"And how does that make you feel?"

Articles
- Special Interest Sessions and OOPE;
- An Art Psychiatrist’s Career

Feature
- An interview with a neuropsychopharmacologist

Reflection
- Reflecting on Reflection, and considering the value;
- Thinking about Pet Therapy
Hello! We are excited to bring you this issue of the Registrar. We have a number of different pieces from trainees around the region each with something different to say! If you would like to contribute to a future issue please do not hesitate to contact us at ptcsupport@rcpsych.ac.uk or tweet us at RCPsychtrainees!

Dr Priya Rajyaguru
Editor
@thispriyaraj
@RCPsychtrainees

Disclaimer: The opinions expressed in this magazine are those of individual authors and do not necessarily represent the views of the Royal College of Psychiatrists.
Hello and welcome to the September 2017 edition of the Registrar. This last 6 months has been a busy time for the Psychiatric Trainees’ Committee (PTC). PTC representatives continue to sit on and contribute to virtually all College committees. We also continue to work with the College on key issues affecting psychiatric trainees, particularly recruitment, retention and ensuring high quality training. However, our primary role is to represent you in the College and ensure that the trainee voice is heard. To do this effectively we need your views and feedback, you can contact us via email ptcsupport@rcpsych.ac.uk or twitter @RCPsychtrainees.

In April 2017 the PTC published ‘Supported and valued,’ a trainee-led review into morale and training within psychiatry. Our primary aim was to engage with psychiatric trainees across the country in order to identify the aspects of training that are currently working well and changes that if made, could improve training and work-life balance.

‘Supported and valued’ identified many positive aspects of psychiatric training, including protected teaching and supervision, team working and supportive senior colleagues.

We are privileged to have special interest sessions and protected supervision in psychiatric training programmes, they are unique selling points for our specialty. However, we are aware of regional variability in their implementation. Therefore ‘Supported and valued’ clearly sets out core recommendations to ensure that supervision, teaching, psychotherapy and special interest sessions are protected and available to all trainees.

‘Supported and valued’ also identified changes that could improve work-life balance and training. From this we have proposed desired commitments including ARCP standardisation across the UK, greater access to flexibility in training and implementation of enhanced junior doctor forums. The College has wholeheartedly supported the PTC throughout the ‘Supported and valued’ project and has committed to working with trainees to meet core recommendations and desired commitments.

‘Supported and valued’ was a team effort. It wouldn’t have been possible had it not been for the dedication of the trainees involved in the organisation and facilitation of focus groups. We also received incredible support from trusts and medical directors across the country. However, trainees are the heart of this report, therefore special thanks need to be made to everybody who engaged with the initiative.

The PTC is committed to ensuring that ‘Supported and valued’ is not just a listening exercise. We encourage all trainees to use this report to start conversations and make changes locally. ‘Supported and valued’ highlights that positive working relationships are a key factor in improving morale and wellbeing. A small change in our behaviour towards one another has the potential to significantly improve our working lives. We will continue to work with the College to ensure that there is tangible action. However, the PTC recognises that the power to make real change, rests with all of us.

De Kate Milward
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EPA 2018
26th EUROPEAN CONGRESS
OF PSYCHIATRY

MENTAL HEALTH
INTEGRATE
INNOVATE
INDIVIDUALISE

EPA2018

Nice, France
3-6 March 2018

AAAP's
64TH ANNUAL MEETING
OCTOBER 23–28, 2017 WASHINGTON, DC

BrainSkin
Colloquium 2017
9 – 10 October • Manchester

THE ROYAL COLLEGE OF PSYCHIATRISTS
INTERNATIONAL CONGRESS 2018
BIRMINGHAM, 24-27 June 2018
Faculty and Section Conferences

September 2017

Faculty of Child and Adolescent Psychiatry Annual Conference
Date: Wed 13 September - Thu 14 September
Location: Nottingham

Faculty of Neuropsychiatry Annual Conference
Date: Thu 14 September - Fri 15 September
Location: London

Annual RCPsych Medical Education Conference
Date: Thu 21 September - Fri 22 September
Location: Belfast

October 2017

Educational Conference for SAS Doctors
Date: Tues 3 October
Location: RCPsych, London

Faculty of General Adult Annual Conference
Date: Thu 5 October - Fri 6 October
Location: Sage Gateshead, Newcastle

Faculty of Psychiatry of Intellectual Disability Annual Conference
Date: Thu 5 October - Fri 6 October
Location: Dublin

Philosophical Issues in Psychedelic Drug Use - Philosophy Special Interest Group
Date: Thu 5 - Fri 6 October
Location: RCPsych, London

November 2017

Faculty of Eating Disorders Psychiatry Annual Conference
Date: Fri 3 November
Location: London

Rehabilitation & Social Psychiatry Faculty Conference
Date: Thu 9 November - Fri 10 November
Location: Bournemouth

