RCPsych Northern and Yorkshire Division

Winter 2025 Newsletter

Editorial

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Welcome to this bumper edition of the Northern and Yorkshire Division RCPsych Winter Newsletter! As we couldn't publish our usual summer edition, the summer submissions were rolled over. We've been inundated with winter submissions too which is fantastic! Our apologies to those whose submissions we weren't able to include and thank you again to all our contributors, old and new.

We invite more articles for our summer newsletter next year! Please do email us articles that you would like considered at: northernandyorkshire@rcpsych.ac.uk. Article submissions can be audits, service evaluations, reflections, or book/film reviews. There is a prize for best article each edition.

Congratulations to our prize-winning article by Dr Kamran Mahmood entitled Pathologizing the Normal: Revisiting Thaniyavarthanam Through a Psychiatric Lens on page 21. This fascinating reflection and analysis of the 1987 Malayalam film Thaniyavarthanam (The Repeating Rhythm) wins this edition's prize of £150!

In this winter edition, as well as the interesting audits and service evaluations, we have several different reflective pieces using cinema, literature, and the psychiatrists' own lives to explore our relationships with our patients, ourselves, and psychiatry itself. There's also a focus on how we can balance or learn from the challenges we face through our work. This includes the benefits of team sport, the unique challenges faced by our IMG colleagues, and burnout/compassion fatigue.

It's always a pleasure seeing the breadth of articles and getting insights into the work and lives of psychiatric colleagues across the region and at all stages, from their first foundation year to retirement. I do hope you enjoy reading this edition as much as I've enjoyed editing it, and whatever the festive season looks like for you, that you can make time for both moments of reflection and joy.

Dr Emily Jackson
Editor

Chair's Column

By Dr Sunil Nodiyal

Welcome to the latest edition of the newsletter for the Northern and Yorkshire Division of the Royal College of Psychiatrists. Here, you can find updates, news, and information about activities of our division and the field of psychiatry in our region. My name is Dr Sunil Nodiyal, and I am the Chair of the division.

Our division is dedicated to promoting excellence in psychiatry and mental health care, and we strive to support our members in their professional development and practice in the region. Through this newsletter, we aim to share insights, resources, and opportunities to facilitate learning and collaboration among our members.

We have had a successful academic year with several webinars and conferences. These included our series of webinars on women and mental health, the online Spring conference and the face-to-face autumn conference.

The Northern & Yorkshire Autumn Conference 2025 brought together over 100 attendees including psychiatrists, trainees and multidisciplinary colleagues for a day centred on 'Resolving Diagnostic Uncertainties-focus on Neurodiversity', a theme chosen to reflect the increasing complexity of modern psychiatric practice. Held in the historic city of York, the event provided a vibrant, intellectually stimulating environment, with lively discussions and notably high audience engagement. It was delightful to see such active participation from delegates throughout the day, as they contributed thoughtful questions, reflections, and shared experiences.

Overall, the 2025 Autumn Conference succeeded in combining academic depth with practical relevance, fostering dialogue across experience levels and clinical specialties. The strong attendance, active participation and breadth of content demonstrated the continued vitality of the Northern & Yorkshire Division's academic community and its shared commitment to addressing the complex dilemmas shaping contemporary psychiatric practice. It's a fantastic opportunity to connect, learn, and share insights with colleagues. There was also our poster competition where there was an opportunity to win the prizes in each category for doctors of all grades including for medical students, foundation year doctors, psychiatry trainee doctors and middle grade doctors. There is more on this in the Autumn Conference Report later.

We had our face-to-face executive committee meeting a day before the Autumn Conference in Grand Hotel, York which was followed by an executive committee members dinner. It was good to socialise with committee members along with some of the speakers and help develop networking. If you are an executive member, please try to join us for the executive dinner next year before the annual Autumn conference.

Dr Sumeet Gupta, our Vice Chair, Moinul Mannan, our Divisions Committee Manager, and I met with a couple of ICBs from our divisional area last year and hoped to continue engaging with them this year also. There was a meeting with the West Yorkshire ICB planned but this has been on hold due to ongoing uncertainties within the NHS England and scope of ICBs themselves. We hope to continue our engagement with the ICBs once there is some clarity on their remit and scope.

We also had another successful Great Northern Psychiatry Summer School which was organised by Dr Jemima Mainwaring. It followed the programme from last year where students had two days of online interactions and then were able to attend face to face on the third day. There was good attendance, and students came from all over the country to see what the Northeast and psychiatry has to offer for them if they were to choose to specialise in psychiatry. Dr Baxi Sinha (one of our two Academic Secretaries) represented the division on the third day. The findings were published as a poster in the division's Autumn Conference.

We encourage you to check back regularly for updates and to engage with the content by commenting and sharing your thoughts. We also welcome contributions from members who wish to share their expertise, experiences, and perspectives on topics related to psychiatry and mental health care in our region.

Our division covers six mental health trusts and many private providers. We had a meeting arranged by the

Dean Dr Subodh Dave to consider the priorities for the region and how the college can respond to the workforce need. It was a useful meeting bringing some of the medical directors together and understanding their views on the issue and how the college could respond. We hope to follow this by meeting again early next year.

We were successful in filling the vacancies for the two academic secretaries (Dr Baxi Sinha and Dr Suman Ahmed), two regional advisors (Dr Mini Joseph for Northeast and Dr Himanshu Garg for Yorkshire) and a few others. Please look out for remaining vacancies in the division. It is a fantastic opportunity to be involved with the functioning of the division. Taking on a role in the division opens opportunities to take on further roles within the division or within the college nationally.

Thank you for viewing our newsletter, and we look forward to connecting with you as we work together to enhance the quality of mental health care in the Northern and Yorkshire region. I wish you all a happy and prosperous Christmas.

Best wishes,

Dr Sunil Nodiyal
Chair, Northern & Yorkshire Division

Autumn Conference Poster Winners

- Best Medical Student/Foundation Doctor Poster Prize: Hannah Humble
- Best Core Resident Doctor (CT1-3) Poster Prize: Dr Edward Jones and Dr Florence Docherty
- Best Higher Resident Doctor Poster Prize: Dr Natalie Kirby
- Best SAS Doctor/Consultant Poster Prize: Dr Swapan Kole

New Members/Roles 2025

- Dr Baxi Sinha – Academic Secretary
- Dr Suman Ahmed – Academic Secretary
- Dr Narendra Sharma – Finance Officer
- Dr Syed Faisal Badshah – Committee Member
- Dr Paul Walker – ETC Representative
- Dr Sandeep Kumar – Workforce Lead
- Dr Syed Murtaza Naqvi – LMC Rep
- Dr Amelia Gledhill – Regional Rep
- Dr Nishanth Gurunthan – Regional Rep
- Dr Mini Joseph – Regional Advisor
- Dr Himanshu Garg – Regional Advisor
- Dr Victor Igwe-Omoke – Deputy RA
- Dr Harry Waterman – PRDC Rep
- Dr Joanne Wallace – PRDC Rep
- Dr Shegufta Huq – PRDC Rep

New Fellows 2025

- Dr John Alderson
- Dr Nisha Alex
- Dr Ayesha Bangash
- Dr Suresh Bhoskar
- Dr Paul Donaghy
- Dr Afshan Jabeen
- Dr Syed Nabeel Javaid
- Dr Mohinder Kapoor
- Dr Madhu Kewalramani
- Dr Musunuru Raja Kumar
- Dr Tracey Myton
- Dr Chhaya Pandit
- Dr Junias Puthiyarackal
- Dr Laura Voss

Patients detained under the Mental Health Act at Barnsley Hospital 2023 – 24: A Mental Health Liaison Team Evaluation

By Dr Alex Burns and Dr Nadia Imran

Psychiatric patients are increasingly being detained in general hospitals under the mental health act, primarily due to the lack of availability of psychiatric inpatient beds for them to transfer to following assessment in the general hospital. Patients with severe mental health problems can present to general hospitals for treatment of physical health issues that are often related to their mental disorder. A+E is also frequently viewed as a place of safety for patients who are viewed as high risk and unsafe in the community.

At Barnsley Hospital between the periods of 2022/23 to 2023/24, there was a 102% increase in use of Section 2 and 76% increase in use of Section 3. When patients are detained to Barnsley Hospital it becomes the responsibility of the mental health liaison team (MHLT) to coordinate their mental health care, including oversight of Section 17 leave, management of psychiatric medications and mental health nursing reviews.

