RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

THE PSYCHIATRY OF VULNERABILITY

REFLECTIONS ON IDENTITY, DELUSION, BURNOUT AND RECOVERY

HOW TO PLAN AN ELECTIVE IN THE USA

FINDING YOUR PLACE AS A DOCTOR

STORY TELLING AND PSYCHIATRY

FuturePsych

RCPsych Magazine for Medical Students and Foundation Doctors

SPRING 2025

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Above: Arif Riyanto via Unsplash. Cover: Joeyy Lee via Unsplash.

FROM THE EDITORS

Welcome to the Spring 2025 edition of *FuturePsych*. This issue takes us to the heart of what it means to be vulnerable, whether as doctors, patients, or people. Our contributors offer deeply personal reflections on identity, delusion, burnout, and recovery. They explore how vulnerability is often hidden behind professional facades, cultural expectations, or systems not built to accommodate difference.

In these pages, you'll find essays that challenge stigma and celebrate honesty. Whether through the lens of narrative medicine, the silence of depression, the complexity of eating disorders, or the ethical grey zones of global psychiatry, each piece speaks to the power of acknowledging and working with our most human moments.

As this is our final issue as co-editors, it feels especially poignant to be closing with a theme that resonates so strongly with our own transitions. Having served our terms as Medical Student and Foundation Doctor Representatives, we're stepping into the next stages of our careers. It's been a privilege to shape this platform and spotlight so many brilliant voices along the way. We hope *FuturePsych* continues to inspire you wherever your own journey leads.

Please note that FuturePsych is intended for our membership. The content is provided by contributors and does not necessarily reflect the views, position, or policy of the College. The Royal College of Psychiatrists does not provide any endorsements or assume any responsibility for the accuracy, completeness, or suitability of the content provided.

DR FELICITY ALLMAN
FOUNDATION DOCTOR REP

Felicity is a Specialised Foundation Programme doctor in the Northern Foundation School, and a visiting researcher/training fellow at Newcastle University. Before medicine, she was a registered mental health nurse.

EMELIA PASTERNAK-ALBERT
MEDICAL STUDENT REP

Emelia Pasternak-Albert is a multi-award-winning medical student at King's College London GKT School of Medical Education and an MPhil (Psychiatry) graduate of the University of Cambridge. Before the PRDC, she was the inaugural Child and Adolescent Faculty Psych Star.

Priscilla du Preez via Unsplash.

WE NEED TO KEEP TALKING ABOUT MENTAL HEALTH: REFLECTIONS THROUGH THE LENS OF MY OWN ANXIETY

Recently, awareness has been raised for mental health, driven by campaigns like “World Mental Health Day” gaining momentum. However, stigma still surrounds this topic; anecdotally, I find this is especially true of medical professionals in other specialties. As an aspiring psychiatrist with lived experience of recovery from mental illness, that is sincerely disheartening. Suicide is the leading cause of death for under 35s in the UK (1). Mental illness need more than only medications, they necessitate listening and understanding.

The mental health of medical professionals is often overlooked. My journey with generalised anxiety disorder underlined the importance of addressing mental health openly. As a teenager I struggled immensely, working hard to regain control of my life. Starting medical school made me realise how little focus is given to doctor’s own wellbeing, despite the profession’s emotional demands. My experiences strengthened my passion for psychiatry. They highlighted how mental health issues can affect one’s ability to care for patients. Mental health issues are often underdiagnosed in doctors due to our perfectionist culture that discourages vulnerability (2). Psychiatrists are therefore essential for treating both patients and supporting other medics who struggle in silence.

Psychiatry is more than diagnosing and treating mental illness. One of its most powerful assets is narrative medicine, which sees patients share vulnerable stories, enabling healthcare professionals to better appreciate their challenges and empathise with them more deeply. This leads to higher quality care. Despite hearing psychiatry be dismissed by the public and other medics, my clinical experiences consolidated my belief that psychiatry is integral to medical training. Understanding a patient’s lived experience can transform treatment outcomes by fostering real compassion. The empathetic, individualised care of psychiatry is not just a specialty, but a patient-centred cornerstone of medicine that every doctor should engage with. Psychiatric principles are vital for treating all patients, not just those with diagnosed mental health conditions.

Initially, I struggled to navigate my anxiety. I suppressed my feelings due to the lack of understanding from those around me of its impact on my life. This only made things worse. Eventually, my anxiety progressed and I needed support. This led me to the same psychiatric tools I now study. This full-circle experience allowed me to combine personal insight with medical knowledge, deepening my appreciation of psychiatry. For people with mental illness, psychiatry symbolises hope, light at the end of the tunnel, and a way back to recovery.

Above all, I want this article to highlight that mental health must not be ignored. Psychiatry and narrative medicine are powerful tools for breaking down stigma and fostering empathy. By sharing our stories, we can provide care rooted in compassion. I hope recalling my experience reminds my peers of the importance of prioritising our own mental health - not just for our benefit, but for our patients.

RHEAGAN EDWARDS
4TH YEAR MEDICAL STUDENT
LANCASTER MEDICAL SCHOOL

Above: Rheagan Edwards. Below: Rozet Balliou.

LEARNING TO SIT ON THE FLOOR

PEEP (Psychiatry Early Experience Programme) is a programme encouraging early student involvement in psychiatry, increasing awareness of mental illness, and promoting interest in psychiatry. It was trialled at King's College London, it revealed that 'longitudinal shadowing experiences sustain positive attitudes towards the field.' (1)

In 2022, Edinburgh advertised a similar scheme which I excitedly signed up for, fascinated and keen to learn more. I met a registrar psychiatrist, and over two years I had a variety of placement days.