Leadership and Management Conference
what keeps medical managers awake at night?
Date: Mon 20 November
Location: RCPsych, London

Faculty of Perinatal Psychiatry Annual Conference
Date: Thu 16 November
Location: London
Join us for our Autumn meeting in Bristol, including visit to the Glenside Psychiatric Hospital Museum - the largest collection of non-paper psychiatric artifacts in the UK

www.Glensidemuseum.org.uk

Date: Thursday 26th October 2017
9.30am – 4.30pm

Venue: Room TBC*, University of West England (UWE) Glenside Campus, Blackberry Hill, Stapleton, Bristol, BS16 1DD

Cost (including refreshments and lunch): £75 (£35 concessions – retired, trainee doctors, £20 students).

For further information about booking/concessions please contact caroline.simms@rcpsych.ac.uk
Reflecting on Reflective Practice

Dr Andrew Lawton
a.s.lawton@gmail.com

Dr Andrew Lawton is an ST5 in South East Scotland, dual training in General Adult Psychiatry and Medical Psychotherapy. He is particularly interested in Medical Education including effective reflection and has a (somewhat unhealthy) love of video games.

Reflective Practice

For better or worse, ‘reflective practice’ has become a part of the training of all doctors from medical school through to retirement. One 4th year medical student recently reported having completed ‘at least 36 reflective assignments’ in his first two years at medical school and commented on ‘a growing sense of “reflection fatigue” in [his] classmates’.

We are all required to ‘reflect’, both by the GMC and as part of our psychiatric training. This can cause anxiety and frustration in trainees and the numerical tally of written reflective pieces makes it easy for reflection to become a tickbox exercise. For many trainees, the need to produce regular written pieces falls outside their comfort zone and there can be anxieties about what is considered “quality” reflection. Following a recent situation where reflections in a trainee’s portfolio were used as evidence in a claim against them, there is a new anxiety: “Can reflective work be used against me?”

Clearly this is not the intention. The aim of this article is to consider the following:

• What is reflection and why is it important?
• What are the essential elements in a piece of written reflection?
• How can I make sure any reflective work will not be damaging to me in the future?

What is reflection and why is it important?

Despite their best efforts, it is clearly impossible for medical schools to teach their students any more than a fraction of what they will need to know in order to follow a career in medicine, likewise the Royal College MRCPsych curriculum and working as a psychiatrist. Nor can they begin to teach us how to cope with the myriad different interactions with
colleagues, patients, carers and others which we will experience. To be effective and safe doctors, it is vital that we build on that initial framework and continue to learn throughout our careers.

“We do not learn from experience... we learn from reflecting on experience.” John Dewey

One way to think about this is to consider Piaget’s ideas regarding cognitive schemata. Piaget thought that our knowledge of and interaction with the world utilised cognitive structures that developed through experience. These structures give us a means to interpret the world and also to predict it. When an experience falls outwith the schema, this creates cognitive dissonance which can be resolved in various ways. One way is to disregard the new information as insignificant and it has been suggested that we often exhibit ‘disconfirmation bias’, setting higher standards for new evidence that opposes our settled world views.

However, where the new evidence cannot be disregarded, it is necessary to accommodate it either by creating new schema or by modifying existing ones.

A piece of written reflection is an overt manifestation of this process. By making it explicit, we may be less susceptible to disconfirmation bias and make sure we learn from our experiences appropriately.

**What are the essential elements in a piece of quality written reflection?**

This is not the place to get into a lengthy discussion on the concept of ‘quality’ (for that, I recommend Robert Pirsig’s ‘Zen and the Art of Motorcycle Maintenance’). However, any piece of writing, be it a novel, a poem or an inpatient discharge letter, is a combination of form or structure and content. This split but also the way these two elements interact should be familiar to anyone who has ever completed a mental state examination! By identifying appropriate structure and content, the likelihood is that your reflection will be of the necessary quality.

Before considering the content, it is necessary to identify the structure. This then provides a framework within which to address the topic for reflection. Reflection is an active process. It involves a decision to consider more deeply an internal or external experience. Reflection is also a temporal process. It involves spending time in the present thinking about the past with the aim of achieving greater understanding, all of this in order to influence what we do in the future. In other words, reflection is a form of narrative with a beginning, a middle and an end. X happened (past), the effect this has on me (present) is Y, looking forward (future) I will do Z.

John Dewey identified five stages consistent with the above and elucidated more recently by Mamede and Schmidt:

1. a state of doubt, perplexity or uncertainty due to an emerging difficulty in understanding an event or solving a problem;
2. definition of the difficulty by thoroughly understanding the nature of the problem;
3. occurrence of a suggested explanation or possible solution for the problem, through inductive reasoning;
4. rational elaboration of ideas produced through abstract, deductive thought focusing on their implications, and
5. testing resulting hypotheses by overt or imaginative action.