In our experience we have encountered several difficulties in managing patients detained to a general hospital under the mental health act. Firstly, the wards are not locked, increasing the risk of patients absconding. In addition, most ward staff are not trained to safely restrain patients to facilitate coercive treatment, manage physical aggression or to prevent patients from absconding, and the hospital security provision is often limited. Secondly, the environment in the hospital is not conducive to the treatment of mental illness. There is a lack of access to outdoor space or meaningful activities, and, in our case, no psychology provision is available, which for patients who are detained for long admissions (often patients with eating disorders), limits their treatment options.

Due to the sharp increase in detentions, we set out to further investigate the demographics of detained patients in Barnsley Hospital over a yearlong period and explore any room for improvement within our team's management of these patients. We have found no similar project undertaken elsewhere in the UK regarding patients in a general hospital setting.

Project Aims

- Increased understanding of the demographics of patients being detained to Barnsley Hospital
- Obtain data regarding bed wait times for detained patients
- Understand the frequency and types of adverse incidents occurring amongst detained patients
- Identify areas of improvement for quality of MHLT practice in managing detained patients

Methods

The period studied was 1st April 2023 – 31st March 2024 and data was collected from the electronic patient records. The Mental Health Act Office provided the data for all the detentions of adults under Section 2 and 3 at Barnsley Hospital during that period.

The data collected for each patient was as follows:

Section type, age, diagnostic category, if the patient was detained due to lack of psychiatric bed, adverse incidents that occurred, number of days the patient was detained to Barnsley Hospital, and time waited for psychiatric bed.

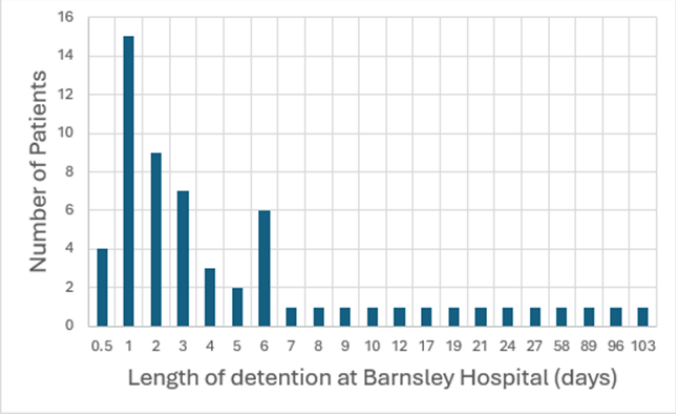
Data regarding the following 3 standards were also collected to evaluate MHLT performance:

- Was there a daily MHLT review of the patient?
- Was advice given regarding level of observations required for the patient?
- Was there a psychiatrist review within 72 hours of detention?

MHLT performance was graded using a traffic light system. Over 80% compliance was considered green, 70-80% compliance was amber and below 70% compliance red.

Results

- There were 65 detentions in total, with 58 under section 2 and 7 under section 3
- The age range was 18 – 82, with a mean patient age of 44
- The 3 most common diagnostic categories were non-organic psychosis with 20 patient episodes, personality disorder with 10 and mania with 7. Patients were also detained with diagnoses of eating disorder, mental and behavioural disorders due to substance misuse, depression, dementia, anxiety disorder and adjustment disorder
- 88% of detentions occurred due to a lack of availability of a psychiatric bed
- The 3 longest lengths of detentions were 103, 96 and 89 days. These occurred for patients diagnosed with eating disorders requiring MEED admissions



- The mean wait for a psychiatric bed was 6.5 days. 5 patients were discharged off their section by the MHLT Responsible Clinician prior to them being transferred to a psychiatric bed following significant improvement in their condition
- There were 24 adverse incidents accounted for by 16 patients. There were 8 incidents of physical aggression, 7 incidents of absconding, 5 of self-harm, 3 of alcohol intoxication, and 2 of sexually inappropriate

Standard	Compliance
Daily MHLT Reviews	75%
Level of Observations Advised?	60%
Psychiatrist review within 72 hours	86%

- MHLT was compliant with the standard of achieving over 80% of patients receiving a medic review within 72 hours of detention
- There was identified scope for improvement for the other 2 standards

Recommendations:

- To create a template for mental health liaison team staff to use for the initial assessment of detained patients
- To incorporate into the team daily handover a check if the above standards have been met
- More proactive consideration of reducing the daily review requirement for detained patients, if deemed appropriate
- We plan to reaudit to monitor the team's performance following the implementation of the above recommendations
- We would welcome linking with other mental health liaison teams to highlight this growing national trend

Conclusion

We have seen a recent significant increase in detentions to Barnsley Hospital, with the trend likely to continue with no sign of pressure on psychiatric services abating in the short term. The management of these patients has now become a substantial proportion of the workload of the MHLT. We have highlighted the unique challenges to managing detained patients in general hospital and observed that adverse incidents are occurring frequently for these patients. MHLT has been providing daily contact and prompt medical review for the majority of detained patients, but we have identified a need for improvement on recommending levels of observations for patients.

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An Audit of Compliance with Minimum Standards for Psychiatric Inpatient Discharge Summaries

By Dr Emma Camilleri and Dr Anisha Page

Introduction:

Accurate and comprehensive discharge letters are essential for safe patient care and effective communication with primary and community services. Several audits have been done on the timeliness of discharge letters but there has been limited analysis of their quality. Internal review had highlighted over 50% error rate in discharge coding and variability in the quality of discharge documentation across inpatient psychiatric wards. We conducted an audit of compliance with trust-agreed minimum standards for psychiatric inpatient discharge summaries with an aim to standardise discharge documentation and improve compliance with governance requirements, whilst supporting clinicians with clearer guidance. We hope to improve patient safety and continuity of care by ensuring discharge letters consistently include essential information.

Methods:

The audit was conducted at Lanchester Road Hospital, Durham, across two inpatient psychiatric wards. The sampling period covered discharges dated 14 December 2024 to 28 August 2025, with data extraction completed between 12–22 September 2025.

The audit assessed compliance with the Trust's minimum standards for psychiatric inpatient discharge summaries, drawing on key references including the Trust Discharge Guidance – Coding and Minimum Standards, NICE NG53 (2016), and Quality Statement 3 (QS159, 2017).

A retrospective sample of 80 discharge letters (40 per ward) was selected to provide a temporal cross-section of practice, including the earliest and most recent discharges within the sampling period. Eligible cases were identified via the CITO electronic records system. Following exclusions for inaccessible letters or transfers without a letter, 66 discharge summaries were analysed.

Data were collected using a structured audit tool based on Section 6 of the Trust Audit Framework. Each discharge letter was independently reviewed by two Foundation Year 1 doctors, who recorded responses in Microsoft Excel using predefined criteria (Yes = 1, No = 0, N/A = 2).

The tool captured key domains including patient identifiers, diagnosis and ICD-10 coding, physical health documentation, medication information, discharge planning, follow-up arrangements, and continuity of care.

Results:

As shown in Table 1, this audit demonstrated full compliance (100%) with the criterion "Discharge summary ensures continuity of therapeutic interventions post-discharge."

High compliance was observed across most domains, with scores typically ranging between 80–97%. Accurate documentation of patient identifiers (91%) and reason for admission (97%) was consistently achieved. In most cases, the discharge letter was completed and sent within 24 hours (88%), accompanied by a clear discharge plan (96%) and tasks for the GP (86%).

Medication-related standards were particularly strong: inclusion of a complete medication list with dosage and prescribing responsibility (97%), clear documentation of medication duration (95%), and record of changes in treatment (82%). These findings indicate robust adherence to the Trust's standards for clinical communication and medication management.

However, several key areas of low compliance were identified. Documentation of the primary ICD-10 diagnosis was present in only 32% of letters, and physical health parameters (such as BMI, blood pressure, smoking status, and blood tests) were also recorded in just 32%.

Similarly, the reason for any medication changes was specified in less than half of discharge summaries (48%). Follow-up details—including date, time, and venue for 72-hour reviews—were often incomplete, and documentation of legal status was occasionally omitted.

These omissions present potential risks to continuity of care, patient safety, and communication between inpatient and community services. Inaccurate or missing diagnostic coding may also affect the reliability of governance data, commissioning, and service planning, while poor recording of physical health information may undermine the Trust's commitment to parity of esteem between mental and physical health.