In an outpatient dementia clinic, I watched the doctor meet patients to broach the subject of diagnosis. He left space for the patients to express themselves while acknowledging the families' worries. Each time, the room felt tense at the prospect of bad news, the patients trusted him. As a spectator outside the doctor-patient relationship yet still privy to a life-altering moment, I reflected on the feelings present and how crucial professional empathy is. I felt more equipped to handle breaking bad news from this experience.

Spending a day in the Intensive Psychiatric Care Unit, I walked through the locked doors, feeling apprehension, my mind unhelpfully offering up movie-like depictions of eerie psychiatric units. Reality was a stark contrast: I met a friendly team, witnessed consultations, took notes in the MDT meeting and met patients from a range of backgrounds, all at various stages of their recovery.

A woman experiencing a delusion of pregnancy stood out to me. She aptly illustrated how psychiatric recovery is a long-term process. Walking into the room, her sitting cross-legged on a bean bag, I followed the doctor's lead and joined her on the floor. One hand clutched her belly protectively. She had a distended abdomen, but due to an abdominal mass. When the doctor mentioned removing the mass, she was distressed, stating that she didn't want an abortion.

The doctor balanced an attempt to get informed consent while managing her distress. They did not reach a fruitful conclusion, but this consultation was one of many, including with the gynaecology department. They monitored the mass while working towards getting the patient emotionally ready for the procedure. I reflected on the ethics of informed consent, the tension between best interests (getting the procedure), capacity (or lack thereof), and the balance of minimising distress and acting in a patient's best interests.

It was truly thought-provoking, and I am grateful for the opportunity PEEPs created, and the variety of people it introduced me to. I would highly recommend it to fellow students and am now more than ever looking forward to my placement in psychiatry.

ROZET BALLIOU
4TH YEAR MEDICAL STUDENT
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Main image: Radu Marcusu via Unsplash. Inset: Imama Khalid.

MEETING THE UNRELIABLE NARRATOR

As much as we love them on the big screen, indulge in Baron Munchausen's tales as fanciful, and Charles Kinbote makes reading "Pale Fire" an encounter with unease, most people would feel miserably unfortunate to be seated next to a real-life unreliable narrator at a dinner party. On psychiatry placement I came to understand that deciphering an unreliable narrative is not an abstract philosophy, but an on-the-spot judgement made by psychiatrists daily. How does one understand the impact of delusions if a patient denies any negative impact, or even says that they are 'on top of the world'? How do you assess paranoia when their occupation carries the real possibility of violence?

On placement I had the opportunity to hear many of these stories. Before interviewing a patient, a doctor warned me that I would hear many untrue things. In between the impossible delusions of police and pyramids, microchips, and widespread accusations of abuse, was the story of withdrawal from conventional social life. This experience taught me that a well-equipped physician is interested in all aspects of a patient's narrative, past the superficial bizarreness, and understands how patients see themselves within it.

I chose to use literary theory to analyse my experience with unreliable narrators. Used in psychoanalysis to understand unconscious mental processes that repress drives and desires, I believe literary theory can help us to understand our reactions to narratives we tell each other, and what drives certain reactions, such as viewing a story as unreliable, unlikely to be true, or likely attributed to a mental illness.

In literary theory unreliable narratives are recognised by not conforming to certain textual, logical, or ethical 'norms' (1). An unreliable narrative might use strange punctuation, have inconsistent logic, or show unethical behavior. People experiencing delusions can exhibit all these signs. Thought disorder can lead to unsound sentence structure or factually inconsistent narratives, and an impairment in decision making due to delusions may lead to someone acting out of character. How do we discern information that is reliable and clinically useful from what is purely the product of mental illness?

Ultimately, I learnt that looking at how thought processes develop and persist is more important than focusing on the conventionality of a self-reported experience. Instead of looking for misrepresentations and distortions, we should look at the emotional and personal experience of the unreliable narrator to determine the authenticity and credibility of their story.

IMAMA KHALID
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CONTROL & RESTRICTION: UNDERSTANDING ANOREXIA AND THE SILENT STRUGGLE OF EATING DISORDERS

As a fifth-year medical student, I had the opportunity to spend time in an eating disorder ward, where I encountered several individuals diagnosed with anorexia nervosa. One of the first things that surprised me was the demographic of these patients. Contrary to my initial expectations of seeing individuals aged 16-25, many of the patients were between 50 and 70 years old. This unexpected demographic shift provided a unique insight into the complex nature of anorexia.

Over time I began to understand that, for many of these patients, the disorder was not merely about weight loss or physical appearance. It was about something far deeper—an issue of control, identity, and addiction. Anorexia had become a defining feature of their lives, serving as a coping mechanism and a source of perceived stability. When coupled with co-existing mental health conditions, such as personality disorders, the disorder became even more challenging to manage.

Anorexia can be viewed through the lens of addiction. Unlike substance addictions, where the goal is to eliminate the intoxicant, managing anorexia requires patients to maintain a healthy relationship with food—something they cannot simply remove from their lives altogether. Asking someone with anorexia to "eat in moderation" can feel akin to asking an alcoholic to "drink a little every day." It is also paradoxical as with alcohol addiction the purpose of recovery is to cut down and eventually remove it, but with anorexia it is the opposite. This highlights the difficulties of treating eating disorders.

Many patients on the ward had moved beyond any initial motivations tied to self-image—a preclinical phase often trivialised as “wannarexia”. Anorexia had become a compulsive need often accompanied by extreme behaviours to maintain control. I was shocked to discover the lengths some patients went to in order to avoid gaining weight. Beyond commonly known methods like vomiting or using laxatives patients found alarmingly creative ways to purge, hide uneaten food, and mask their weight.