With that in mind, what of the content?

**What is a suitable subject for reflection?**

Some subjects are required and some are recommended (see below) but the range is as wide as human experience.

Reflection on certain situations is a mandatory part of the ARCP process:

The Gold Guide highlights that trainees MUST

- ‘participate in discussion and any investigation around serious untoward incidents in the workplace, and record reflection of those in their educational portfolio’ (page 55).

Form R, which must be updated as part of each ARCP includes the following requirement:

- If you know of any RESOLVED significant events/complaints/other investigations since your last ARCP/RITA/Appraisal, you are required to have written a reflection on these in your Portfolio.

In addition, the Gold Guide also requires that trainees

- ‘reflect regularly on their standards of medical practice in accordance with GMC guidance on licensing and revalidation’

This is further referenced in the various trainee curricula both explicitly in ILO 12 (To develop reflective practice including self reflection as an essential element of safe and effective psychiatric clinical practice) and also in demonstrating lifelong learning (ILO 9).

The curricula also suggest that ‘A completed Work Place Based Assessment (WPBA) accompanied by an appropriate reflective note written by the trainee and evidence of further development may be taken as evidence that a trainee demonstrates critical self-reflection.’
That said, there is no reason reflection should be restricted only to untoward incidents or adverse events. Indeed, that sounds to me like a clear path towards defensive medicine.

Stage 1 above refers to a ‘state of uncertainty’. I would suggest that any experience where you encounter a prediction error, i.e., the outcome differed from your initial expectation has the potential to be a subject for reflection. This then is the beginning of the ‘narrative’.

The middle (present) involves attempting to understand why the prediction error occurred and there are numerous routes of exploration, for example:

- Did I make incorrect assumptions (about a patient, a colleague, myself, etc)?
- Was I lacking technical knowledge that would have changed my expectations (e.g., being unaware of a known side effect of a medication)?
- Were the circumstances a factor e.g., location, noise, temperature, hunger fatigue etc.

This process can be enhanced by seeking the knowledge and perspective of colleagues.

It may not be possible to identify one clear explanation. The practice of psychiatry involves complexities and uncertainties of diagnosis, of personalities and interpersonal dynamics, of medication choices and of decisions around risk, patient autonomy and patient welfare.

Having considered the possible factors contributing to an unexpected outcome, we should then be in a position to identify what we might have done differently, and by implication what we can do differently in the future.

I have included an example (see opposite) to try and illustrate some of these ideas. References here to mental health legislation refer to the Mental Health (Care & Treatment) (Scotland) Act 2003.

### Avoiding any medico-legal issues

Last year, it was reported that a trainee GP’s written reflections had been used in a court case as evidence against the trainee. Understandably, this has made many trainees rather anxious and reluctant to reflect on anything where there may be a perception of harm.

However, as highlighted above, reflection on adverse events is a requirement of the ARCP process. How then can trainees balance those two issues?

Firstly, remember that the purpose of reflection is to augment learning and it is a requirement precisely because, as I said before, it is impossible to pre-program doctors to achieve perfect outcomes in all imaginable circumstances. Mistakes are inevitable but do not automatically equate with either criminal or civil liability.
If you have any doubts or concerns regarding action(s) you have taken that may have legal consequences, contact your medical defence organisation for advice. Reflection can wait!

Secondly, ensure that any written reflection is as anonymised as possible. This should be second nature anyway because the various electronic portfolio websites used by trainees are not considered secure enough to store confidential information. It has been suggested that portfolio entries would only be admissible in court if they identified a patient. (In the example above, there is no information that would be sufficient to identify the patient)

Thirdly, where there has been a significant outcome, avoid attributing or speculating about blame. Instead, focus on the impact of the experience upon you and how you handled it.

Finally, if you do receive a request to provide reflective work to a third party (i.e., for any reason outwith your training), contact you medical defence organisation and take advice about what (if any) obligations you may have to do so.

In summary

1. As with anything, what you get out of reflective practice will depend on what you put in. Recognise the value in it, invest some time and effort and the experience will be far more rewarding. Not only that, it will make you a better doctor.
2. Quality reflection involved the combination of relevant subject matter and an appropriate structure. Remember, the aim is to improve your future practice by taking time in the present to explore a past event.
3. Anonymise any patient information. If you have any concerns about your medico-legal position, seek advice immediately.