Table 1: A depiction of the results obtained during the first cycle of this audit

		Current Cycle Results (66)		
#	Question	Yes	No	N/A
1	Does the discharge letter include the patient's full name, DOB, NHS Number and Discharge Date?	91% (60/66)	9% (6/66)	Nil
2	Reason for admission clearly documented	97% (64/66)	3% (2/66)	Nil
3	Primary ICD-10 Diagnosis included	32% (21/66)	67% (44/66)	1% (1/66)
4	If a primary code is a Z/X code, is it only used for malingering? Are relevant secondary ICD-10 codes included where appropriate?	1% (1/66)	3% (2/66)	96% (63/66)
5	Date for 72-hour follow-up included	71% (47/66)	26% (17/66)	3% (2/66)
6	Time for 72-hour follow-up included	61% (40/66)	35% (23/66)	4% (3/66)
7	Venue for 72-hour follow-up included	65% (43/66)	31% (20/66)	4% (3/66)
8	Discharge letter provided within 24 hrs of discharge	88% (58/66)	9% (6/66)	3% (2/66)
9	Discharge plan clearly documented	96% (63/66)	4% (3/66)	Nil
10	Tasks for GP are clearly outlined	86% (57/66)	10% (6/66)	4% (3/66)
11	The medication list included dosage and responsibility for ongoing prescribing	97% (64/66)	1% (1/66)	1% (1/66)
12	Duration of medications is clearly indicated	95% (63/66)	3% (2/66)	1% (1/66)
13	Medication changes are clearly documented, including what was stopped/changed	82% (54/66)	14% (9/66)	3% (2/66)
14	If changes were made to medication, the reason for these changes is clearly documented	48% (32/66)	33% (22/66)	18% (12/66)
15	Physical health appropriately documented, including smoking status, BMI, BP, HbA1c/glucose, lipids, lifestyle factors	32% (21/66)	65% (43/66)	3% (2/66)
16	Legal status documented	76% (50/66)	24% (16/66)	Nil
17	Patient progress clearly documented, e.g., interventions, key meetings, relevant issues	95% (63/66)	4% (3/66)	Nil
18	Discharge summary ensures continuity of therapeutic interventions post-discharge	100% (66/66)	Nil	Nil
18	If no accommodation is identified, the duty to refer is documented, with senior clinician involvement	8% (5/66)	1% (1/66)	90% (60/66)

The percentages included in this report have been rounded to the nearest whole number

Action Plan and Future Directions:

Although no direct patient safety incidents were identified, the audit highlights systemic documentation gaps with potential Trust-wide implications. Action points have been developed to address these, including dissemination of a Discharge Letter Aide-Memoire/Discharge Template. We workshopped this template with our team, discussing areas requiring improvement. We involved the ward pharmacists and reached out to the community pharmacists to gather input from a community perspective. This prompted us to reflect on things we had not previously considered e.g., if a patient is on a depot, to document the date it was started and when and where it was last administered. We then escalated the discussion of our audit results to our senior MDT 'Supercell' meeting, as certain areas identified for improvement required senior-led action e.g., recording the ICD-10 diagnosis. We also sought input from the community inpatient interface consultant meeting to incorporate both community and inpatient consultant opinions. This Aide Memoire has now been circulated amongst our existing team and is used as an active reference when completing discharge summaries.

We presented our findings at the trust-wide audit presentations in October, achieving third place. We also plan to present the findings at our local 'Supercell' meeting in November. A re-audit is planned for January 2026 to assess whether our interventions have been impactful. We have submitted an abstract for the National Foundation Doctors Presentation Day (February 2026), where we hope to present our complete results, including the re-audit.

The aide memoire has already been circulated to West Park Hospital and Foss Park Hospital in North York. After our re-audit, if we find that we have made a positive impact, we intend to roll out this template trust-wide and have begun discussions with our clinical teaching fellow about developing guidance for the trust-wide induction sessions. Longer term, we are considering working to update the current CITO template for discharge summaries to include elements from our aide memoire.

References

- 'Coding and Minimum Standards' – Trust Discharge Guidance - Coding and Minimum Standards.pdf
- NICE NG53 (2016)
- Quality statement 3 (QS159) 'Transition between inpatient mental health settings and community or care home settings' Sept 2017
- How to create a discharge prescription using EPMA and transfer letter using CITO - 96784ef0a21fbbf2784b93fba33934ca47202f7fca5b2814370b39e3e3f4.pdf
- Admission, transfer and discharge from inpatient settings - Admission-Transfer-and-Discharge-from-Inpatient-Settings.pdf

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Navigating the Tightrope: Resilience and Burnout in Geriatric Psychiatry

By Dr Girish Rao

Geriatric psychiatry is a deeply rewarding field, yet it also presents unique challenges that can take a toll on clinicians. We often work with patients facing complex medical and psychiatric comorbidities, navigate intricate family dynamics, and grapple with ethical dilemmas surrounding capacity and end-of-life care. Witnessing the decline associated with aging and dementia can be emotionally taxing, and the administrative burdens of our healthcare system can feel overwhelming.

The COVID-19 pandemic exacerbated these challenges, placing unprecedented strain on mental health services. Increased workloads, staffing shortages, and the emotional toll of the pandemic itself have contributed to a rise in burnout among healthcare professionals, including geriatric psychiatrists.

Burnout is a state of emotional, physical, and mental exhaustion caused by prolonged or excessive stress. It is characterized by feelings of cynicism, detachment, and a reduced sense of personal accomplishment. In geriatric psychiatry, burnout can manifest as:

- **Emotional exhaustion:** Feeling drained, depleted, and lacking empathy for patients.
- **Depersonalization:** Developing a detached and cynical attitude towards patients and their families.
- **Reduced personal accomplishment:** Feeling ineffective and disillusioned with one's work.

The consequences of burnout can be significant, impacting not only the individual clinician but also the quality of patient care. Burnout has been linked to increased medical errors, reduced patient satisfaction, and higher staff turnover.

However, amidst these challenges, there is also resilience. Resilience is the ability to bounce back from adversity, to adapt and thrive in the face of stress. It is not simply the absence of burnout, but rather a dynamic process of navigating challenges and maintaining well-being.

Building resilience is crucial for clinicians in geriatric psychiatry. It involves cultivating self-awareness, developing healthy coping mechanisms, and fostering a supportive work environment. Here are some strategies that can help:

- **Mindfulness and self-care:** Practicing mindfulness, engaging in regular exercise, prioritizing sleep, and maintaining a healthy diet are essential for managing stress and promoting well-being.
- **Setting boundaries:** Learning to say "no" to excessive workloads, delegating tasks when

possible, and taking breaks throughout the day can help prevent burnout.

- **Seeking support:** Connecting with colleagues, supervisors, or mentors can provide a safe space to share experiences, seek advice, and receive emotional support.
- **Finding meaning and purpose:** Reflecting on the positive impact of our work, celebrating successes, and focusing on the meaningful connections we make with patients can help sustain us through challenging times.
- **Advocating for systemic change:** Addressing the root causes of burnout, such as excessive workloads and systemic inefficiencies, requires advocating for change within our healthcare organizations and beyond.

Resilience is not an innate trait; it is a skill that can be learned and strengthened over time. By prioritizing self-care, seeking support, and actively cultivating resilience, geriatric psychiatrists can navigate the challenges of their profession and continue to provide compassionate and effective care to their patients.

The tightrope walk between resilience and burnout is an ongoing journey. It requires self-awareness, self-compassion, and a commitment to prioritizing our well-being. By investing in our own resilience, we can not only sustain ourselves in this demanding field but also inspire hope and resilience in the older adults we serve.

References

1. Rotenstein LS, Torre M, Ramos MA, et al. Prevalence of Burnout Among Physicians During the COVID-19 Pandemic: A Systematic Review. JAMA Netw Open. 2021;4(12):e2137847.
2. Panagioti M, Panagopoulou E, Bower P, et al. Controlled interventions to reduce burnout in physicians: a systematic review and meta-analysis. JAMA Intern Med. 2017;177(2):195-205.

Author details

Dr Grish Rao
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Use of Rapid Tranquilisation in Acute Inpatient Wards at Lanchester Road Hospital, Durham

By Dr Pablo Fiks, Dr Etido Effiong, Dr Archana Sreekumar, Dr Tom Hills, Dr Alice Easton

Background:

Rapid tranquilisation (RT) is used in managing acute behavioural disturbance in psychiatric inpatient settings.

National audits [1] have shown sub-optimal physical health monitoring post-RT, and lack of appropriate documentation.

This audit was conducted to evaluate how rapid tranquilization (RT) is administered in acute inpatient wards in Lanchester Road, Durham. The aim was to ensure that its administration aligns with the NICE guidelines [2] and local (TEWV) protocols [3].

Objectives:

1) To assess whether RT is used appropriately – only after de-escalation/oral medication.
2) To evaluate documentation of rationale, capacity and legal status.
3) To assess compliance with TEWV algorithms for RT medication.

4) To evaluate post-RT physical health monitoring.

5) To assess staff and patient reflection post-incident.

