of human connection felt on both sides of the encounter. I believe this cannot be taken for granted even in the caring professions and needs to be fostered in a supportive culture.
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