One particularly striking case involved a patient who had worked in the food industry—a seemingly ironic profession for someone with anorexia. However, through conversations with senior colleagues and further research, I learnt that this is not uncommon. Many individuals

THIS ARTICLE COMES WITH A TRIGGER WARNING FOR EATING DISORDER

with anorexia are drawn to environments where they can experience food vicariously, deriving a sense of control from feeding others while denying themselves. The psychological complexity of anorexia is profound. Patients often fear the very thing that could save their lives.

To treat anorexia effectively we must address the broader picture. Anorexia is a coping mechanism, an identity, and a source of comfort. Stripping this away without providing alternative tools for managing emotions and challenges risks leaving service users adrift. Treatment must therefore involve teaching healthier coping mechanisms and fostering resilience from the start. We are now experiencing a new challenge in the digital age. Whilst promoting awareness of eating disorders is great, it can also expose individuals to harmful behaviours they may not have otherwise known. Teaching children and adolescents about body image, emotional regulation, and coping strategies in a controlled educational environment is essential to reduce this risk of developing eating disorders.

NAVJOT DHANOA
FINAL YEAR MEDICAL STUDENT
UNIVERSITY OF LIVERPOOL

Teodor Drobota via Unsplash.

A PSYCHIATRIC DISSECTION OF AFTERSUN (2022) AND DEPRESSION

Aftersun is a beautiful, semi-autobiographical, BAFTA-winning drama written and directed by Charlotte Wells about her tender and complex relationship with her father, with an overarching theme of intergenerational depression permeating through the film. The cinematography, music and screenplay weave together to illustrate the unspoken melancholy. The film follows Sophie (Frankie Corio), an 11-year-old, on a trip to a Turkish resort with her young 30 year-old father Calum (Paul Mescal). The film requires inference rather than having a detailed plot. It allows the viewer to glance into the mind of a person experiencing depression, how this manifests itself into his experience of life, how this seeps into his relationship with his child, his parenthood, and how a young child may bear the weight of this silently.

This film can teach us about our patients with depression, their lived experience and the nuanced interpersonal layers which are not always obvious.

Calum is portrayed as a single parent throughout the film. Without explicit verbalisation of his emotional landscape, the viewer is to infer the emotional weight he's carrying through his demeanour, often through his quiet moments. His role as a single parent depicts loving fulfilment along the pressure and isolation evoked from wanting to show up for his daughter, in dichotomy with his unvocalised mental health issues. There are moments during the film where Calum overindulges in alcohol use and within these moments the viewer can palpate a struggle to cope. He states his surprise to "make it to 30", and later in the film he is watching back some footage they've been shooting on a camcorder, where his daughter compliments him as a parent. His facial response to this is bittersweet, almost pained, indicative of the undercurrent of the effort it is requiring him to mask his struggles. In many shots (between dreamlike present-day visuals and nostalgic shots of the past), Calum can be seen disappearing into a backdrop of darkness suggestive of risk to self and potential suicide by the closing scenes.

The film is Sophie's recollection of this trip with her father. As she recalls this period, the viewer senses she is trying to retrospectively understand her father's behaviour. Due to her age, it is apparent she could not fully understand what was going on for him, but was aware that something was not quite right. Her own onset of pensiveness and potentially precursory depressive symptoms are depicted. In one scene she is seen gazing, lost in thought and her father asks, "You okay through there?" She responds, "I don't know. I guess, I just feel a bit down or something," later stating: "Don't you

ever feel like you've just done a whole amazing day, and then you come home and feel tired and down, and it feels like your bones don't work? They're just tired and everything is tired. Like you're sinking. I don't know. It's weird." Calum is seen glancing in the mirror, exchanging a look of pain and horror about what inevitably awaits his daughter.

The film utilises an overall subdued colour palette, symbolising how vibrance is incapable of penetrating through the darkness. The sun-soaked backdrop of the holiday contrasts with Calum's apparent inner coldness. The use of camcorder footage and flashbacks convey a sense of nostalgia. The cinematography often emphasises open spaces where the characters are small within the frame, possibly symbolic of isolation and insignificance.

This tender film highlights a colloquial depression, which is often not extended the same compassion as acute mental illness. I hope we can extend our bandwidth of compassion.

DR MOLLI KAUR
FY2 DOCTOR
NHS TAYSIDE

Below: Dr Molli Kaur. Right: Teodor Drobota via Unsplash.

RCPSYCH RESOURCES FOR MEDICAL STUDENTS AND FOUNDATION DOCTORS

Wes Hicks via Unsplash.

The Royal College of Psychiatrists (RCPsych) has dedicated faculties and Special Interest Groups (SIGs) aligned with many of the topics featured in this issue of FuturePsych, including:

- Faculty of Neuropsychiatry
- Faculty of Academic Psychiatry
- Faculty of Perinatal Psychiatry
- Faculty of the Psychiatry of Intellectual Disability
- Faculty of General Adult Psychiatry
- Transcultural SIG
- Neurodevelopmental SIG
- Digital Psychiatry SIG
- Volunteering and International SIG

...and many more.

You can join the College as a Student Associate Member today– completely free. You'll gain access to events, networking opportunities, e-learning, and publications including RCPsych Insight and FuturePsych.
We also recommend checking out RCPsych Learn, the College's platform for free learning resources, and subscribing to the RCPsych Podcast on Spotify, Apple Podcasts, SoundCloud or Amazon Music for regular insights relevant to med school and beyond.

Essay prizes and bursaries – see page 13
Submission guidance for FuturePsych – see page 19
Events and opportunities – visit rcpsych.ac.uk/events

The RCPsych website is full of helpful information about psychiatry careers, training pathways, and opportunities, whether you're in sixth form or foundation training. Stay connected and get involved!

