

The Student Associate Newsletter

# future $\Psi$ Psych



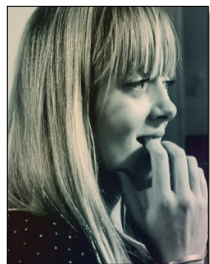
Winter 2017 Edition

Why Psychiatry?



## Editorial

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### **Amy Darwin, Editor**

Amy is a fourth year medical student from Leeds University and Student Associate Representative on the RCPsych's Psychiatric Trainees' Committee (PTC).

During the success of the Ban the Bash Campaign last year, stories were shared about why *not* to choose psychiatry, 'pest control' (yuck) and psychiatry being a somewhat fluffier option. However, the psychiatrists I speak to love their jobs, respect their patients and want to share their enthusiasm for psychiatry.

So in this edition, I wanted ask, 'Why Psychiatry?'. We have spoken to psychiatrists or aspiring psychiatrists ranging from Pathfinders and Foundation Doctors, Trainees and Consultants, to the Royal College of Psychiatry's Registrar, to ask what it is about a career in psychiatry that appeals.

We also hear from a student who spent their elective at a high security unit, student selected components spent making films, and students making positive changes to policy in mental health as part of The Royal Society of Medicine Initiative. There is news of psychiatry buddy schemes and a #banthebash event, as well as a prize-winning essay linking advances in neuroscience to better understanding of psychiatric disorders.

We are always interested to hear from you and on the look-out for people to get further involved with Future Psych: email [FuturePsych@RCPsych.ac.uk](mailto:FuturePsych@RCPsych.ac.uk) for more information.

Thanks to everyone else who contributed to this issue, happy reading!

*@RCPsychStuAssoc* RCPsych Student Associates

*@AmyVDarwin* Amy Darwin

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### **Front Cover Artwork: Dr Guy Undrill, Consultant Psychiatrist**

*'I've been doing the cover image for the BJPsych Bulletin for about five years now. I often take inspiration or draw a style from art history, taking in fine artists such as Magritte and Durer, collagists such as John Heartfield and Hannah Hoch as well as graphic design and street art. The 'Headshopping' cover was for an article on headshops, shops selling 'legal highs'. It's inspired by the psychedelic graphic design of album covers in the 1970s. All of the chemical compounds coming out of the explosion are the actual structures of some common legal highs, though I don't think anyone actually spotted this!'*

<http://pb.rcpsych.org/content/39/6/316>

## The Royal Society of Medicine Student Policy Initiative

**Mao Fong Lim** Medical Student  
King's College London, Vice  
President of King's College  
Psychiatry Society

**Claire Brash** Medical Student  
Imperial College London, RCPsych  
Pathfinder Fellow

**Organising Committee Members,  
2017 Royal Society of Medicine  
Student Policy Initiative**

In 1959, Charles E. Lindblom of Yale University published an article on policy formulation under the title 'The Science of "Muddling Through"'. On the weekend of 21-22nd January, over 60 medical students from around the UK gathered at the Royal Society of Medicine (RSM), to "muddle through" the health and education policy landscape and its impact on mental health. Together, their reflections on medical school and recommendations to improve welfare systems steered the fourth forum convened by the RSM Student Policy Initiative, entitled 'Student Mental Health in the Medical Profession'.

Over the weekend we were fortunate to have some of the field's leading minds offer their perspectives, including Professor Sir Simon Wessely (President of the Royal College of Psychiatrists and President Elect of the RSM), Dame Sue Bailey (Chair of the Academy of Medical

Royal Colleges) and Dr Charlotte Wilson-Jones (King's College London Undergraduate Psychiatry). In addition to overviews of current research and education efforts, we were moved by Dr Donna Arya (Forensic Psychiatrist) and Dr Richard Gorrod (Mind Trustee and retired GP), who shared beautifully honest and open accounts of their personal experiences, underlining the importance of valuing colleagues within the NHS. Closing the forum, Dr Clare Gerada (Sick Doctor's Trust) reminded students that they should "put on their own oxygen mask first" because "in putting yourself first, you will be able to treat your patients well". Such advice felt poignant in the wake of the NHS Junior Doctor contract negotiations and in light of Student British Medical Journal findings that up to 80% of medical students with an existing mental health condition feel under-supported by their institution.