6) To identify examples of good practice and areas for improvement and potential safety risks.

7) To make actionable recommendations to improve future practice.

Methods:

- Study Design: A retrospective audit of medical records from 2 acute inpatient wards during a three-month period in 2024.
- Data Collection: Review of patient records from a 3-month-period (from 01/07/25 until 01/10/24) for inpatients in two acute inpatient wards, at Lanchester Road Hospital, Durham.
- RT administration data was requested from the trusts' pharmacy team. There was a total of 237 recorded administrations during this period amongst both inpatient wards.
- The Cochran formula was used to determine the minimum required sample size to ensure that findings would be statistically valid. Ultimately, 99 RT administration events were included in the data analysis.
- The audit data was collected by using a standardized audit tool.
- Electronic records were used to review the patients notes and obtain relevant data.

Results

- Sample Size: 99 recorded administrations of RT.
- The data showed that in 92% of the cases there was a clear rationale recorded for using RT.
- 97% of the patients were under a section of the MHA.
- There was a record of oral medication offered prior to administration of RT in 68%.
- Choice of RT medication was in line with the local TEWV RT guidelines in 75% of the cases.
- Monitoring: In 80% of the cases, there was no record of post-RT physical health monitoring, however in 57% of these cases there was a record of patients refusing to have their physical observations recorded.
- There was no evidence in any of the cases that the patients had used illicit substances prior to the RT administration.
- In 90% of the cases, there was no record that the staff met to reflect on the incident before the end of the shift.

In 26% of the cases there was evidence that the patient had been offered the opportunity to reflect on the incident.

There was evidence of an assessment of capacity in 53% of the cases in which RT was administered.

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Forged in Foreignness: Resilience, Identity, and the IMG experience

By Dr Aashna Singh

As a psychiatry trainee who moved countries to practice medicine, resilience hasn't always looked like strength. Sometimes, it has looked like surviving silence, translating oneself daily, and rebuilding confidence from unfamiliar soil. This reflection explores that quiet evolution—one not found in textbooks, but in lived experience.

They say fear keeps people alive.
But there are some who have already died a hundred small deaths—of comfort, of certainty, of familiarity—and kept living anyway.

Those who moved across borders in their twenties, not for adventure, but for survival, for ambition, for a life with more than what was handed to them.
They arrived not with confidence, but with paperwork, pressure, and a soft, steady will to begin again.
They didn't land into open arms.
There were no welcome signs.
Only cold mornings, mismatched plugs, and a silence that stretched across every room.

They opened bank accounts without knowing which document was proof enough.
They decoded taxes, job contracts, council letters written in polite threats.
They navigated healthcare systems with unfamiliar acronyms.
Their questions were quiet, their fears quieter still. But they moved through it all like fog through a city—soft, persistent, unstoppable.
They didn't just learn a new language.
They learned new rhythms—of speech, of small talk, of systems.
They learned to pronounce their own names slowly, clearly, in rooms where no one tried.

And when they worked—especially in places where emotions run thick, where silence is heavy, where minds are frayed—they did so not with ease, but with a kind of compassion that can only be forged through their own isolation.

In psychiatry clinics and children's wards, they carried the weight of other people's pain while shouldering their own invisible loneliness.
They stayed late. Listened more. Wrote notes in the margins and reminders in their hearts.

They saw patients heal in bits and pieces—and sometimes, they did too.

There is a unique strength in those who feel deeply yet continue to serve.
Who make homes out of hospital corners and comfort out of tea breaks.
Who know the ache of missing festivals back home and still show up early the next day. Who smile through questions like "Where are you really from?" and answer with grace, not just because they have to—but because they've learned that the answer is far more than a place.

These people are not loud.
They are not reckless.
But they are made of something ancient—something that understands survival as both endurance and elegance.

Fear? It's not that they never feel it.
It's that they've made peace with its presence. They've learned to walk with it.
So no, they don't fear anymore—not in the way they used to.

Not the silence.

Not the starting over.
Not the spaces in-between.

Because when someone has lived as a stranger in a foreign land, healed in places they once got lost, and stayed long enough to become a part of something—they don't just belong.

They become.

And those who become like that—quietly, slowly, with dust on their shoes and stories in their bones—

Those are the ones forged in foreignness.

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Adults with intellectual disabilities – Family influence on quality of life!

By Dr Vanessa Dalton

I am a Core Trainee currently placed in a community team working with adults with intellectual disabilities and wanted to share my reflections from my post so far. I have previously worked as a psychologist and have a particular interest in family dynamics.

At times it has been thoroughly heart-warming to witness the support and care that a person with an intellectual disability receives from their parents, ongoing well into their adulthood. I am not sure that when committing to parenthood many people consider that it could extend well beyond the pre-conceived 18 years or so notion of birth to independence. I myself have four children and certainly did not consider, preconception, that I could be faced with the possibility of dedicating my whole life to their care. I love being a parent and I will also love it when they fledge the family home and develop their own independent lives. Having a child with an intellectual disability means a completely different life pathway for some parents.

The adult child often has lifelong care needs and parents face difficult decisions about how long they can continue to provide this and at what expense. I have witnessed the physical, emotional and relational strain this places on families. Many parents appear to have dedicated their lives to their adult child's care but I wonder at what personal costs to themselves, their own relationships, their ambitions, their hopes and dreams. There must be a great sense of loss for what life could have been like; a

resentment that this has happened to them; guilt for considering alternative options for care or finding caring for them a struggle; anxiety around what happens to the child when the parents get too old to manage themselves; a smorgasbord of conflicting emotions surrounding the person you love so dearly. Yet these are the well-educated and well-resourced families and in essence the fortunate children. Adult children whose caring parents have created them lives filled with meaningful and enriching activities. Adult children who have holidays and cultural experiences and are helped to access the wider world. The support and advocacy that a well-resourced family can provide seemed to enhance the person with intellectual disability's quality of life and their experience of the world.

In contrast, when a person with an intellectual disability comes from a family with fewer personal, emotional and financial resources, this can have a negative impact on their overall quality of life. I saw one young man whose single parent mother struggled to fill in the application for day care services and consequently he spent his days wandering the streets. He sought out playmates close to his developmental rather than chronological age and consequently was bullied for being a 'paedophile'. For a patient population who struggle to advocate for themselves, it is crucial that somebody does this for them. All too often this seems to fall to the family members and if you have the misfortune of being born into a family that is not well resourced then you are unlikely to have access to the enriching lifestyle opportunities of your counterparts. Should it be the responsibility of care teams to plug this gap, and if so, why are we failing to achieve this?

In summary, it has been humbling to witness the relationships between parents and adult children with intellectual disabilities; the joy shared in the friendship and the mutually beneficial elements of the caring relationship. My only wish was that this life was available to all individuals with intellectual disabilities whether provided by the family or the care system. Helping to lessen this gap should be a priority for all working in intellectual disability services.

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The Lessons from the Burnout and Compassion Fatigue in Healthcare Professionals During the COVID-19 Pandemic

By Dr Walid Khalid Abdul-Hamid

Introduction:

The COVID-19 pandemic placed unprecedented psychological burdens on healthcare workers, not only due to the direct risk of infection but also from the relentless stress associated with patient care during a global health crisis. Studies then indicated significant increase of rates of depression, anxiety, insomnia, and psychological distress among frontline healthcare professionals, with research from China and the United Arab Emirates (UAE) confirming severe emotional consequences. Even well-structured psychological support programs failed to alleviate distress in some cases.

Beyond the immediate challenges of the pandemic, healthcare professionals face long-recognized emotional tolls associated with treating trauma victims, often described as *compassion fatigue*, *secondary traumatic stress*, *burnout*, and *vicarious traumatization*. Burnout, as originally defined by Maslach, refers to a psychological syndrome marked by emotional exhaustion, depersonalization, and reduced personal accomplishment. However, trauma psychologist Eric Gentry refined this definition, emphasizing the role of *perceived threat*, sympathetic nervous system dominance, and chronic anxiety in the development of burnout, framing it as a condition where professionals feel trapped in inescapable stress.

Psychological Mechanisms Underlying Burnout:

The root causes of burnout lie in how professionals perceive workplace demands. Gentry's research highlights that burnout stems from an imbalance between perceived demands and available resources, triggering chronic stress akin to a fight-or-flight response. This perceived threat, much like Martin Seligman's concept of *learned helplessness*, leads to professionals feeling powerless in the face of persistent workplace pressures.