FOOD FOR THOUGHT: ARE OUR MENTAL HEALTH SERVICES SUPPORTING NEURODIVERGENT PATIENTS?

Main image: Hiki App via Unsplash. Inset: Lucy Bargh.

A neurodevelopmental condition (NDC) is 'a condition that affects the development of brain function', leading to differences in receiving and processing sensory information compared to 'neurotypical' peers. Our growing understanding and acceptance of each other's differences seamlessly integrated the term 'neurodiversity' into the public lexicon, attracting the attention of researchers, healthcare professionals and patients alike. Does this unique sub-set of patients with NDCs receive the level of support they need to fully engage with and access mental health services? CAMHS waiting lists are leaving increasing numbers of service users who meet the NDC diagnostic threshold undiagnosed, culminating in mental health challenges in adulthood.

The term 'neurodevelopmental disorder' is an umbrella term for a broader set of challenges; from communication, sensory processing, and executive function, to rejection sensitivity, dysphoria. and complex social and emotional difficulties. Providing a high quality of care for this vulnerable group is difficult. Despite the immense amount of skill and resources required to effectively engage with this population, it is important to recognise that missed opportunities incur opportunity cost through increased demand for adult acute inpatient beds, longer bed occupancies, repeated admissions, carer burnout, and a reduction in patient life expectancy .

It has been a privilege to follow patient journeys on placement. I have developed an understanding of acute mental health presentations whilst gaining confidence in exploring the nuances of this diverse patient group. Talking with patients about their engagement with services, I could see how holistic care and the therapeutic relationship can positively shape healthcare outcomes, which was refreshing to witness. But not only do these patients have to face the internalised and generational stigma of accessing mental health care, but they also had to do this whilst their needs were not being sufficiently met.

One patient confided in me that they seriously considered suicide before they felt their concerns could be properly voiced. If patients are already having to surmount obstacles to survive in a world that wasn't engineered for neurodivergence, isn't it our duty to go the extra mile to ensure that those who are in greatest need of support have timely and equal access to care? This left me considering resource allocation in context of the Inverse Care Law. As a medical student set to graduate in two years' time, how can I fight to advocate for my patients to mitigate our rapidly developing society leaving behind the most vulnerable?

LUCY BARGH
3RD YEAR MEDICAL STUDENT
KEELE UNIVERSITY

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Anthony Tran via Unsplash.

THE SILENT CRISIS: HOW BURNOUT AFFECTS BOTH DOCTORS AND PATIENTS

During my first year of medical school, I shadowed a GP who embodied patient care - attentive, compassionate, and endlessly patient. Yet beneath his calm demeanour, I noticed quiet sighs between appointments and a vacant gaze as he moved on to the next patient. At the time, I couldn't quite name what I was seeing. Later, I realised it was burnout.

Burnout doesn't begin in senior doctors - it starts in medical school. The persistent fatigue, emotional distancing and relentless pressure aren't future concerns; they are present realities. A meta-analysis published in the Journal of Psychiatry Spectrum reported that approximately 25.9% psychiatrists experience burnout, according to the Maslach Burnout inventory, with this figure rising to 50.3% when assessed using the Copenhagen burnout inventory (1). High emotional demands, patient suicide and the stigma surrounding mental health all contribute.

The problem starts early. In the UK, nearly 40% of medical students report experiencing anxiety or depression, with almost 20% considering dropping out due to mental health struggles, according to a study published in the BMJ (2). Yet, like the GP I shadowed many suffer in silence, fearing judgement.

Burnout doesn't just harm doctors - it harms patients. A meta-analysis found that burnt out physicians are nearly three times more likely to report medical errors (3). This exemplifies that without proper support, these issues worsen, harming both patients and doctors. Emotional exhaustion leads to withdrawal, miscommunication, and a breakdown in patient trust. Without systemic change, these problems will persist, worsening both patient outcomes and clinical wellbeing.

Medical institutions must foster environments where mental health can be discussed openly without fear of judgment. Normalising these conversations would help prevent many from internalising struggles that ultimately affect both their mental wellbeing and their practice.

Medical schools and hospitals need robust mental health services for students and doctors. Resources such as counseling services, peer support groups, and workshops on stress management are crucial in creating an environment where seeking help is the norm, not the exception.

Curricula should include mental health training, resilience strategies, and self-care techniques. Doctors need to learn how to manage their mental health just as they do their patients.

Burnout is not just an individual struggle; it's a systemic crisis. Institutions and the healthcare system must do more to recognise and address the damaging effects of burnout on medical students and doctors. By tackling burnout early and providing support, we can end the notion that exhaustion is simply 'part of the job'. The GP I shadowed cared for his patients despite his own struggles- but no doctor should have to suffer in silence to do their jobs. If we want to provide the best care, we must first care for ourselves. After all, how can we help others when we are running on empty?

SHAHNOOR ADIL
3RD YEAR MEDICAL STUDENT
ASTON MEDICAL SCHOOL

Above: Anthony Tran via Unsplash. Below: Shahnoor Adil.