As medical students, we may not think of ourselves as being able to contribute to policy, especially as this isn't often featured specifically within medical curricula. Despite this, we engage with policy every day: informing the education we receive, the GMC guidelines governing our fitness to practice, the shape of our professional training, and the healthcare services we ourselves access. Students must therefore be empowered to influence policy more actively, and with broader insight than their individual university experience may afford, which is one of the reasons that Nick Cork (Past Principal Student at the RSM and Medical

Student at the University of Cambridge) founded the forum in 2014.

Regardless of policy expertise all students have the capacity to drive change, and design innovative solutions to problems we encounter, in order to improve medical education provision for subsequent learners. As Dr Arrash Yassaee (Chair of the Royal College of Physicians' Student and Foundation Doctor Network) commented, "the best people to design a support system are the people who would use it". We were thrilled to combine the contributions of attending delegates with a truly interdisciplinary Twitter debate, via the #RSMStudentPolicy hashtag; discussions around the biological, psychological, and social drivers of student mental health and burnout were informed by evidence of good practice across UK medical schools, alongside areas requiring improvement.

The organising committee guided their fellow delegates from observing and listening on day one, to debating and creating on day two, as breakaway roundtables explored four key themes: medical student mental health, student support systems, professionalism, and valuing students and trainees. Policy proposals and practical interventions were drawn out of the rich discussions and presented back to the plenary by the roundtable Chairs, allowing all delegates opportunity to debate the benefits and limitations of each suggestion.

With the weekend now concluded, the real work begins. The committee will act as an editorial team to produce a report

condensing the forum's findings to reflect a collective student perspective. Our proposals will be submitted for peer-review publication, and we look forward to presenting these to relevant stakeholders, including the British Medical Association Medical Student Council, in coming months. Ultimately, we must ensure that tomorrow's doctors can access any and all support they may need – today. We hope that our work contributes in realising this goal, and advances the wellbeing of the medical student population.

*@maotweets Mao Fong Lim*

*@Rosedewy Claire Brash*

## An Elective at Rampton

Palvasha Mumraz: Fifth year medical student, Leeds University

### Where did you do your elective?

I went to Rampton Hospital. It is a high secure NHS forensic hospital in Nottinghamshire that is home to over 300 patients and has over 1700 staff members. The hospital has been classified by Her Majesty's Prison Service as having Class B prison security in regards to building specifications but with Class A procedures.

Patients at Rampton hospital have been diagnosed with or are being assessed for learning disability, mental illness and/or a personality disorder (PD). The majority of the patients are admitted for treatment under section 3 of the Mental Health Act 1983. Most have an average admission of 5 years, however some have a much longer stay. Rampton has the only high secure services in the country for women, deaf men and for men with a learning disability, with separate wards allocated to each. As well as this it provides mental illness services, a PD service and the peaks unit (dangerous and severe personality disorder unit).

### Why did you choose an elective in Psychiatry?

My fourth-year psychiatry placement was based in geriatric psychiatry placement with one day assigned to visit a medium secure forensic unit. I aimed to use the

elective period to explore other aspects of psychiatry and further my knowledge in forensic psychiatry. I wanted to develop my communication skills with forensic patients. I also wanted to use the opportunity to enhance my mental state examination skills. I wanted to further my knowledge in the assessment and treatment of PD patients. Furthermore, I intended to determine whether I would be happy working in a high secure hospital if I were to pursue a career in forensic psychiatry.

### What did you do to prepare for and during the elective?

I initially contacted the hospital to determine whether it would be possible to conduct my elective at the Rampton hospital. I was assigned a tutor in the PD service who I emailed prior to attending Rampton. Before I was able to officially start my elective, I had to attend a security induction at the hospital that spanned over four days.

When I started the elective I shadowed my tutor in attending ward rounds, multi-disciplinary meetings, hospital clinics and patient seclusion reviews. My tutor was based mostly in the DPSD services, on these wards all patient interactions with an individual that was not a member of the nursing staff had to be supervised. This meant that all my patient interactions here were supervised, however, on the lower dependency wards I could interact independently with patients.

For a wider experience, I also attended consultant ward rounds in the mental illness, deaf and women's services. Additionally, I was given the opportunity to attend Her Majesty's Prison and Young Offenders Institute (YOI) in Doncaster where I shadowed a mental health nurse and psychiatrist.

In order to understand assessment and treatment of the PD patients I spent some time with other multi-disciplinary team members such as speech and language, art and occupational therapists, and psychologists.