The body's autonomic nervous system plays a crucial role in determining reactions to stress. When individuals perceive threats, their sympathetic nervous system activates, releasing stress hormones to enhance survival instincts. While this was essential for human survival in prehistoric environments, modern professionals frequently misinterpret workplace stress as a dire threat, leading to prolonged sympathetic dominance. Research has demonstrated that during such dominance, individuals lose 25–30% of their agility, strength, and cognitive precision, leading to reduced problem-solving capabilities.

A crucial function of the human *prefrontal cortex* is distinguishing between perceived and actual threats. However, chronic sympathetic activation compromises this function, leading individuals to react irrationally to workplace challenges. Professionals experiencing burnout often respond by either attempting to escape their work environment or aggressively confronting workplace stressors, neither of which resolves underlying perceptions of threat. Without intervention, sustained activation of the stress response can result in compromised integrity, reduced effectiveness, and physical health deterioration.

Strategies learned for Managing Burnout and Compassion Fatigue:

Effective management of burnout requires targeted psychological interventions aimed at altering perception, reducing sympathetic dominance, and promoting resilience. Two broad approaches exist:

1. **Relaxation-Based Interventions:** Teaching professionals to initiate parasympathetic nervous system activation counteracts the effects of chronic stress. By consciously relaxing the body, individuals restore prefrontal cortex functionality, regaining cognitive clarity and emotional balance. This approach prevents professionals from accumulating repeated traumatic stress reactions throughout their workweek, reducing long-term psychological strain.
2. **Cognitive Perception Shifts:** The second strategy involves modifying workplace attitudes. Rather than perceiving work tasks as imposed demands, professionals can reframe them as intentional choices. For example, viewing an urgent request from a superior as an *elected duty* rather than an *inescapable obligation* reduces the perceived threat associated with work tasks. This shift fosters psychological autonomy and minimizes stress responses.

Additionally, Gentry and colleagues propose structured intervention programs for professionals experiencing burnout, including:

- **Psychoeducation** on the effects of workplace stress.
- **Timeline construction** of past work-related stressors to identify underlying patterns.
- **Self-care planning** incorporating relaxation techniques.
- **Development of intentionality** through an internal locus of control.
- **Creation of professional mission statements** to align personal values with career objectives.
- **Peer support networks** fostering collective resilience among professionals facing similar stressors.

Conclusion:

Burnout and compassion fatigue are significant risks for healthcare professionals, exacerbated by the extreme stress conditions like that of the COVID-19 pandemic. While workplace stressors are inevitable, their emotional and psychological impact can be managed through effective interventions targeting both physiological responses and cognitive perceptions. Understanding the underlying mechanisms of stress responses, particularly the role of sympathetic nervous system dominance,

provides a foundation for developing targeted strategies that help professionals maintain resilience. By integrating relaxation techniques, cognitive reframing, and structured peer support programs, healthcare workers can navigate their professional responsibilities without succumbing to chronic emotional exhaustion.

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Work-life balance: the benefits of team sport alongside a Psychiatry career

By Dr Alice Cockhill

In 2017, my 4th year of university, a fellow student set up a women's branch of the medics' rugby club. This attracted a small group, including myself, whose enthusiasm for trying rugby far outweighed any previous experience. It is fair to say, I think, that we were pretty useless at the sport, but the thrill of throwing ourselves around in the mud every weekend was an excellent antidote to the stress and pressure of medical school. This was my first step towards establishing the elusive yet highly sought-after 'work-life balance' that could maintain me through my medical training, and where my love of team sport began.

In 2019, newly graduated and finding my feet as a junior doctor, I was asked one evening to fill in for my partner's new tag rugby ('Tag') team. The rules weren't too complicated: pull Velcro tags off people's shorts, score tries, and go for a chip butty together at the pub afterwards. It was the perfect balance of healthy competition and care-free socialising. Six years - and many chip butties - later, this team are some of my closest friends, and we still play Tag together every week.

The weekly routine of leaving work behind and showing up for the team turned out to be more valuable than I could have realised. I had not appreciated how much this childish delight in being outdoors, running around, and building lasting friendships was fundamental to my work-life balance and mental wellbeing. Suddenly, in March

2020 with just 6 months of medical experience under my belt, I was thrust, alongside many others, into the frenzy of random daily ward allocations, PPE, and overwhelming anxiety. When the pandemic brought group activities to a halt, somehow our team knew that we still needed to show up for each other, even if we couldn't play rugby. Thus, weekly sport became weekly team catch-ups over zoom, and, like many in lockdown, the true importance of a strong, reliable friendship group was realised. Despite struggling with burnout at work, there was a continuous glimmer knowing that the all-important Tag Zoom quiz would be waiting for me each week.

Before applying to Psychiatry, I decided to take two years out of training to recover from the whirlwind of Covid-19. Without the threat of an incomplete portfolio inching into my free time, truly switching off from work at the end of the day was a breath of fresh air. I was again able to taste what work-life balance felt like and, with that, appreciate the importance of boundaries, and sticking to them. For many years, medicine had seemed to be my whole personality, and so with this new freedom and apparently endless enthusiasm I started playing Tag three, then four times per week. Tag provided me with an identity outside of medicine, and a connection with people from so many different walks of life. The escape from the medical world was exhilarating.

In 2023 I began Psychiatry training. I quickly felt the familiar tendrils of anxiety and imposter syndrome creeping back in to my mind, but gradually I reinstated those boundaries about respecting my work-free, switched-off time, and was able to prioritise. I realised that no matter the pressures of workload, I needed to go and play Tag, not just to not let down my team, but also to ensure that I was ready to tackle work again the next day.

Alongside keeping me mentally fit, in the four years since I had first picked up a rugby ball, I had learnt a thing or two, and I was thrilled to be selected to represent Yorkshire for the first time in 2024 at the UK Tag Nationals tournament. It was then I realised how much I had doubted myself. I had been my biggest critic when a mistake was made, but learnt to accept these and move on, and not allow it to affect my ability to take on the next task. This confidence boost carried over into work, where I had always received feedback to 'have faith in my own ability', and I began to feel more comfortable with leadership. Whether a direct or a softer approach was preferred, I learnt that communication styles in Tag players was variable and often linked to skill set and position on the pitch. This bolstered my communication skills in work, which remain key to my psychiatric practice.

In 2024, I had to take a prolonged break from Tag through injury. I still went down to the pitches each week but glumly watched from the sidelines. As I entered my CT2 year, I suddenly began to fret about Higher Training applications. In a panicked meeting with my supervisor, I realised that whilst jumping through the training hoops of ARCP, audits and exams, stress had crept in and quietly worn me down over the 6-month period where my key stress-reliever, Tag, had been inaccessible. This clarity on how essential hobbies can be in supporting other areas of life gave me the motivation I needed to commit to my rehabilitation. It was a lengthy and laborious process, but I was rewarded when, shortly after returning to Tag, I was selected again to represent West Yorkshire, as well as for the Great Britain Women's Seniors training squad. Imposter syndrome continued to lurk in my periphery, but I was able to take pride in my achievement, which showed growth.

Certainly, the balance of work and play can also tip in the other direction, and the commitments of GB training are considerable alongside juggling the pressures of work. However, I now know that time and energy spent doing something you enjoy never feels wasted. On those days where I return from work exhausted and want to collapse on the sofa, I think back to those months where Tag was unavailable to me, and the consequences that had on my mental health. Most days, that gives me the motivation to lace up my boots and get back out there.

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A Service Evaluation Project exploring menopause and perimenopause in patients under the care of York and Selby Early Intervention In Psychosis Team

By Dr Umair Nasir and Dr Daniel Whitney

Background

The average age of menopause in the UK is 51 years1. However, perimenopausal symptoms exist between the age range of 40-60 years, in some instances even earlier than age 40. The perimenopausal period can be associated with a range of neuropsychiatric symptoms including anxiety, low mood, paranoia, anhedonia, irritability, dissociation, insomnia and feelings of low self-worth. Psychological symptoms associated with menopause may be sufficiently severe to qualify 'caseness' for a mental disorder or may exacerbate underlying pre-existing mental disorders 2.

In perimenopausal patients with a history of mental illness, there is a danger of diagnostic overshadowing and new onset perimenopausal symptoms being misdiagnosed as a relapse of a pre-existing mental illness. This can lead to delays in diagnosis and correct treatment 3. When patients experience a relapse of their mental illness in the perimenopause, clinicians often prioritise the treatment of the mental illness with a view to consider the perimenopausal symptoms when the acute mental illness is optimised; it can be argued that this reductionist method is unhelpful, and that treating the perimenopause and mental illness in parallel is likely to lead to speedier recovery and better long-term outcomes 4.

There had been no previous audits or service evaluation projects exploring the prevalence and relevance of the presence of perimenopause/menopause in the York and Selby Early Intervention in Psychosis Service. The need was thus felt to undertake a service evaluation project to explore this area.