UPCOMING PRIZES AND BURSARIES FROM THE RCPSYCH

The Evolutionary Psychiatry SIG Charles Darwin Essay Prize
Deadline: 1 September 2025
Prize: £100 prize money and a certificate for the winner in each category, publication in the EPSIG Newsletter
Eligible: Medical students, foundation doctors, resident doctors, SAS doctors, based in the UK
Further Information

Perinatal Faculty: Medical Student Essay Prize
Deadline: 15 September 2025
Prize: £150 and subsidised attendance at the faculty conference
Eligible: Medical students and foundation doctors in the UK
Further Information

Perinatal Faculty: Medical Student Project Prize
Deadline: 15 September 2025
Prize: £150 and subsidised attendance at the faculty conference
Eligible: Medical students and foundation doctors in the UK
Further Information

Old Age Faculty: Trainee Essay Prize
Deadline: 1 November 2025
Prize: £150 for foundation doctor or CT1-3 resident doctor winner and £150 for ST4-6 resident doctor winner
Eligible: Foundation doctors, resident doctors, in the UK
Further Information

Intellectual Disability Faculty: Joan Bicknell Medical Student Essay Prize
Deadline: 1 December 2025
Prize: £250 and subsidised attendance at the faculty conference
Eligible: Medical Students in the UK
Further Information

Old Age Faculty: Medical Student Essay Prize
Deadline: 31 December 2025
Prize: £250 and subsidised attendance at the faculty conference
Eligible: Medical Students in the UK
Further Information

Neuropsychiatry Educational Bursary
Deadline: available throughout the year
Bursary: up to £200
Eligible: Medical students, foundation doctors, psychiatric resident doctors, SAS doctors, based in the UK
Further Information

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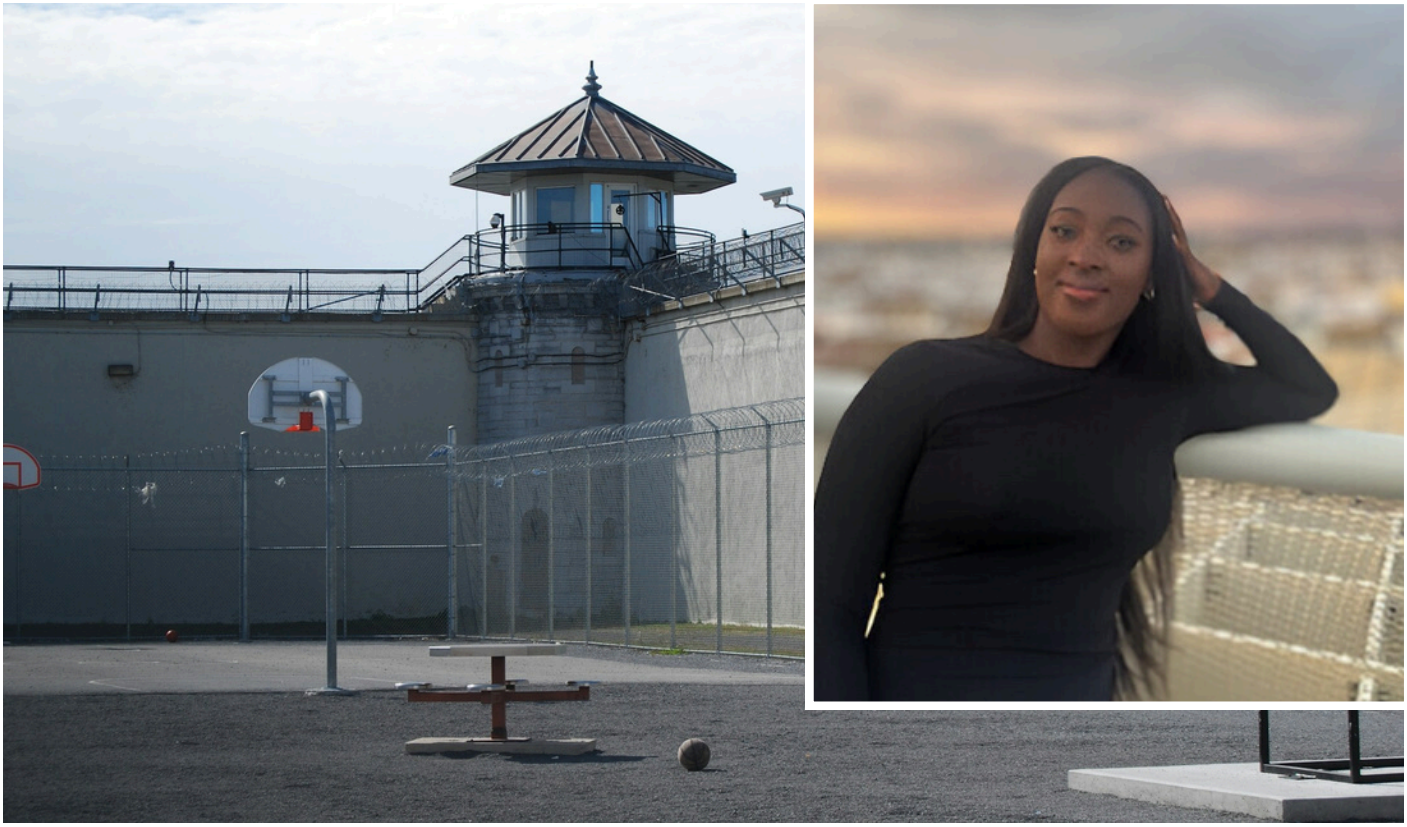

Main image: Larry Farr via Unsplash. Inset: Mosope Ajegbomogun.

HOW I ORGANISED A US PSYCHIATRY ELECTIVE (AND WHAT YOU SHOULD KNOW)

I spent 6 weeks at the Department of Corrections in Pennsylvania, USA for my medical elective. My time there was spent at a medium-security prison. Inmates experiencing acute psychiatric illness that can't be safely managed at other correctional institutions are sent here. While I enjoyed every minute of my elective, organising it wasn't easy. When planning a psychiatry elective in the United States, there are some key points to consider that I will share from my experience.

Before finding an elective, it is important to have a preliminary understanding of the culture there. I noticed that there is more of a hierarchy in the US than in the UK. Everyone refers to doctors as 'Dr Lastname'. Calling a doctor by their first name is considered rude.