### Did you have a good elective experience?

Going to Rampton hospital for my elective was an invaluable experience. Forensic psychiatry is now one of the options that I am considering as a future career and I feel as though I would be happy to work in a high secure forensic hospital. Having the opportunity to interact with some of the most dangerous patients in the country in a safe and controlled environment has allowed me to appreciate mental health services in their views; although admittedly there were some incidences in which the behaviour of some of the patients was quite daunting.

#### Psychiatrics' Trainees Committee Bursaries 2017: Email [ptcsupport@rpsych.ac.uk](mailto:ptcsupport@rpsych.ac.uk)

The Royal College of Psychiatrists is keen to attract high calibre doctors to the specialty of psychiatry and to foster good attitudes towards psychiatry and the College as a whole.

The Psychiatry Trainees' Committee (PTC) is pleased to offer bursaries for medical students looking for financial support with their electives in psychiatry or to undertake research in the UK or overseas.

There are a number of bursaries which are offered in the following three types of activities:

##### **To undertake an elective in psychiatry**

- £150 per week for a maximum of 8 weeks (total £1200)

##### **To undertake a period of research on a psychiatry related topic**

- £150 per week for a maximum of 8 weeks (total £1200)

##### **To prepare a research presentation**

- £100 for submissions in the UK
- £150 for submissions abroad



## Why Psychiatry?

**Why are you interested in a career in Psychiatry?** I am a mature student at the University of Leeds and have just re-joined my medical studies following a year of maternity leave. When I did my A-levels I thought long and hard about studying medicine but decided the time wasn't quite right for me and instead went on to study Classics at Cambridge. After four years of hardcore study I then decided to do a drama course for a 'break' and did a masters in performing at Drama Centre, London. I always worked alongside my studies, mostly as a support worker for young people with disabilities which I very much enjoyed. When I finished my drama course I continued this work and found it was something that I am really interested in. This is one of the main reasons I went back to the idea of studying medicine and I am very pleased I did.

**How have you learnt more about Psychiatry?** I applied for the Pathfinder Fellowship after attending psychiatry summer schools and student conferences: it was going to these type of events and hearing more about psychiatry as a career that made me think about applying. The support that the Fellowship has to offer was something that really appealed to me.



**Danielle Trigg, RCPsych Pathfinder Fellow,  
Year 4 Medical Student, University of Leeds**

**Why did you choose psychiatry?** I find treating mental illness more rewarding than treating physical illness. I love having the resources to completely change a person's life for the better, and I enjoy being able to look at the person as a whole. I find the brain and its psychopathology fascinating. For example, I love seeing patients improve dramatically after just a short course of medication or ECT.

**What is your day to day job like?** I see patients either alone or as part of Ward Round with my Consultant and other members of the MDT. I also undertake ward jobs with my F1.

**Why do you think medical students should choose psychiatry?** It is a privileged job where you look after patients when they are potentially at the most darkest vulnerable place and can change their lives for the better.



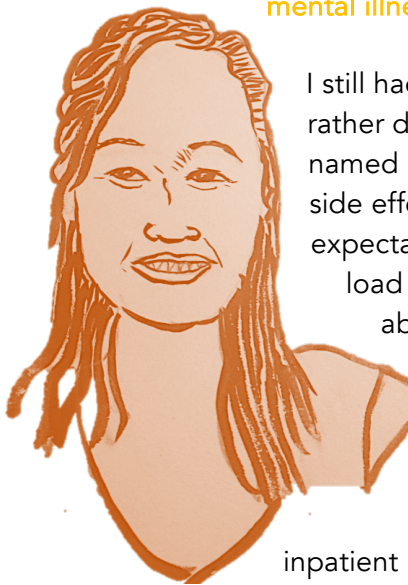
**Dr Rosemary King,  
CT2 Trainee, General  
Adults Inpatients,  
Gloucester**



Claire Eccles, RCPsych Pathfinder Fellow, FY2 Yorkshire

'I am interested in people, and not just parts of the body. I heard an interview on Radio 4's The Life Scientific by the eminent psychiatrist, Professor Robin Murray. He spoke in a very interesting, and accessible, way about schizophrenia and the role of dopamine, and his fascination with the mind. At one point he said **'What does the heart do? The heart's just a pump; but the essence of us is the brain'**. I thought, yes, that is how I see it too, and decided then that is the area of medicine I was most interested in. The next question was whether to do neurology or psychiatry. I had done a PhD in genetics at UCL, so had a love and familiarity with basic science. Increasingly though, our understanding of mental illness is that it comes from the interaction between the basic sciences (for example, genetics and neurobiology) and social factors (such as an individual's place in society, the family and their life experiences). This is the area covered by psychiatry.