Key Areas for Investigation

The aim of the project was to evaluate the presence of perimenopausal symptoms in a sample of patients referred to the York and Selby Early Intervention in Psychosis (EIP) Service in the year 2024 and to draw conclusions or inferences regarding the possible impact of perimenopausal symptoms on these patients' mental health care and treatment by the team.

The objectives of the projects were:

a) To identify all the female patients between the age of 40-60 years who were referred to EIP during the year 2024.

b) To evaluate if these patients had a diagnosis of menopause, were on HRT or if perimenopausal symptoms were explored during medical reviews with EIP either during an unstructured interview or using structured scales such as GCS (Greene Climacteric Scale).

c) To draw inferences or conclusions regarding the possible impact of perimenopausal symptoms on the patients' mental health by using indirect measures such as the diagnoses they received or if they were prescribed antipsychotic medications.

Methodology

The project focused primarily on the patients referred to the York and Selby EIP team in the year 2024 (i.e. from 01/01/2024 to 31/12/2024).

Patients between the age of 40-60years who were referred to York and Selby EIP during this period were identified and comprised the sample size of 20.

Data collection took place between 01/01/2025 to 01/03/2025.

Data was gathered using existing patient records (electronic patient record and GP summaries).

The project was undertaken with an exploratory approach, starting with an unstructured review and subsequent data organisation using a data collection tool.

The data gathered did not contain any patient identifiable information.

Results/Findings:

The project highlighted that 35% (7/20) of the patients had a diagnosis of menopause/perimenopause. However, only 2 of these patients were in receipt of HRT at the time of the referral, or subsequently whilst under the care of EIP. A review of the GP records of the remaining 4 patients showed that the HRT was stopped by their GP in the weeks to months preceding their referral to EIP. It is worth considering if some of the symptoms these patients experienced which prompted the referral to EIP could be attributed to cessation of HRT. One possible improvement in this area is for the medical team to explore whether a patient presenting with perimenopausal symptoms had HRT prescribed at some point in the past and if it was ceased by GP, to explore the reasons for this discontinuation.

In the case of 1 out of the above 7 patients, EIP medical team advised the patient to consult their GP regarding prescription of HRT. The project highlighted that all patients presenting with perimenopausal symptoms would benefit from discussion with the EIP clinicians and their GP regarding the relationship between raised oestrogen and psychosis (including the effects of oestrogen on antipsychotic medications).

We found that perimenopausal/menopausal symptoms were explored in 35% (7/20) of the patients during medical reviews with EIP. Given the importance of excluding these symptoms in women of the relevant age group (20-40years), these symptoms should be explored in 100% of the patients. 29% (2/7) of cases utilised a structured scale such as Green Climacteric Scale to gather the required information.

The project noted that the perimenopausal symptoms were only explored during medical review with patients. All professionals involved in the patient care (such as Care Coordinators, psychological therapists, occupational therapists etc) could explore these symptoms. Similarly, physical health reviews (which are conducted regularly by EIP) could be another suitable opportunity for this purpose.

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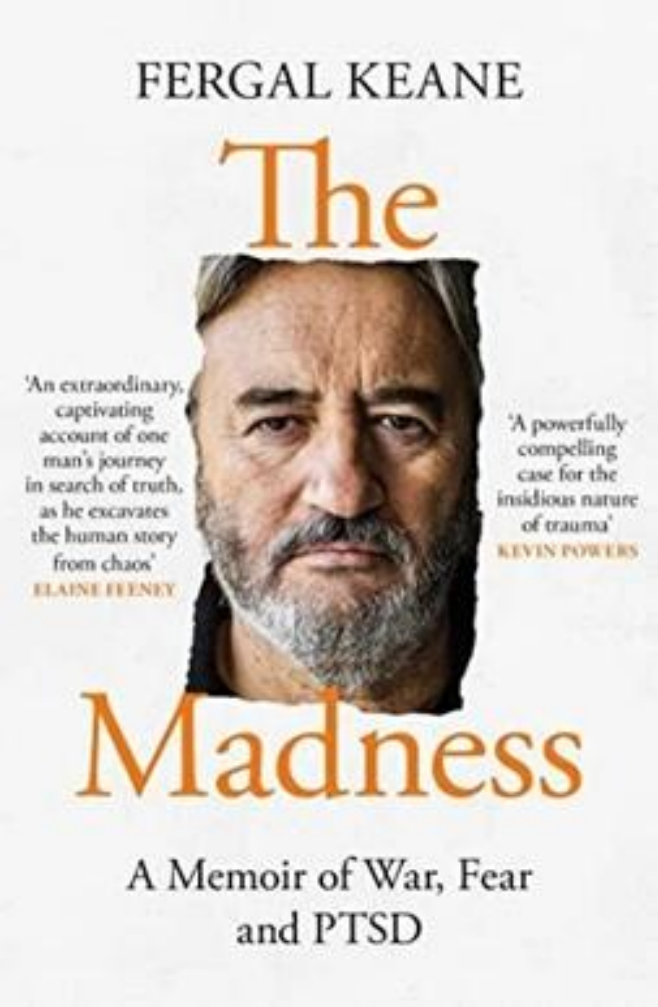
The Madness, A Memoir of War, Fear and PTSD

By Dr Wico van Mourik



Fergal Keane is one of the most well-known journalists of our time, who stands out as being fully engaged with the subject of his reporting. For many years it was war, civil war, war crimes, oppression and torture that he brought to our screens. At a certain point in this he does seem to go from one shocking scenario to another: Bosnia, Burma, Rwanda, South Africa, Palestine and latterly Ukraine. However, the book is less about these scenarios than what brings a person to report on them. Why he continued, even though his work took a heavy toll on him: years of depression, suicidality and alcoholism were the regular payments he had to make. Only in 2008 does he finally accept that the PTSD he suffered was the underlying faultline causing the visible tremors.

The book opens with a section about his family background in North Kerry in the Republic of Ireland, including the Civil war of 1920-1922. In an earlier book 'Wounds: A Memoir of Love and War' he describes the partisan conflict that played out in the town of his family roots. People were murdered by people who had been neighbours, had been living cheek by jowl; just like in Bosnia and Rwanda, where some of his earliest reporting came from. What are striking are the intergenerational effects of such violence: his grandmother having been within the partisan conflict, but who never spoke about it- a world of secrecy. In his journalistic work Keane sets out to speak openly about violence, bearing witness, but also a duty moral reckoning he places upon himself. This sensitivity to violence brought upon by others, by those in power, finds its roots also in the institutional abuse suffered by his father and Keane himself at the hands of teachers in various Christian Brother schools in Ireland. Violence tolerated but not exposed for what it was/is until secularisation in Ireland paved the way for such exposés. Add to that the abuse in childhood he suffered at the hands of his actor-father who was a functioning alcoholic. Witnessing the domestic violence in which he tried to intervene between his parents sowed seeds of wishing to prevent or heal the damage. In his working life, this translates into a determined quest for justice for the victims. The persistent fear from childhood however is insufficiently dampened by this, so alcohol becomes a refuge both whilst on assignment and at home. What is remarkable is that over the years he has been reporting, he has come across as together, humane and balanced- the epitome of a good journalist. Nothing gave away the tortured person that was/is Fergal Keane. PTSD can hide within well-functioning people. He indicates that he was not good at being a family man: being irritable, restless, depressed, drinking when at home. As in the book 'My War Gone By, I Miss It So' by Anthony Loyd, also a war correspondent, who describes very well how there is compensation offered by being in warzones with like-minded people; whereby inversely, being at home becomes near intolerable.

It took years of sobriety and therapy for Keane to realise he was suffering from PTSD and that he should not return to the front line to face more atrocities. He is still drawn to these places, however after a mental breakdown and hospitalisation it is clear that he should restrict himself to journalism behind the front line, reporting on the effects

of conflict on those carrying the scars: the refugees and the survivors. (He has been very visible in this role during the war in Ukraine).

A pivotal moment is when his therapist focusses on the guilt he continues to feel, a guilt derived from the near grandiose task placed upon himself to save lives by the work that he does. A guilt emanating from his childhood: witnessing the violence meted out by his father towards his mother and the powerless feeling of wanting to but failing to save her. The guilt and the actions it drives offer no resolution to either his personal or his professional dilemma's; a guilt that depresses or that needs numbing with alcohol.