Many US hospitals also simply do not take international medical students or require you to have sat the USMLE Step 1 exam that US-medical students take in their 2nd year. Sitting it just for an elective is a lot of work! For me, this ruled out lots of electives. It is therefore crucial to start the research process early.

Understanding the eligibility requirements is vital. Many programs want final or penultimate year medical students and require a vaccination history, malpractice, and health insurance. I even got asked for a chest X-ray to check for TB!

The US cost of living is higher than the UK and accommodation and food is not cheap. Most electives charge high fees too. Mount Sinai charges $3000 for a 4-week elective + $500 as a non-refundable application fee. This doesn't include hidden costs like vaccinations and insurance, and while these can be reimbursed via NHS bursary, the elective cost can't. Research elective bursaries and start saving early.

VSLO is an online service that gives you access to US psychiatry electives. Your university must be registered, so check early and ask them to join if needed. Not all US medical schools are on VSLO. I spent time searching each school for 'international medical student'. There are third-party companies that charge for electives. They can be hit or miss, but they guarantee you a spot. Using connections can save you money and stress. This doesn't have to be doctor relatives or friends. Anyone you know there can ask around for you. If you don't ask, you don't get!

So why go through all this? My US elective allowed me to explore different approaches to psychiatry and I'm sure the experience shaped my future practice.

MOSOPE AJEGBOMOGUN
MEDICAL STUDENT
KING'S COLLEGE LONDON

TRAPPED IN THE GREY ZONE: UNDEREMPLOYMENT AND MENTAL WELLBEING

Priya Sharma was thriving at her dream company in Dubai when her parents asked her to relocate to India for marriage. She returned to a small town hoping for work that would satisfy her potential, but years have gone by and she still hasn't found a stable job. She tutors two or three children - far from what she had in Dubai. Her potential feels wasted, and so does her self-esteem. Priya's story is not unique—it mirrors the plight of countless women trapped in the grey area of underemployment, where unfulfilled potential takes a silent toll on mental well-being.

The term 'underemployment' was first used early in the 19th Century when economists began to distinguish between sufficient and inadequate employment. It then described a state of low-skill and low-pay, but today underemployment refers to the mismatch between the skill level of current work and potential. This problem has been found to target highly-skilled women in jobs that do not fulfil their potential from the education they have, leading to unhappiness.

Research has focused on the negative impact of unemployment on wellbeing, overlooking underemployment, especially in women. Our quantitative research involving 126 women in India found underemployment can have even more profound impact on wellbeing than unemployment. We used WEMWBS-14 to assess wellbeing and three assessments of underemployment, including the Subjective Assessment of Underemployment (SAU). As subjective underemployment increased, wellbeing decreased. The correlation value of -0.4 showed a negative moderately linear relationship. Findings across subgroups were striking. Underemployed women reported 5% poorer wellbeing compared to unemployed women and 24% poorer wellbeing compared to sufficiently employed women. Alarmingly, two thirds of underemployed women reported poor wellbeing.

Psychiatry offers critical support in mitigating the harmful consequences of underemployment. These findings highlight the importance of assessing employment quality, not merely employment status. Mental health screening should include questions assessing job satisfaction and skill underutilization. Psychiatrists and Medical Students can advocate for workplace interventions to help develop a supportive and inclusive workplace community. By recognising underemployment as not only an economic problem but also a psychological one, we can restore a sense of purpose to countless women worldwide.

AAYUSHI DUBEY
HIGH SCHOOL STUDENT
WEST BENGAL, INDIA

DR KIRAN PINDIPROLU
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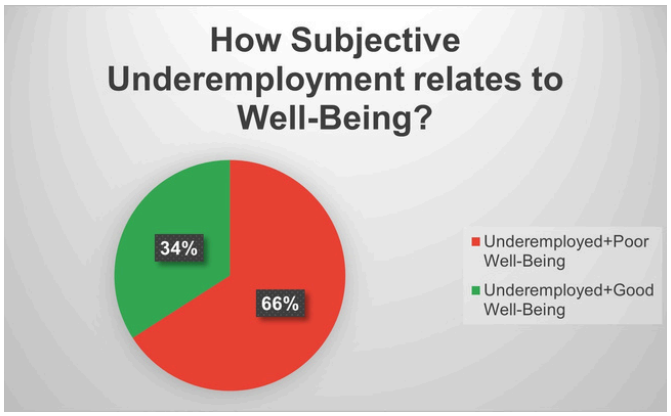
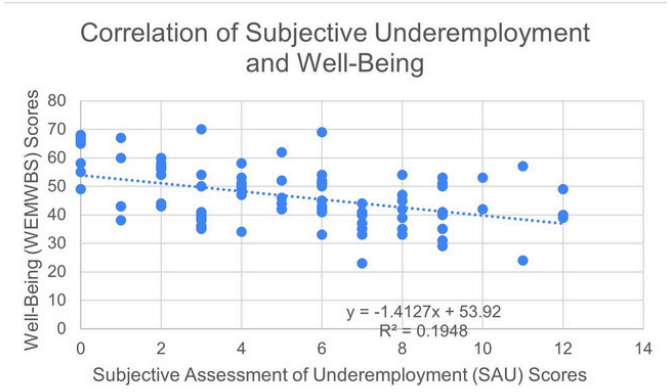
SHSC NHS TRUST





Top and centre: supplied by authors. Below: Aayushi Dubey.