I am fascinated by psychosis. By what happens in the brain, when someone hears or sees something that is not there, or believes something (sometimes really quite elaborate) that is not true. Both my younger brothers have experienced psychosis. Their illness and recovery have been profound lessons for me, both in how isolating and frightening mental illness can be, but also in the importance of good support and treatment. **I hope that my career can combine both the privilege of working with patients, with research into the science of mental illness, particularly psychosis.**



I still had some preconceptions that psychiatry was mostly about the rather dubious categorisation of psychopathological symptoms into named illnesses, and then administering medication with pretty nasty side effects (occasionally against a patient's will), with little expectation that patients would get better. Turns out that is mostly a load of rubbish, but it was meeting good psychiatrists and hearing about advances in our understanding of the basic science and pathology, along with advances in treatments, that showed me that.

I would love to tell you about some of the most interesting patients (I really would), I spent eight months on a male inpatient psychiatric ward during FY1. I saw a wide range of acute psychiatry, from schizophrenia, bipolar affective disorder, psychotic depression and personality disorder; to more unusual cases of Cotard's syndrome, severe Korsakoff's, and Folie a deux. I found it endlessly fascinating, often complex, but immensely rewarding.

**Quite simply, psychiatry is the most interesting speciality.** The mind is who we are. Psychiatry offers the opportunity to really get to know our patients, and practice medicine that, at it's best, can make lasting positive change in our patient's lives. Psychiatry is challenging, because you must be able to combine excellent communication skills and compassion with a thorough understanding of physiology and pharmacology. Finally, I think if you are interested in research, then psychiatry offers an almost unparalleled opportunity to make advances in our understanding.'

**Dr Eleanor Romaine CT3, Northumberland, Tyne and Wear**

**What made you choose psychiatry?** I had thought I wanted to be a GP. Whilst doing a GP F2 post I found the patients I enjoyed seeing the most were those with mental health problems. When these were of a severity needing secondary care referral, I found it frustrating that I couldn't be part of that phase of treatment. I was avidly waiting for letters to find out what had happened to my patients. I found that the consultations in primary care that I enjoyed the most were around mental health.

**How did you find psychiatry as a medical student?** I didn't actually enjoy my time as a medical student in psychiatry. I found it difficult to find patients who wanted to speak to me and often they didn't turn up to clinic, so there was a lot of hanging around. However, I do remember that often consultant psychiatrists seemed to be some of the happiest and most keen to teach consultants that I saw as a student. They spoke about finding their careers rewarding. As a psychiatry trainee, I certainly don't have much time for hanging around! I feel happy in my training and I think the majority of my colleagues are as well.



**What is good about a career in psychiatry?** Psychiatry has allowed me to achieve a great work-life balance. The range of posts for higher training is wide and there is something for everyone there. I've had opportunities to get involved in teaching, audit, research and leadership.

**What does your typical day look like?** At the moment, I am doing a 6 month rotation within a crisis team. My day starts with a MDT handover of patients who have been seen by the team in the past 24 hours. The consultant and I then divide up medical reviews in patients' homes between ourselves and carry these out. I might write a few prescriptions for patients before I leave. I carry out my home visits to patients in crisis and assess their presentation, come to some form of diagnosis and discuss if and what medical management might be appropriate with the patient and their carers. There is a consultant available for me to contact with questions if I need to. I head back to the office and write up notes, GP letters, request investigations and complete any other required paperwork. The best parts are being out and about and seeing patients in the community. Most of the time I manage to leave on time! I also enjoy working within a strong MDT and spending the working day with colleagues who are fun to be around. I think the worst part of being a Core Trainee is the short time (6 months) we spend in each post. I'm not the biggest fan of change.

**Why do you think medical students should choose psychiatry?** I think this is the best specialty to practice truly holistically. We treat our patients as whole people who are part of relationships, families and wider communities.