Worthy of re-reading is the final chapter where some resolution comes through resetting the lens through which he approaches his work and his life: no longer just reporting victimhood but reporting goodness, those that are building up, human endurance and active rather than passive survival. This is brought about by a meeting he has with a woman whom he witnessed, as a girl, being taken to safety by a humanitarian convoy and who had learnt and exemplified this lesson for living with trauma. In seeing the good, he has also learnt to see things to be grateful for in his own life, an antidote against the perennial sense of being worthless, as the good one experienced is an expression of one's worth. "Good things happen.", becomes "Good things happen to you/me". The ultimate outcome of focus on the good is that he starts to see the good in himself.

As a clinician reading this book, that has worth beyond clinical interest, I became aware of the importance of context in the understanding of PTSD. We can focus on the current symptoms and neatly tick them off, however the story for the person with PTSD is more complex and embedded. I was particularly struck by –contrary to the concept of avoidance- how Keane, like a moth drawn to a flame, stays within the trauma-prone scenarios. The book showed me that this may derive from the perennial seeking of resolution to the various manifestations of trauma: the intergenerational trauma, the early trauma of childhood and the repeated trauma encountered in the futile attempts at resolution. This helped me understand how people with PTSD carry on living in scenarios of re-traumatisation through for example abusive relationships, addiction; defying logic. The silence which violence and trauma appear to demand from the person, leads to the spotlight being turned on the secondary manifestations such as depression and addictions leaving the PTSD to continue to wreak havoc.

With regards to my own professional life, a lesson is also to be found: does grandiosity drive my desire to heal the mental wounds of my patients, or can I also see my limitations and their strengths and their endurance?

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Pathologizing the Normal: Revisiting Thaniyavarthanam Through a Psychiatric Lens

By Dr Kamran Mahmood

I first watched the 1987 Malayalam film *Thaniyavarthanam* ("The Repeating Rhythm") years ago, long before my clinical experience in psychiatry. The film stayed with me, not only for its cinematic brilliance, but for the discomfort it left about how poorly society understands mental health. Recently in my clinic, after meeting a boy adamant that he was not psychotic, I returned to this film. But first, it's worth revisiting this underrated gem of Malayalam cinema, directed by Sibi Malayil and written by A. K. Lohithadas.

Mammootty, one of Malayalam cinema's greats, plays Balagopalan (Balan Master), a respected art teacher living in a conservative joint Nair family in rural 1980s Kerala. Balan is kind and principled, sharing a peaceful life with his wife, children, mother, brother Gopi, and sister. The household is ruled by an authoritarian maternal uncle steeped in superstition. Upstairs lives another uncle, Sreedharan, confined in chains for years; believed to be "mad."

The family attributes Sreedharan's condition to a divine curse, passed through generations after an ancestor desecrated a sacred idol. Supposedly, one male in each generation must inherit this "madness," which only appears after the previous sufferer dies.

When Balan, moved by compassion, unchains Sreedharan, it is an act of humanity against years of injustice. The metal restraints symbolize the cruelty of mistaking grief for madness. Sreedharan's distress began after his wife's death. Hoping to restore dignity, Balan frees him so he can play music again, which he once really enjoyed. But the next morning, Sreedharan is found drowned, his death ruled accidental. Balan, guilt-ridden, believes his kindness caused it. Though he resumes normal life, the guilt festers quietly.

After Sreedharan's death, a chilling question arises: who will inherit the curse - Balan or Gopi? The question soon becomes prophecy. One night, Balan wakes from a nightmare in distress. His startled scream awakens the family. Clinically, it's a benign night terror, yet the family interprets it as the first sign of "madness." Fear replaces understanding.

Soon, suspicion spreads through the village. Neighbours watch his every move. If Balan seems distracted, they call it detachment. If he scolds a student, they whisper he's losing control. His colleagues avoid him; even loved ones begin to see him through the lens of fear.

As a psychiatrist, what struck me was how quickly society assumes the role of diagnostician. Before any clinician is consulted, the verdict is already in: Balan is "going mad." Every ordinary gesture becomes pathological.

In one scene, Balan, unable to find a ruler, picks up a stick to draw a line. His colleague panics, believing he might use it as a weapon. This moment exposes a deeply ingrained myth - that mental illness equals violence.

As scrutiny intensifies, Balan becomes understandably irritated. When he protests the suffocation of being constantly watched, his frustration is cited as further proof of illness. "He never used to raise his voice," they say, oblivious that their own behaviour provoked his change.

This perfectly illustrates Thomas Scheff's Labelling Theory, which argues that once labelled "mentally ill," both individual and society begin reinforcing that label. The diagnosis, real or imagined, becomes a social identity, bringing stigma and isolation rather than healing.

Even Balan's sympathetic friend carries quiet doubt, showing how fear seeps into relationships. It reminded me how easily clinicians, families, and peers can reinforce

illness narratives, not through cruelty, but through anxiety and expectation.

Gopi, the voice of reason, takes Balan to a qualified doctor. The physician finds no mental illness, but the verdict comes too late. The community's judgment drowns out clinical truth.

The film also embodies the Diathesis-Stress Model, which explains how vulnerability interacts with stress to trigger illness. *Thaniyavarthanam* extends this by showing how social stress alone from fear, surveillance and ostracism, can drive psychological collapse. Balan begins with no illness, but constant suspicion and loss of agency erode his reality. The label precedes the illness; the diagnosis becomes destiny.

As stigma mounts, the family arranges Balan's sister's marriage, hiding his "condition" from the groom's family. Balan is excluded from the wedding to avoid shame. His wife, pressured by her father, leaves with their children. When Balan later goes to bring them home, he's blocked and beaten by his in-laws. His desperate attempt to reunite with his family, an act of love, is misread as violence. The villagers restrain him, convinced he needs psychiatric intervention.

In a harrowing scene, Balan is forcibly taken to a psychiatric hospital and subjected to electroconvulsive therapy, apparently without anaesthesia. His screams echo the cruelty of misapplied medicine. Afterward, he stops resisting. His silence and vacant gaze capture what many patients experience, not acceptance, but surrender to a narrative too heavy to fight.

Eventually, Balan is locked in the same room that once imprisoned his uncle. The image of history repeating itself is devastating, where cruelty is masquerading as care. In the final act, Balan's mother poisons him to "spare" him further suffering. The act is portrayed not as madness but as tragic love, revealing the deepest horror: in a society consumed by stigma, death can appear more merciful than mental illness.

The film lays bare how cultural beliefs shape psychiatric narratives. The family's fear of hereditary curse and social disgrace mirrors the stigma that persists globally. When illness is seen as moral failure or divine punishment, healing becomes impossible. The community doesn't just diagnose, it condemns.

Rewatching *Thaniyavarthanam* through the lens of psychiatry, I saw how closely fiction reflects clinical reality. Many patients live with labels that outlast their symptoms, reshaping how others see and treat them. For psychiatrists, this film is a reminder: a diagnosis is never merely a clinical term; it becomes part of a person's identity. Our words ripple through their lives long after the consultation ends.

The film isn't a psychiatry textbook. It offers no diagnostic checklist or treatment algorithm. But it teaches something more imperative: the responsibility in naming illness, the social power of our labels, and the harm that arises when care turns into containment. *Thaniyavarthanam* holds up a mirror to our profession. It asks us to speak carefully, judge gently, and label only when necessary; and never when convenient.

That brings me back to the boy I recently saw in clinic. Calm, articulate, with no current psychotic symptoms, yet burdened by a past diagnosis of a brief psychotic episode, likely triggered by stress and substance use. The symptoms had resolved quickly without medication. But I couldn't help wondering: now that he carried this label, would every disagreement or emotional moment be viewed as relapse? Would he ever be allowed simply to be himself again? And isn't that exactly what *Thaniyavarthanam* warns us about?

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Darkness visible[1] - the psychiatrist in psychotherapy

By Dr Ioana Toma

'Why Psychiatry?' is the impossible question we are all greeted with as we enter training. It provokes me, it gets under my skin. From the 'desire to help others' to a 'fascination with medical advancements in the field', these conscious motivations seem to fit the indispensable attributes everyone looks for in a promising alienist. What about unconscious, personal motivations?

The desire to help has infinite ramifications, from genuine expression of compassion and moral duty of abolishing pain and evil, or even strong feelings of guilt. Other reasons, such as a wish to feel needed and striving for power, are as valid and influence, more than we would like to admit, our career choice.

Psychiatry seems to convey a mysterious type of truth about our shared humanity that cannot be answered at once, but rather gingerly. Psychotherapy, one of Psychiatry's 'children', perhaps the most talkative and silent at the same time, can feel like a breakthrough in the wall that keeps us from living. It has the potential to shed some light into the reasons for having chosen this 'impossible' profession.

In this article, I would like to discuss some of the insights I gained during my personal psychodynamic therapy, which were of unexpected help in deconstructing my professional identity and enriching my work as a trainee psychiatrist.