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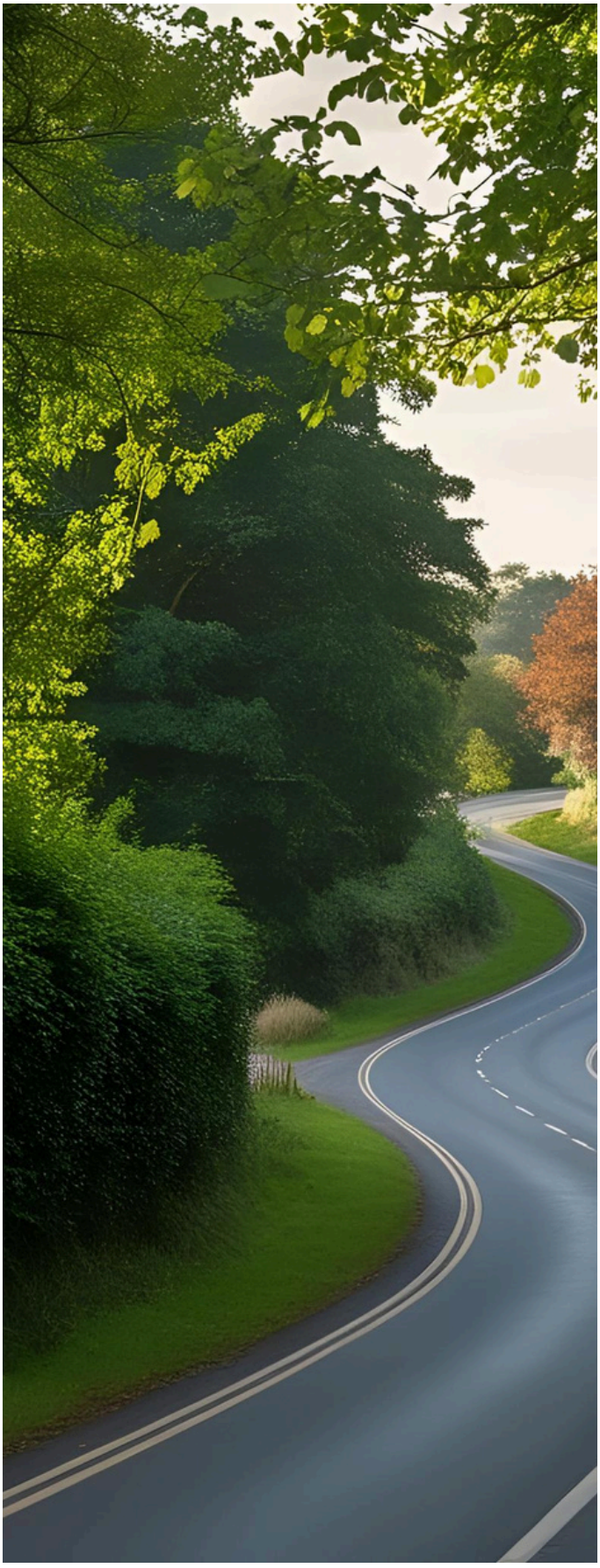

Canva Magic Media.

A WEEK IN REHABILITATION SERVICES: LESSONS FROM A UNIQUE PLACEMENT

Before medical school, I had never considered a career in psychiatry – this has changed from my exposure to the specialty through my placements, such as one at Littledale Hall, a 33-bed residential addiction centre on the edge of the picturesque Trough of Bowland.

Littledale Hall provides people with a safe and therapeutic environment to stop drug and alcohol use [2]. Structured programmes last from 3 to 12 months and involve a wide range of sessions – these include psychological therapies and a general focus on health and wellbeing [1].

The service provided is not NHS-funded; residents (not patients!), are either self-funded, or receive funding from their Local Authority.

I had no experience of formal rehabilitation services; my only encounters with addiction had been in hospital settings with patients receiving treatment for alcohol withdrawal.

It took time for me to adjust to the non-clinical setting. On my first day, I thought I'd taken a wrong turn driving onto the narrow lanes of the Lancashire countryside!

Initially, the only practice familiar to me was the morning handover – however, I was able to quickly settle in with the community. Every morning, residents were invited to meet as a group before the day's activities. It was encouraging to see the support from the group when individuals weren't feeling at their best, whether that be due to being new to rehabilitation, or receiving upsetting news.

On observation, the community, although supported by staff, was not 'run' by staff members, with many tasks (such as cleaning and kitchen work) completed by the residents – the importance of responsibility and taking ownership was refreshing to see, and somewhat of a contrast to inpatient settings.

The integration of various models such as the neuro-biopsychosocial model and the Six Cornered Addiction Rescue System (SCARS) [3], made me realise how addiction is upheld by a variety of circumstances. Without addressing these, it can be extremely difficult to stop the cycle.

One session I found particularly insightful was centred around trauma. I thought this would involve sharing experiences.

However, the focus was on how trauma as an event can be identified, and the various effects it may have on a person mentally and physically. I became aware of Adverse Childhood Experiences (ACEs), and their long-term impacts.

During my week in the service, the greatest benefit was undoubtedly being able to learn from residents. Developing a true picture of the various circumstances which have led people to addiction and the consequences of it was challenging at times. I became acutely aware that addiction can affect anyone under the wrong circumstances.

However, it was also positive to see the futures that residents hoped to have – although it was not the first time attending rehabilitation for many of the service users, the level of hope and confidence the programme was able to bring to them was inspiring.