Further reading:

- Reflective writing as an agent for change, BMJ Careers, 06 Jun 2016
- Reflection: tick box exercise or learning for all? BMJ Careers, 16 Nov, 2012

References

1 Trumbo SP. Reflection Fatigue Among Medical Students. Academic Medicine Apr 2017. 92(4):433–434
2 http://www.gmc-uk.org/guidance/ethical_guidance/11817.asp
7 Davies M and Kremer D. Available at: http://careers.bmj.com/careers/advice/Reflection%3A_how_to_reduce_the_risks
Special Interest Sessions and Out of Programme Experiences

Dr Tara Walker
tarawalker92@doctors.org.uk

Introduction

The Psychiatric Trainee Committee have recently published the results of their Supported and Valued project (1) which aimed to assess which key factors had a significant affect on the morale of current Psychiatric Trainees. Trainees highlighted that one improvement to increase their morale would be having greater career autonomy and flexibility for their learning. It is felt improving the quality and access to components such as Special Interest Sessions and Out of Programme Experiences are a key way of doing this.

Special Interest Sessions are unique to Higher Training in Psychiatry and can potentially act as a unique selling point to help promote retention. A higher trainee will be given one day off per week to pursue their chosen interest. For part time trainees, this is allocated pro rata. The time is part of training as usual, offered to every trainee. There is no application or interview to be granted this time, and the trainee has the freedom to pursue whatever they feel their special areas of development should be. Special Interest Sessions act as a unique selling point to make psychiatry an attractive career. No other specialty offers such a unique opportunity for a trainee to take control over their own interests in this way with specific allocated time.

Unfortunately, information regarding Special Interest Sessions available around the UK is variable between deaneries and it was felt the lack of information regarding availability and inspiration for placements was a potential issue which could promote a lack of retention of trainees through to specialty training if core trainees are not aware of its existence.

Out of Programme Experiences (OOPEs) present an opportunity for trainees to have greater autonomy over their training and embellish their skills in whatever areas they desire taking a set amount of time out of a training post to pursue other interests away from clinical work. Opportunities can involve research or even working abroad and are accepted on a case by case review. Applications for OOPEs within Psychiatry overall is very poor. Osman-Hicks et al. (2) in a paper published in 2015 stated that only 90 applications for OOPEs were received over 6 years within Psychiatry, which is equivalent to only 2% of all Psychiatric trainees. In addition the paper stated 53% of all applications were from London, suggesting a skew in available opportunities across the UK. There is no equivalent data in other specialties to assess if a similar number of applications are made. It is not known whether trainees are not interested or are not aware of OOPEs available to them.

When reviewing recent research there appeared to be no data relating to what trainees use their allocated special interest time for or the quality and effectiveness of special interest placements. It seems illogical that trainees are granted a day a week for special interest study without there being any formal research considering its effectiveness to complement training and skills.

In light of this through the Psychiatric Trainee Committee, a survey of all trainees in the UK was completed in March – May 2016, to discover their opinions regarding Special Interest Sessions and OOPE’s.

Method

A survey was created on survey monkey with assistance from the Royal College of Psychiatrists, reviewing information on OOPE and Special Interest Sessions. The survey was then distributed to all core and higher trainees though social media, email distribution, and advertisement on the College website.

Results

Overall 54 trainees answered the survey. Information was gathered from all areas of training in the UK. The tables below provide further details of data. The survey showed a variety of Special Interest Sessions were completed with the majority being in clinical areas, highlighting the significant extra practical experience outside their given post trainees can access for their future careers as Consultants. Fortunately, the survey showed 57%
had assistance with organising their Special Interest Sessions, however this support was only from their Consultant supervisor at the time. Only one deanery, South West was reported to have regularly emailed opportunities for Special Interest Sessions. Interestingly 57% of trainees felt Special Interest Sessions would not be a reason to encourage them to remain in training, but in addition 54% did not feel there was enough information available about their opportunities, and therefore if there was more information this may encourage them to stay on in training to make the transition from core training to specialty training. For those who had completed Special Interest Sessions 90% found these experiences to be either useful or extremely useful, highlighting they are a key component to trainees learning and development. General comments from trainees appeared to highlight an ongoing lack of information regarding Special Interest Sessions, one stating they weren’t sure how to use the sessions, whereas others feeling the sessions were invaluable to their training as a future psychiatrist. To improve the quality of Special Interest Sessions, 80% of trainees stated they would welcome a Guidebook.

Regarding OOPEs, please see table for a full breakdown of results. Only 4% of trainees had completed an OOPE equating to just 2 trainees. One trainee had completed a placement in Ghana for 3 months working and training staff. He became aware of it through training scheme in London. Another trainee completed a National Medical Directors Clinical Fellow Scheme as a CT2 and found out about this opportunity online. Encouragingly 68% of trainees stated they would like to complete a OOPE, and 52% felt awareness of this opportunity would encourage them to remain in training. Interestingly only 9% of trainees had been given information regarding OOPE. General comments offered regarding OOPE were all based upon a lack of information, a fear it would be damaging to their training, and only being able to find information after ‘extensive searching’. Because of this 98% stated a guidebook would be useful for inspiration.
Do you think there is enough information regarding special interest sessions?  