'I wish I knew no astronomy when stars appear'[2]

'Say whatever comes to mind'. Staring at the walls becomes desirable in the face of the engulfing spiral that silence is in the consulting room. Intellectualization is a hindrance, and pendulating identities between 'the psychiatrist' and 'the patient', a never-ending quest. How can the wounded heal? What would the therapist think about my motives when they see the abyss of darkness within?

Perhaps the most painful lesson learnt in therapy is that it takes time. The ability to think, to talk about thoughts and to feel feelings when being on the other side of the table gave me a glimpse into how it is to expose your vulnerability to a stranger. That experiencing my humanness is a pre-requisite to delve into others' and to do it with grace, humility and gratitude.

Guilt and Reparation

In her study of infant anxieties and primitive defence mechanisms, Melanie Klein introduced the ideas of guilt and reparation towards internal objects. This could well represent an embryonic stage of what later we go on to call 'empathy' and the ability to put ourselves in others' shoes. She describes a 'dual position' we unconsciously take: the 'good parent' stance we take towards a loved person when we behave as we would have wanted our parents to do, and that of a 'good child' towards his parents, which we wished to have done in the past. Through this intricate process we become 'good parents' and we re-create the wished-for love of our own parents in order to repair the frustrations and deprivations of the past, to undo the hate for these frustrations through the very essential feeling of guilt.[3] This reparation is fundamental in all human relationships.

Thus, we identify with our patients and attempt to mend the wrongdoings they suffered because we recognise parts of ourselves in them. This realization has the potential to alleviate some of the pervasive narcissism of therapeutic power, when we tend to see ourselves as morally superior and emotionally healthier than our clients. There is something profoundly painful in our grandiose dreams of healing others, pointing towards islands of despair in ourselves that we are desperate to heal.

In the foreword of Michael Sussman's book, 'A Curious Calling', an uncomfortable yet illuminating question is asked: 'Why would anyone take on the Herculean task of wrestling with another's demons in the hopes of an often elusive transformation?'

It's all in the relationships

How did this experience shape the way I relate to and interact with patients and their families? I no longer see myself fundamentally different from them, but I acknowledge it is all a matter of context, circumstances and chance. Our shared humanity demands we learn from each other. I listen and try to understand what their actions symbolize, when there are no words. Or what words have to say, when they are distilled in intense, unbearable emotions.

I had the tendency to transform difficult silences in extended, almost mechanical interrogations, to avoid staying with not knowing. Or believing my professional expertise is the solution to their problems, instead of prioritizing the hidden resilience in them. I share my thoughts and feelings as they occur to me however difficult the issues raised might be, as I believe transparency is also part of deconstructing hierarchy. The more we cultivate secret knowledge as professionals, the more power we have over clients, and this can engender a painful vulnerability from their part.

There is still enormous experience in the consulting room and even more in the realms of self-knowledge and self-awareness. I wish this continuous encounter with myself will prove to be fruitful in coming together with patients, as we are all bound to lose and find ourselves in relationships.

References:

1 'No light, but rather darkness visible', represents a line from John Milton's 'Paradise Lost' and underscores the hidden values that unearthing suffering has by crystallizing it into something noble, greater than the self

2. 'A song', poem by Joseph Brodsky

3. Melanie Klein – Love, Guilt and Reparation and other works, 1921-1945

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Thrive in Psychiatry

The College is running a Thrive in Psychiatry campaign to help retain psychiatrists and support our members to thrive in the profession.

Who is the campaign for?

If you're a College member and you're thinking of taking a break, or you're on a break, or you're asking yourself whether you should continue in psychiatry, this campaign is for you.

If you're a resident doctor, if you're an SAS doctor, if you are a consultant, and you are considering leaving the profession, this campaign is for you.

If you're part of our membership and looking for more support, or if you're seeking a different challenge within psychiatry, this campaign is for you.

If you're a psychiatrist who knows someone in that position, and wants to support them, this campaign is for you.

If you are a medical director or have a senior position in a mental health trust, health board, health and social care trust or other employer structure, or are in a position to influence the environment psychiatrists and mental health teams work in, this campaign is for you.

The College is discussing the issues and signposting support to help you and your colleagues thrive in psychiatry.

Please visit the Royal College of Psychiatrists for further information:

About Thrive in Psychiatry

Northern & Yorkshire Division Autumn Conference 2025 Report

By Dr Sumeet Gupta

The Northern & Yorkshire Autumn Conference 2025 brought together over 100 psychiatrists, trainees and multidisciplinary colleagues for a day centred on '*Resolving Diagnostic Uncertainties- focus on Neurodiversity*', a theme chosen to reflect the increasing complexity of modern psychiatric practice. Held in the historic city of York, the event provided a vibrant, intellectually stimulating environment, with lively discussions and notably high audience engagement. It was delightful to see such active participation from delegates throughout the day, as they contributed thoughtful questions, reflections, and shared experiences.

The conference was opened by Dr Sunil Nodiyal, Chair of the division, and was planned very thoughtfully by Dr Baxi Sinha, Academic Secretary, and was duly supported by Dr Suman Ahmad, Academic Secretary.

The programme then explored a diverse range of clinical dilemmas encountered in routine practice. Dr Niraj Ahuja (RADS, Newcastle) delivered a nuanced session on the diagnostic uncertainties between bipolar disorder and borderline personality disorder. Drawing on recent research and clinical examples, he unpacked areas of diagnostic overlap, the risk of both over- and under-diagnosis, and the implications for treatment planning. His talk emphasised thorough longitudinal assessment, avoidance of diagnostic parsimony, and the value of structured tools used collaboratively with patients.

Dr Abdul Raoof (EPUT) followed with a highly practical and well-received presentation on applying the Mental Health Act in situations of diagnostic ambiguity. He highlighted the tension between medicine's comfort with uncertainty and the law's requirement for clarity, offering clear strategies for translating clinical formulations into legally coherent evidence for tribunals. His focus on "communicating complexity with clarity" resonated strongly with clinicians managing risk, detention criteria and medico-legal scrutiny.

The conference also addressed an important yet under-discussed area: personality disorders in older adults. Dr Ayesha Bangash (SWYPFT) explored how personality pathology can present differently later in life, the impact of ageing, cognitive change and medical comorbidities, and how clinicians can differentiate personality disorder from neurodegenerative, neurological or trauma-related conditions. Her talk provided a rare and valuable lens into a population often overlooked in mainstream personality disorder research.

Some of our poster presenters at the conference

The conference closed with a keynote address from Professor Subodh Dave, Dean of the Royal College of Psychiatrists, who offered an incisive and forward-looking perspective on the changing role of psychiatrists in an evolving NHS. He highlighted how community mental health transformation programmes are reshaping expectations, emphasising collaborative, population-level practice and the importance of leadership across clinical pathways. His message centred on adaptability, advocacy and the critical future contribution of psychiatrists in community-embedded multidisciplinary teams.

A further highlight of the day was the high-quality trainee poster presentations, showcasing original research, service evaluations, and innovative quality-improvement projects from across the region. The enthusiasm and rigour demonstrated by trainees reflected the strength of the local training programmes and the commitment to continuous improvement in patient care.

Overall, the 2025 Autumn Conference succeeded in combining academic depth with practical relevance, fostering dialogue across experience levels and clinical specialties. The strong attendance, active participation and breadth of content demonstrated the continued vitality of the Northern & Yorkshire Division's academic community and its shared commitment to addressing the complex dilemmas shaping contemporary psychiatric practice.

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The Royal College of Psychiatrists is the professional body responsible for education and training and setting and raising standards in psychiatry.

The Northern & Yorkshire Division is made up of members from areas including Leeds, York, Bradford, Cumbria, Tyne & Wear and Gateshead.

We would like to thank all members for their contributions towards Northern & Yorkshire Division activities throughout the year.

Northern & Yorkshire Division Vacancies

The Northern & Yorkshire Division have a number of exciting roles to share. Please see our vacancy list below:

Regional Representatives

· Academic: Division-wide
· Child and Adolescent: North East region
· Eating Disorders: Division-wide
· General Adult (shared role): North East region
· Intellectual Disability: North East region

Regional/Deputy Regional Advisor

· Deputy Regional Advisor (North East and Yorkshire regions)

Executive Committee

· Recruitment Lead

For more information on these roles and to apply, please click here: Northern and Yorkshire Executive vacancies (rcpsych.ac.uk)

Deadline for next edition: 22 May 2026
Submit your articles for Summer edition by 22 May 2026 to: northernandyorkshire@rcpsych.ac.uk

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