ZAINAB KOLIA
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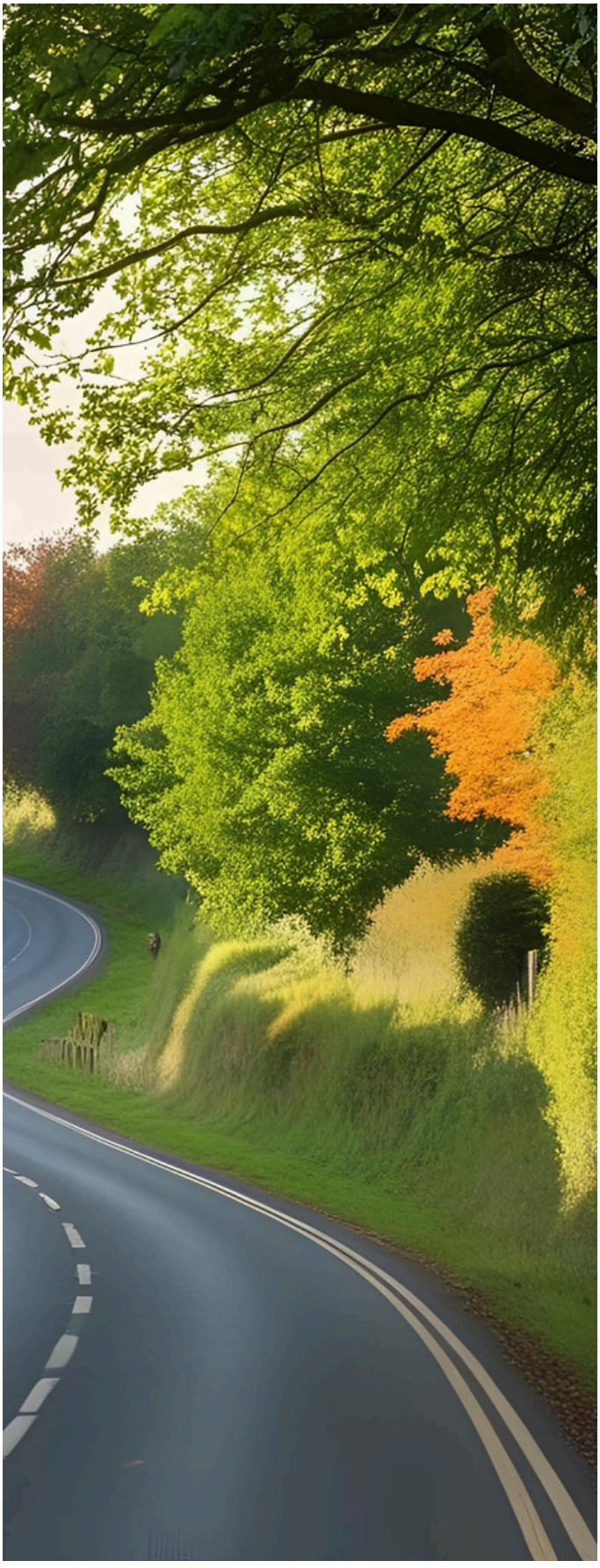
LANCASTER UNIVERSITY

Below: Zainab Kolia. Right: Canva Magic Media.



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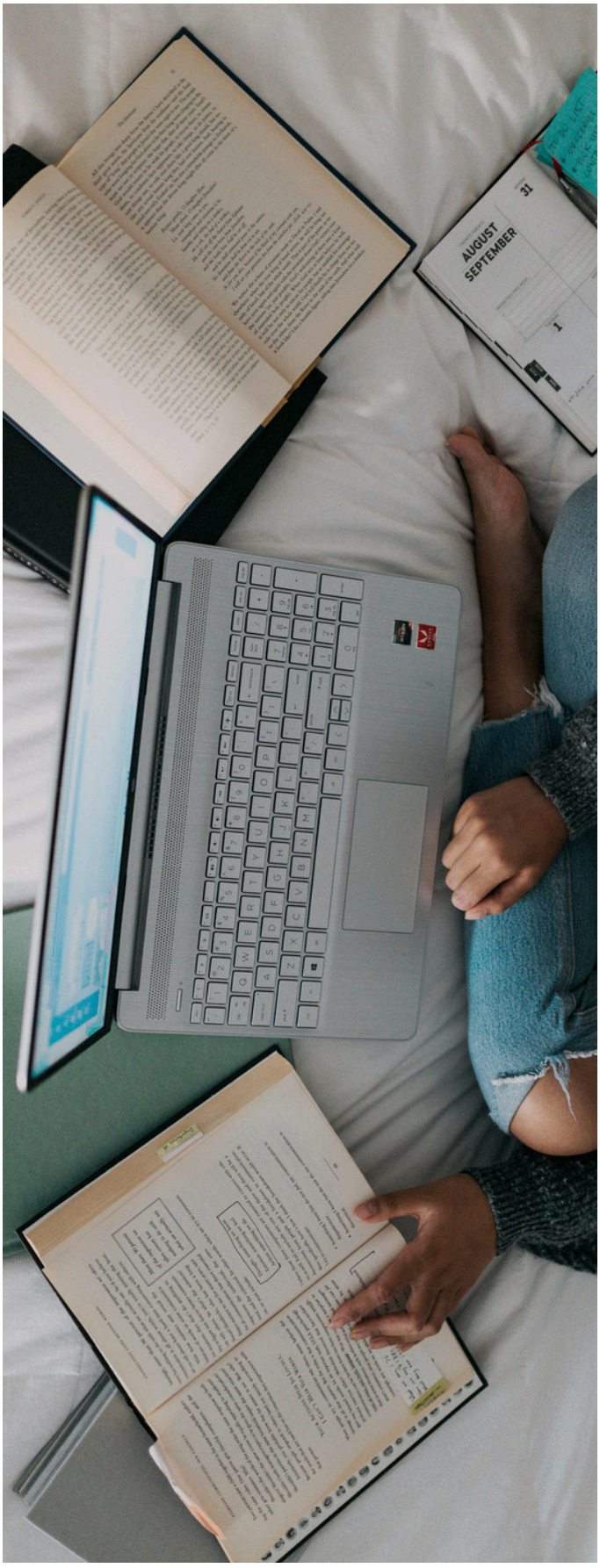

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