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<tr>
<td>Yes</td>
<td>33</td>
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<td>No</td>
<td>54</td>
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If you were considering leaving training would awareness regarding special interest sessions encourage you to remain in training?  

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<td>57</td>
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Would you like a guidebook regarding special interest sessions?  

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References


Meet Dr Nancy Hillis. A practicing psychiatrist and abstract artist based in California USA, Nancy’s career has certainly been diverse. From clinical medicine to therapist and successful art teacher, Nancy has managed to strike a balance across all worlds. We spoke to her about her experiences and her career so far.

Where did your journey first begin- were you always going to be a psychiatrist?

I think in some ways I was always going to be psychiatrist. When I was in second grade, there was a young girl who looked different. She seemed older, had tattered clothes, dishevelled hair and didn't really seem to fit in. One day she asked me to her Christmas party, and as my mother drove me to her home I couldn't believe what I saw. She lived in an orphanage and I had no idea. In that moment I felt an overwhelming amount of compassion towards this young girl who befriended me. It's these connections with people that I recognise as so valuable and humbling.

As I got older I proceeded to do many other things including drama, acting, playing the piano. I eventually ended up going to university by which time I knew I wanted to go to medical school. In fact in those early days I was actually drawn to plastic surgery, because of my passion for sculpture.

I eventually got involved in diagnostic radiology, and when I think about it now it was so appealing because of its visual, cognitive component. I ended up getting into Radiology training at Harvard.

Radiology seemed to satisfy the left side of my brain for a while, but as time passed I found myself feeling hungry for art- for something beyond CT scans and the dark room. I continued to march along in radiology but it was stifling. I felt starved of wonder, curiosity, meaning. Then one day I picked up the phone to Stanford and asked for a place to study Psychiatry- and the rest is history!

How did your artistic side develop?

I never once attended an art class whilst I was growing up, but I know i've always had an appreciation for it. My father used to have these beautiful Rembrandt reproductions in our house, which he would stare at for hours. I developed a special affinity for Rembrandt perhaps because of his attention to detail- he would paint the eyes, express humanity and focussed on poverty, and his art left a deep impression within my psyche.

As I started developing as a psychiatrist, my search for meaning and wonder met its partner in art. Art is constantly getting at these questions and allows the artist to explore the unknown.

Do you practice clinically?

Yes, I do see patients. I have a small clinic where I practice existential psychotherapy and see patients regularly. Many of my patients themselves are artists, creatives and writers.

You run a series of workshops- can you tell us more about these?

I'm basically taking my love of abstract painting and helping others explore their relationship with themselves, understanding their inner landscape. What I do with these workshops is act as a guide for people on what I call the artist's journey as someone who has been through the process myself. Guides
however can only take you so far, and at some point you have face yourself. As the artist you are the one who decides when to stop or start, you are the composer. The work I do is psychiatry too, it’s a different medium of expression.

What does a typical day look like for you?

One day per week I see my patients in the practice, and this takes all day. The rest of the week I spend doing many different things. I run my online course, I write my blog posts and I’m also in the process of publishing books. I paint everyday and draw once per week. I spend a lot of time replying to emails. I have a lot of people email me, and many respond to what they are seeing online. Some people write to me with their stories often in response to something I have written.

What challenges have you faced in pursuing your career as both artist and psychiatrist?

It hasn’t been straightforward and it was difficult to get my dairy to as it is now. I always wanted to incorporate more art into my life but I had to work, earn money and I needed to continue with psychiatry. I had my daughter when I was 41 and it was when she was 5 years old I realised that I really wanted to put my work out there. I started showcasing it and eventually found my way to abstract painting. People started liking it and eventually I created an entire online course. The scariest thing for me however, was learning to use the computer!

What advice would you give psychiatrists in training?

I would say hold on to what you love, do not let it go. Listen, go inward, dig down deep. Hang on to your passions, you never know where they might lead. Do this and you will find you bring so much more to your practice, and your patients will recognise that too.

Dr Nancy Hillis has a new forthcoming book released later this year titled Bold Strokes: Trust Yourself, Experiment & Activate Your Artistic Breakthrough.

Find Nancy on Twitter at @nancyhillis

Call for Poster submissions in November 2017! Please see RCPsych webpages nearer the time for further information
Chatting to Dr Ben Sessa: Neuropsychopharmacology

Dr Guy Stewart
namethatmolecule@gmail.com

Dr Stewart is a CT3 in psychiatry and Cornish emigre now based in Bristol. He enjoys cooking and gardening.

“This is not a crazy fringe subject anymore. This is not something a bunch of Californian hippies are doing. Look at the places that now have active roles running psychedelic programmes: Oxford, Cambridge, UCL, UCLA, John Hopkins, Imperial, Cardiff, Bristol, Yale, Harvard—these are cutting edge state of the art neuroscience institutions.”