## Dr Adrian James, Consultant Forensic Psychiatrist, College Registrar, RCPsych

### What factors influenced your decision to choose psychiatry?

I come from a non-medical family and thus had no preconceptions when I went to medical school about the different specialisms. Back then, we had 12 weeks on psychiatry, which might be a little longer than today's medical school standards. I found that in contrast to other specialities in hospital medicine, we actually had time to spend with the patients and were able to communicate with them. It was a genuine interaction, with the chance to find out more about their lives. I also found that psychiatrists were open and interesting people who really welcomed medical students onto the wards and into the team. They seemed to lead interesting lives and be involved in writing and the arts. As a consultant now, I try to remain friendly and approachable, saying hi to medical students in the hallways.

### Tell us about a typical day at work

There does not seem to be such a thing as a typical day for me- I am fortunate that my working life is very varied and I am able to balance being a clinician with my role in management, recruitment, communication and policy at the RCPsych. Last week I was in India representing the college at a conference and yesterday I was at the college, meeting with Simon Wesseley and the Faculty of Addictions about possible public health strategies- more people are dying now than ever from heroin addiction.



This morning I arrived and did a quick review of each patient who is with us at the moment, wondering who is at risk- both to us and to themselves- before having a meeting about four patients who the team are particularly worried about. The patients were invited to these meetings and were able to speak about their care and needs before we spoke with the rest of the team. Its important to me that there is no secrecy and patients always have the opportunity to communicate with us. At the end of the day I will be either biking around London on my Brompton or going mountain biking around Dartmoor- this clears my head and I find it a great way to relax.

**It is an exciting time to be a psychiatrist- what policy change have you seen during recent years.** Prior to being Registrar for the College, I was the Westminster representative for the Psychiatrists' Trainee Committee and witness to huge changes. David Cameron was vocal about the importance of mental health; though Theresa May addressed people only briefly when she took up her post at 10 Downing Street, mental health was on the agenda and there has been a new appointment of a Shadow Minister for Mental Health by Jeremy Corbyn. I felt that in the past, psychiatrists held a position behind cancer, paediatrics and other specialties, whereas now, they feel more threatened by us! There has been a large amount of money promised to mental health services and there is a role for psychiatrists in ensuring that this trickles down to where it is most required.

**How can medical students address stigma towards the profession or patients that they might experience?** I think it is important to stress to other doctors that 'it could be you'! It could be yourself or a family member that is affected by mental illness, and I think that it is good to point out that in this case, anyone would want the best of the best taking care of them or their loved ones. We want to recruit the best medical students so that our patients get the best possible care.

**Is there anything else that you would like to add about psychiatry and why you chose it?** It is a great time to get involved in mental health and currently secondary care is being devolved into the community. This is a time when other specialties will begin to learn from us. Psychiatrists have been reliant on multidisciplinary teams and working to de-institutionalise patients for a long time and other specialties are beginning to realise the importance of this. There is also evidence of effectiveness of psychiatric treatments and interventions which is sometimes overlooked and should be emphasised.



Dr Alex Langford, ST5 Liaison Psychiatry,  
Oxford

**What made you choose psychiatry?** I got sick of treating dozens of chest infections and UTIs in an identical manner. I wanted to get to know my patients as a necessary part of my job. We treat incredibly unwell people, with variable but impressive results, with very little resource. Psychiatry gets criticism sometimes - but my theory is that every other specialty shares our flaws, but gets away with them. Being such a diverse, broad field, there are always opportunities to write papers, organise events, and teach. We welcome enthusiasm, instead of competing with the enthusiasm of others.

**What does your typical day look like?** I see a wide variety of presentations as a liaison psychiatrist. Plenty of organic stuff, plenty of severe mental illness, and plenty of functional disorders. The best part of my job is helping physicians make an accurate diagnosis and get someone out of hospital. The worst part is having to witness the local Mental Health Trust try to work with so little money. Psychiatry is the absolute opposite of the myths surrounding it. It is highly evidence based, with great treatment results, very organic, and clinically complex. You will never see two similar patients. We value the work-life balance (a day per week for special interest!) and use the training we receive to develop as individuals, not just doctors.

# How Are You?

## Making a Film to Beat Stigma: A Student Selected Component in Psychiatry

### Munzir Quraishy, Fourth year medical student at Cardiff University

For the first time while at university, we were given free reign of what we studied. Our Year 3 SSCs allowed us to design our own projects as opposed to choosing from a preapproved list which we'd done in previous years. I took this as an opportunity to avoid being stuck in a lab again and to do an SSC I'd actually enjoy.