Dr Ben Sessa, (a senior research fellow in neuropsychopharmacology at Imperial College London and Bristol University) is frustrated at the familiar line of questioning being levelled at his study.

“When I started doing this 15 years ago as a trainee some of my tutors took me aside and said, 'Ben, you know you are crazy, don't do this, you're aligning yourself with this crazy field; It's career suicide' they said.”

And now?

“Open the pages of BMJ, BJ Psych, Journal of Psychology, Nature, Science; all of these mainstream journals. Not a week goes by these days without some psychedelic article in the mainstream press.”

Ben is one of several key UK figures in the burgeoning field of psychedelic research; his tentative 2004 editorial highlighting the resurgence of studies abroad was followed by a steady stream of journal articles, books, media appearances, and an annual conference.

His old research colleagues from Bristol University (Professor David Nutt and Neuroscientist Dr Robin Carhartt-Harris) will be well known to anyone with an interest in the field, having been key players in the early days and appearing from time to time in the mainstream media. With Ben they have since joined the Psychedelic Research Group at Imperial. Among the group’s upcoming studies is an RCT that will use fMRI to compare treatment mechanisms for psilocybin and escitalopram in depression.

I’m curious to know what’s driving this renewed interest. Ben jokingly tells me that it is partly down to the demise of the “hippy”; that ostensibly benign counter-cultural icon of the 1960s. Their championing of psychedelic use and zealous consumption seemingly transformed what had been a ‘serious' academic interest into wide-eyed promises of a “chemical utopia.”

“It's 50 years this year since the Summer of Love in 1967. A lot of water has passed under the bridge,” says Ben. "People looking at psychedelics today, they take them for what they are, they don’t take them for what Tim Leary said they were so we’ve moved on from a lot of that.”

The Psychedelic Renaissance
Reassessing the Role of Psychedelic Drugs in 21st Century Psychiatry and Society
Second Edition
Ben Sessa

Image courtesy of Dr Ben Sessa
Timothy Leary: Harvard lecturer, clinical psychologist, political hopeful, convict, jail-breaker, international fugitive, hostage, 'the most dangerous man in America'. Things went bad for Dr Tim in a big way. A beguiling but deeply flawed figure, his bizarre adventures have made him a salient feature of the psychedelic landscape. His legacy still lingers there like an onerous smell.

"Look at me," Ben, fresh from work, nurses a coffee while slouched alongside me on a matching sofa. We are in the Bristol Museum cafe. Around us baristas sweep and tidy in anticipation of our exit; it is past closing but they let us talk on. "People invite me to go and give lectures on psychedelics and they probably expect some guy in a big beard and a kaftan to turn up, you know with finger symbols and incense, but they get me standing there showing them pages and pages of data and talking about neurobiology [...] we are not making claims that these drugs are going to transform society and that was one of the mistakes of the 1960's. So there is a certain degree of conservatism and sobriety about the way we are approaching it now."

The past aside, Ben points to technological advances in neuroimaging as having reclaimed some credibility for this nascent field.

"We now have the ability to actually see brain processes at work with functional imaging. So all of the narratives around how psychedelics work - which was all kind of conjecture back in the 1960's- are now being driven by data from these studies'.

There is also, he feels, a fermenting desire for innovation among those working in mental health; "people are getting increasingly disillusioned with biological psychiatry and the pharmaceutical industry. Clinicians are recognising that a lot of the treatments we have are not effective or not effective enough and whilst we continue to dish them out as they are there is a sense that both clinicians and patients are thinking 'surely there must be something else you can do'."

Ben is currently running a study on MDMA assisted psychotherapy. Although not a 'classical' psychedelic, MDMA (the main psychoactive component of Ecstasy) is a member of the entactogen (or empathogen) subgroup. He believes that MDMA assisted therapy could hold the key to tackling treatment resistant PTSD, anxiety and substance misuse rooted in past trauma.

I raise some concerns about this combination; with such a vulnerable patient group is there not a risk that the clinician might simply be replacing one maladaptive coping mechanism with another: the drug itself?

"The drug is a small part of it [...] a typical psychotherapy course would be, say 12 weeks. 2 sessions would be MDMA and the other 10 are non drug sessions so it is the drug in combination with the psychotherapy. Just taking the drug on it's own is not going to work very well."

"Over 1600 doses of therapeutic MDMA have been given in the last 8 years or so. There haven't been any cases of people going out and becoming recreational ecstasy users because it is delivered in the clinical context, and it's very tied to that clinical context. It's a bit like having a surgical operation and then thinking 'right I'm going to go out and do my own appendix.' You just don't, you recognise that it's being delivered in a very specific way in the clinical setting and going out and buying an ecstasy tablet just isn't going to do it."

And what of the 'come-down' following the recreational use of MDMA? A period of crashing mood and anxiety that supposedly varies in intensity and duration from person to person. It is commonly attributed to the depletion of serotonin following the preceding surge. Could such an effect not exacerbate the problems of an already troubled mind and undo any progress made in psychotherapy? I naively assume that Ben will be using doses far below that of the recreational user to guard against this...

"No, not at all [...] there is no actual neurobiological evidence for serotonin depletion in humans after MDMA. It's a very strongly felt narrative from the raving community. An alternative theory, and one I hold, is that it's the result of multiple confounding factors."

Ben points to the relative impurity of recreational MDMA or Ecstasy (which is often a combination of different psychoactive substances) as a potential contributor to the 'come down', as well as the manner in which MDMA is used.

"[Users will] go to the pub, they drink 3 pints, they go to a club, they drop a pill at midnight, they do another one at 2am, they drink a few more pints then they do one at 4am, go back to someone’s house, sit up all night doing lines of cocaine, smoking loads of cannabis, maybe have a little bit of food and get a couple of hours sleep on Sunday and then they feel..."
like rubbish on Monday or Tuesday morning and then they go 'Oh man, it's my serotonin depletion.' No, it's a hangover and they've missed out on sleep, they've missed out on food and they've danced vigorously. Now, there may or may not be some degree of serotonin depletion but that needs to be studied because there is no data for that."

"Of the 1,600 or so doses of therapeutic clinical MDMA given in the last 8 years we are not seeing this 3 day hangover thing [...] like all psychedelic drugs, it's also about set and setting." By 'set and setting' he means the individual's state of mind at the time of use and the environment in which use occurs. These are a frequently cited prerequisite to avoiding a negative experience while under the influence of a psychedelic drug.

The safety profile of MDMA is, says Ben, far better than the general public have been led to believe:

"It is extraordinary the incredible power of the war on drugs narrative to twist people's minds."

"Nothing is 100% safe [...] but I use David Nutt's famous quote here; 'if you've got somebody who is both ecstasy naive and peanut naive and you have a bowl of ecstasy tablets and a bowl of peanuts, which is the safer to take? The answer is the ecstasy by a factor of 350."

"750,000 doses of ecstasy and MDMA are taken every weekend in this country and have been for the last 25 years, yet the rates of morbidity and mortality are staggeringly low; probably 5 deaths a year could be attributable to pure MDMA in this country [...] and that's recreational ecstasy [...] taken in this poor setting with other drugs, people dancing all night, not looking after themselves. Huge proportions of people with that size of population would have problems and yet, find me a psychiatrist who will tell you that their wards and clinics are burdened by ecstasy users; they are just not on the radar."

Another frequently cited caveat for safe psychedelic use is the absence of psychotic illness in the subject's personal or family history; such individuals are inevitably excluded from contemporary psychedelic studies. "That's certainly been a kind of rigid narrative," says Ben," loads of studies exclude that [patient group as a precaution] and not just pharmacological ones; they tend to be the higher risk groups. It is pretty standard in lots of research that you exclude people with schizophrenia or Bipolar 1 unless you are looking specifically at those groups."

Ben is evidently frustrated by my readiness to conflate anecdotal accounts of recreational use with clinical grade MDMA and is quite put out when I ask if part of him relishes the controversy around the subject: "I'm a doctor. I want to present evidence based data and develop new treatments for my patients that will be safe and efficacious. I have no interest in railing against the establishment."

"I'd be very naive to say "Oh no there's no controversy with this subject. Of course there is controversy but the point I am trying to make is there ought not be."

"Look, I am a child psychiatrist. I give 6 year olds amphetamines and no-one bats an eyelid, you know, it's way more toxic. MDMA [...] and LSD doesn't even come close to the toxicity of Methylphenidate and I give that to 6 year olds and everyone is like "Oh great thank you. So if there are controversies they're just misplaced."

Ben tells me that in 2006 he was the first person in 33 years to be given a psychedelic drug legally when his then supervisor, David Nutt, administered a dose of IV psilocybin. And it didn't stop there... "In the last 10 years [as a study participant] I've been administered LSD, DMT, MDMA and Ketamine and I am happy to say it on record as this was all legal. I don't think there is any one person in the world that has actually been on all of those studies... so that probably makes me quite unique."
The "Psychedelic Renaissance" is chronicled in Ben's book of the same name. Originally published in 2012, the Second Edition is out this summer. Accessible to both the lay and clinical reader, it comprehensively charts the history of psychedelics; from their conception and use by early man to the present day. There are nods throughout to the popular mythology that has grown up around the subject and biographies of the compounds themselves (including many you are unlikely to have heard of) sit comfortably alongside those of key figures in their history. Early chapters provide a good grounding for the later exploration of clinical potential and it is well referenced, with many excellent suggestions for further reading. As an introduction to this intriguing field it stands as a finely written and accessible piece of work that should appeal to anyone with an anthropological or clinical interest in psychedelic use.
Pet Therapy: An Alternative Management for Mental Illness

Dr Nisha Rajyaguru
nisha.rajyaguru@nhs.net

Introduction

Cognitive interventions, medications, lifestyle changes and... Animals? The latter is not what we would traditionally recognize as a conventional aspect of management for mental illnesses but perhaps it’s one that deserves further consideration.