Two of my biggest interests are film and psychiatry, so I thought, why not make a documentary film about psychiatry, specifically about stigma.

Then came the challenge of convincing the medical school to let me make a film, something that on the face of it was far less academic than the audits and literature reviews my friends were doing. They approved it in the end, provided I did research with it to ascertain its effectiveness as a teaching tool.

One of my course-mates and I then had three weeks to make the film, after which four weeks would be spent conducting research. With the help of Cardiff's National Centre for Mental Health we found three patients and four doctors to talk about their experiences of mental health stigma.

The aim of the film was to educate people about mental health stigma, and to make them aware of it, so that they would be more open to talking about mental health. Stigma remains one of the big barriers to recovery for many and if we were able to influence people, then we might be able to play a part in helping patients recover.

To do this effectively however, we took note from what other famous documentary filmmakers had done such as Michael Moore (Fahrenheit 9/11, Bowling for Columbine) and Asif Kapadia (Senna, Amy). Both talked about how a documentary should still be a film and still tell a story of a character. You should be able to emotionally resonate with this character and you should come away with an emotion that makes you think and makes you want to make a change. Hence the patients and their stories became the focus of the documentary, with doctors adding contextual information about the illnesses themselves.

The patients talked about their struggles with illness, how stigma had made it all worse, but also how we can change things. The three patients were incredible and their stories were rich and insightful, they had different ideas about stigma but one theme seemed to emerge, talking. We need to be able to talk openly about mental health and teach children that it is ok to talk about mental health, such a simple thing can make a huge difference to so many lives, and yet it still exists as a barrier to recovery. We've done it with cancer, so why can't we do it with mental health?

In the end we had roughly six hours of footage which we had to cut down to ten minutes. The film was then sent out in a survey to medical students and sent to a variety of film festivals. Initial results showed it to reduce stigma and have an emotional impact on the audience. Film is so often compliant in increasing stigma,

it was great to be able to use that same powerful medium to do the opposite.

I hope the success of this SSC does three things. That it gets more people talking about mental health, that it encourages medical schools to allow students to do more varied and artistic SSCs, and that Cardiff lets me do another film for my next SSC, for which I'm still trying to find a subject matter to cover (any ideas would be appreciated!).

Watch the film here:  
<https://goo.gl/I9w4JG>

## How can advances in neuroscience help our understanding of psychiatric disorders?

Dr A. Allen, currently on a year out between F2 and GP training

The rapid growth of neuroscience over the last two decades has fascinated and enlightened us. It is not difficult to be excited by the dynamic frontiers of research into the living mechanisms underpinning psychiatry: discoveries in neurotrophin epigenetics have led on from maps of neurogenesis; observations of hippocampal atrophy have been superseded by visualisations of cortical activity. We have come a long way since the initial monoamine hypothesis of depression was serendipitously sparked by isoniazid. How does neuroscience inform our understanding at present, and how is this knowledge evolving? As neuroscience advances, which of its avenues are likely to be of greatest importance to psychiatry, and where are the limits?

I will take depression as my example of the strength of neuroscience in understanding a psychiatric disorder. MRI has produced an impressive map of architectural change<sup>[11]</sup>; fMRI has revealed neural mechanisms of disorders, e.g. how activity within the amygdala and cingulate cortex correlates with dysphoric emotions<sup>[2]</sup>; and PET can use immuno-labelling to research pathological signalling. For example, the radiotracer 11C-DASB is 5HTT-specific, so can be used to study serotonergic transmission and neuronal loss in depression and HIV-associated neurodegeneration<sup>[18]</sup>. Magnetic resonance spectroscopy can identify levels of detail that

would have been unimaginable a few decades ago: a recent study visualised changes in neurotransmission in the cingulate cortices of people with OCD receiving CBT<sup>[17]</sup>. After intensive CBT, N-acetyl compounds rose from an abnormally low baseline in the right pregenual anterior cingulate cortex, and glutamate fell in the left anterior middle cingulate cortex. Studies such as these are valuable for several reasons. Firstly, they localise abstract treatments to specific nuclei. Secondly, they demonstrate neural correlates and therefore therapeutic targets. Thirdly, they may be able to provide prognostic information; in the above study, baseline N-acetyl compounds level correlated with the degree of changes in symptom severity post-CBT.

This wealth of neuroscience means we have an immensely greater understanding of the basis of psychiatric disorders, but how is neuroscience advancing? Discovery is being guided by studies marrying research techniques, like the international ENIGMA Consortium which correlates genome-wide association studies with MRI data<sup>[10]</sup>, and like current research into the relationship between amygdala volume and serum BDNF in the search for biomarkers<sup>[9]</sup>. We can expect intriguing correlations between neuroimaging, biochemistry, genomics, and the emergent fields of proteomics, epigenomics, degradomics, transcriptomics... The combined strength of these avenues will help clinical psychiatry in numerous ways. For instance, they may better inform nosology, such as in the case of the DSM-5<sup>[14]</sup> and NIH's Research Domain Criteria project<sup>[3]</sup>, which aims to guide diagnoses away from "descriptive phenomenology". Moreover, they will join the search for biomarkers of psychiatric disease and for novel antidepressants. Although well-defined neural correlates of cognition and

behaviour are a long way off, future better-understood models of pathogenesis seem tantalisingly close.

Neuroscience can help our understanding in another sense – where ‘our’ is not merely psychiatrists’ understanding, but that of the general population. Misunderstanding, discrimination and stigma remain rife and cause misery to those struggling with mental illness. Although over 900,000 people were in contact with mental health services in January 2015 in England<sup>[5]</sup>, Mind reported that 12% of adults in England thought people with mental illness didn’t deserve their sympathy and 25% would not be willing to work with someone with a mental health problem<sup>[6]</sup>. Neuroscience could have a powerful role to play in encouraging public acceptance of psychiatric disorders. The general population enjoys neuroscience: books that contain, or purport to contain, accessible neuroscience are frequently bestsellers<sup>[19][20][21]</sup>. Including superfluous or irrelevant neuroscience in explanations of psychological phenomena increases the perceived quality of the explanation and makes bad explanations more satisfying<sup>[7][8]</sup>. Whether this is a positive or negative trait, it seems likely that increased neuroscientific knowledge will help the public understand mental illness and thus decrease stigma.

In conclusion, the dramatic progression and wealth of neuroscience has transformed our understanding of aetiology and pathophysiology in psychiatry, and will continue to do so. Fundamentally, we want neuroscience to help us answer the primary questions of psychiatry. Which individuals are at higher risk for developing psychiatric disorders, what is their pathogenesis and, always, how can we better treat them? But we should also ask: What can advances in neuroscience *not* help us understand? The historical split of neurology and psychiatry,

brain and mind, was artificial and binary, and therefore created a niche for neuropsychiatry, an integrative and expanding discipline that may encompass more of clinical psychiatry in future<sup>[4]</sup>. But as this mind-brain dualism philosophy, which might also account for a large part of the public’s conception of psychiatric diseases as not ‘real’ illnesses rooted in anatomy, recedes, will a new outlook on neuroscientific monism answer all our questions? One might say that the measurement of outcomes in terms of neurotransmitters negates the very purpose of psychiatry: we don’t know how the person is *feeling*. Glutamate levels may well have changed, but how does this affect the person’s self-worth? Can BDNF upregulation show us how an individual’s happiness has changed?

Does greater neuroscientific knowledge bring with it an inherent danger of increasing reliance on well-understood pharmacotherapies, rather than address social factors and usage of physician-patient relationships? It is too simplistic to state that neuroscience only impacts the biological part of our biopsychosocial model in which psychiatry is rooted. So neuroscience will indeed aid our understanding of and guide us towards better treatment for the social aspect of disorders, but it seems likely that there exist areas of great importance that will be impervious to the advances of neuroscience. When I talked above about neuroscience underpinning psychiatric disorders, was I falling into the afore-mentioned trap of thinking that adding neuroscience to psychiatric theories makes them more ‘real’?

*This is an edited version of the original essay, for references or the full essay, please email [FuturePsych@RCPsych.ac.uk](mailto:FuturePsych@RCPsych.ac.uk)*



## World Café Event – ‘Bash or Banter?’

Dr A Ajaz. Dr B Lewis. Dr H Grant-Peterkin. Dr T Barry. Dr C Marshall. Prof A Korszun.

### What’s the problem?

In spite of many efforts psychiatry remains less popular than other branches of medicine as a choice of career for medical students<sup>[1]</sup>, we know that negative comments about a speciality by other medical professionals have an impact on student perception and career choice<sup>[2,3]</sup>. The publication of the BASH (Badmouthing, Attitudes and Stigmatisation in Healthcare) paper in the BJPsych Bulletin in 2016<sup>[4]</sup> once again highlighted this phenomena and led to the launch of the #banthebash campaign by the RCPsych.