Florence Nightingale wrote “A small pet animal is often an excellent companion for the sick, for long chronic cases especially. A pet bird in a cage is sometimes the only pleasure of an invalid confined for years to the same room.” (1)

Owning a pet dog arguably has clear physical health benefits; the daily activity of walking the animal will improve fitness, reduce blood pressure and increase mobility. Many pet owners may also state how their furry companion reduces stress and provides a sense of purpose and fulfilment. Therefore, it’s not surprising that animals may also have an extremely positive impact on one’s mental health and wellbeing.

The inclusion of animals in mental health treatment is a longstanding practice, dating back to the eighteenth century. In 1796, the York Retreat was opened, as an institution for individuals with mental health needs. It was one of the first programs where patients with mental health needs were treated with compassion and kindness, and part of their therapy came from interacting with small animals. (2)

Pet therapy, also called animal assisted therapy (AAT) can take place in the hospital or outpatient setting, or even in patients’ own homes. It is known that for some war veterans, the use of dogs to help combat post-traumatic stress disorder has been a beneficial practice and an excellent form of therapy (3). However, animals can also be used in the management of depression, anxiety and autism disorders.

Animal involvement in healthcare can be divided into two categories: animal assisted activities (AAA) and animal assisted therapy. Animal assisted activities “provide opportunities for motivational, educational, recreational, and/or therapeutic benefits to enhance quality of life” (4). These activities have a casual, less structured approach and can be carried out by volunteers. An example of AAA would be a volunteer bringing an animal (often a dog) into the hospital setting and patients are then able to interact with the animal.

Animal assisted therapy (AAT) is a more structured and goal-directed program, delivered by a health service provider working within the scope of practice of his/her profession. It has a specific therapeutic objective and is delivered as part of a specific management plan (4).

The Positives

A systematic review of randomized controlled trials (5) looked at eleven studies which investigated the effect of AAT on a variety of diseases; seven of the studies looked at mental health and behavioural disorders. A variety of different animals were used, including: dogs, cats, dolphins, birds, cows, rabbits, ferrets and guinea pigs. A one-year controlled study where elderly patients with schizophrenia were provided with a cat or dog (depending on the patient’s preference) found a significant improvement in Social Adaptive Functioning Evaluation (SAFE) scores. Another study, which looked at the effect of animals on mild to moderate depression, found that the mean severity of the depressive symptoms was reduced in the animal treatment group. The systematic review found that other areas that improved following AAT include patients’ self esteem, psychological wellbeing and anxiety symptoms. As well as this, AAT can improve patients’ feelings of isolation and consequently enhance their overall quality of life.
The Negatives

There are, of course, disadvantages to AAT; the most obvious being that some people simply don’t like animals. This is not something that can be changed, so in these people the concept of AAT would be rejected from the very beginning. Other issues to be considered would be the possibility of animal allergies and phobia of animals, as AAT would not be compatible with these patients.

Looking at the cost of intervention, often AAA programmes are delivered by volunteers from a charity, thus incurring no cost for the patient or hospital team. However, based on the location of the patient and the demand for volunteers, there may be difficulties in arranging sessions as frequently as needed.

Although the animals chosen to be trained for use in a healthcare setting are very well behaved and friendly, it is impossible to ever be entirely certain that nothing will distress the animal, causing it to become agitated. This may consequently have a negative impact on the patient(s). Although this is not a common occurrence, it would always remain a risk where animals are being used in a therapeutic setting.

Final thoughts

Working on an elderly care ward as a medical SHO last winter, one of my weekly highlights was the arrival of a pet therapy volunteer and her companion: a friendly dog called Layla. She would cheer up the patients on the ward and I can confirm that she would cheer up most of the staff also! This is an example of an animal assisted activity. Despite being the most basic form of animal therapeutic intervention, it provided a break from the normal day-to-day atmosphere on the ward. The intrinsic love of animals that so many of us share, means that this proved to be a truly effective albeit subjective way of lifting our patients’ moods and providing something for them to look forward to in an otherwise monotonous week.

AAT may be an interesting avenue to consider with certain patients, depending on their condition and personal preferences. Taking the time to enquire if it would be something they would be willing to engage in may result in a positive outcome. An awareness of the various charities available within the UK (for example, Pets as Therapy- a national UK based charity) may prove helpful for patients that would benefit from this novel approach.

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