### What did we do?

Barts and The London School of Medicine & Dentistry turned the spotlight on BASHing by holding a ‘World Café’ style event. We brought together medical and dental students from all years, as well as a smaller number of practising doctors and dentists, to explore the problem of BASHing in a fun and informal setting – plenty of pizza and some wine. The evening started with a quiz about BASHing – was it inevitable? Had it affected perception of specialities? The quiz was conducted via audience voter handsets and anonymised answers were displayed immediately to all. After the quiz the organisers acted out scenarios which the participants had to

vote on to decide whether the content was BASHing or ‘just banter’; for instance in response to the question ‘*where’s the psychiatric ward?*’ a doctor replied to a student ‘*the nutters are that way...and I don’t mean the patients*’. The participants then split into groups and explored written scenarios that focused on different domains where BASHing might take place – a large lecture theatre, on a clinical placement and between students. The line between BASHing and banter was explored and the students quickly provided their own examples of BASHing they had witnessed – scribbling them on the paper table cloths provided for brainstorming.

### What happens next?

The evening moved towards finding solutions and once again there was plenty of humour, discussion and creative proposals. Students suggested ‘myth-busting’ factsheets to counter speciality stereotyping i.e. myth that psychiatric treatments don’t work as well as other treatments. Having decided that culture in med schools and role modelling was crucial, participants suggested an ‘educate the educators’ scheme which would help lecturers and clinicians see the impact of how they communicate. Other suggestions included having more lectures where clinicians from different specialities spoke about clinical care of the same patient and having ‘a day in the life of...’ talk to challenge perceptions of a speciality. We are hopeful that medical schools and Royal Colleges will take these ideas forward, a culture of BASHing is damaging to all specialities not only psychiatry.

## What can you do now?

A significant positive for those organising the event was that the event itself changed attitudes - at the start 91% of participants thought BASHing of specialities was inevitable whilst at the end only 48% thought so. This, and our experience of the event, suggests that increasing discussion about this topic will challenge practice, good humour and bante. So, do talk about this topic with students and colleagues, as one student said on their post-it note feedback 'very good to discuss this unspoken issue'.

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## UCL Psychiatry Buddy Scheme

Dr Abiram Selladurai  
FY1, Princess Royal University  
Hospital, Kings College NHS Trust.

**The buddy scheme attaches medical students to psychiatry trainees with an aim to enlighten students about what a career in psychiatry entails and give them advice on career building. It hopes to be the start of a mutually supportive and mentoring relationship.**

### The process

Organising the buddy scheme at UCL was led by myself and a fellow medical student. We recruited 18 medical students interested in psychiatry through a variety of platforms including lecture shout-outs, emails and social media advertisement in the UCL MedSoc Group. We then sent emails to psychiatry trainees in London recruiting them to the scheme, and selected a lead trainee.

We had a welcome drinks events, where both students and trainees were able to meet their buddy for the first time and find out more about the aims of the scheme.

### Pre-scheme questionnaire

During the scheme we asked students to fill a questionnaire about what interested them in psychiatry. Common themes included: 'variation' and 'diversity' of the

field, the opportunity to nurture 'long-term relationships' with patients and the 'holistic' approach utilised. Similarly, we asked students what would deter them from a career in Psychiatry. The most common responses included: emotional burden, perception from other medical colleagues and not 'seeing results' or 'finding cures'.

### Outcome of the scheme

Feedback after the first year was positive with students saying that 'it was really nice to meet a doctor who actually liked her job!' One student's buddy proof read an essay on Mindfulness and "really appreciated the fact that [he] had someone to look over...and I ended up winning!". Some medical students struggled to meet regularly with their buddy asking for more formal events in the year to increase meetings and improve the scheme in the future.

The UCL buddy scheme is now successfully running into its third academic year with students from their first year of medical school to final year benefiting from the advice and mentorship of psychiatry trainees.

If any medical students or psychiatry trainees are keen to create their own local psychiatry buddy scheme, please don't hesitate to contact me on: [abiram@doctors.org.uk](mailto:abiram@doctors.org.uk)

Alternatively to find a buddy or start a scheme, you can contact the RCPsych directly: [careers@rcpsych.ac.uk](mailto:careers@rcpsych.ac.uk)