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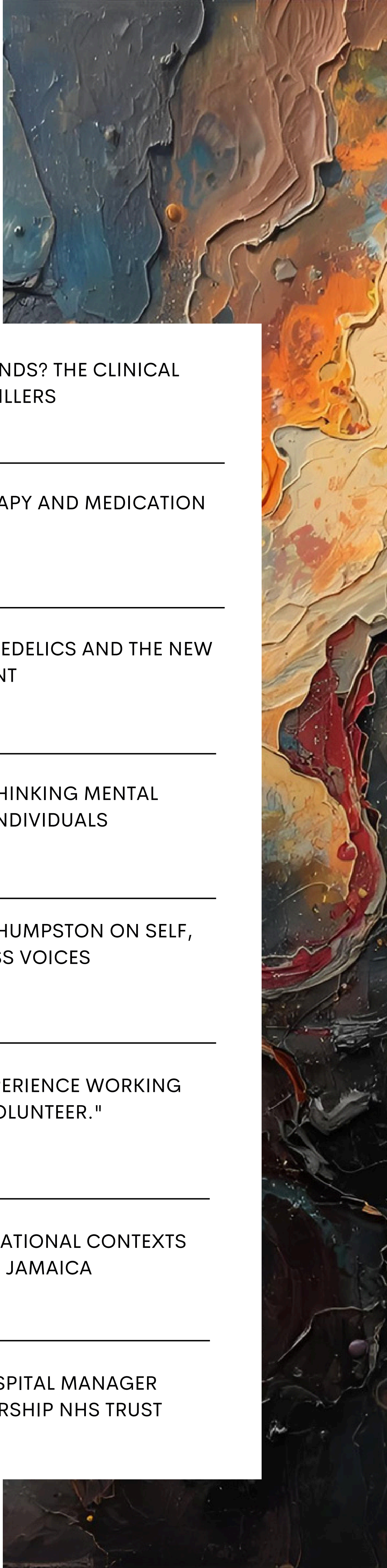

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From the Editor

This issue delves into the essential, yet deeply personal, realm of Mental Health and Clinical Psychology. In a world that moves at a relentless pace, understanding and nurturing our inner lives is not just a personal concern, but a collective one.

Within these pages, we explore topics such as clinical assessment, the stigma of seeking help and innovations changing therapeutic care. Our goal is to foster understanding and open conversation, approaching each piece with both empathy and rigor.

Please be mindful of your well-being as you read; a content warning is included on the following page.

I would like to take a moment to thank all of our student authors who contributed wonderful feature articles, Dr Clara Humpston for taking the time to partake in an incredibly thought-provoking interview, and the staff supervisor of PsychOut, Alex Reid, for his continued support.

I absolutely love working on this publication and I hope you enjoy reading this issue! Make sure to stay tuned for future publications! Please note, an accessible version of this issue, full citations, along with previous publications are available online.

Caoimhe Farrelly

PSYCHOUT EDITOR

CONTENT WARNING

The following issue contains discussions on potentially sensitive topics; reader discretion is advised. Articles discuss topics such as mental health, sensitive ethical dilemmas, morality, murder, crime, suicide, drugs, and therapy.

SOCIAL MEDIA

We have recently transitioned our social media profile to BlueSky. This is an exciting new opportunity & we hope to connect with many of you on the platform. Follow us @psychoutyork.bsky.social to stay up to date with PsychOut!

PAST ISSUES

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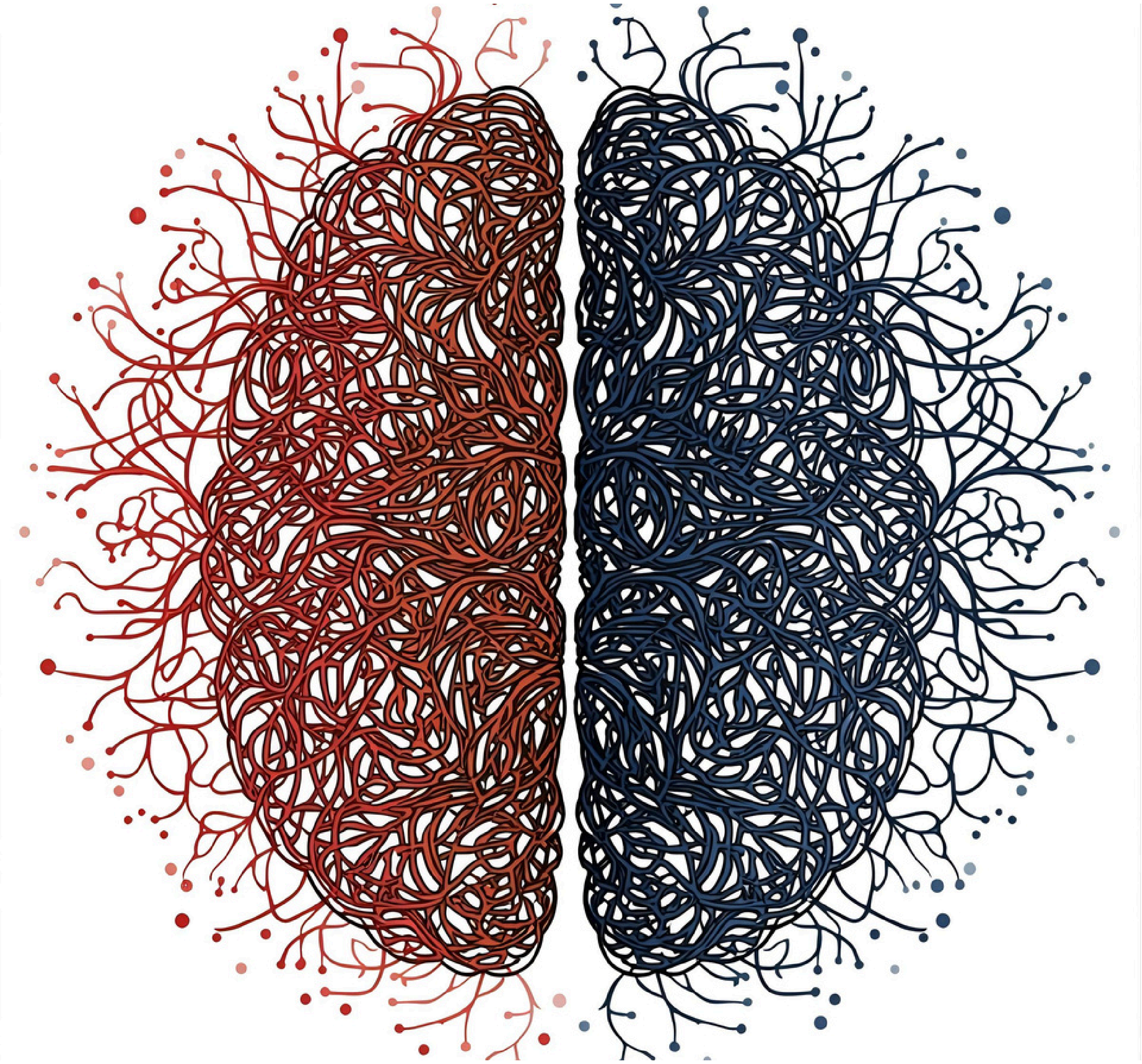
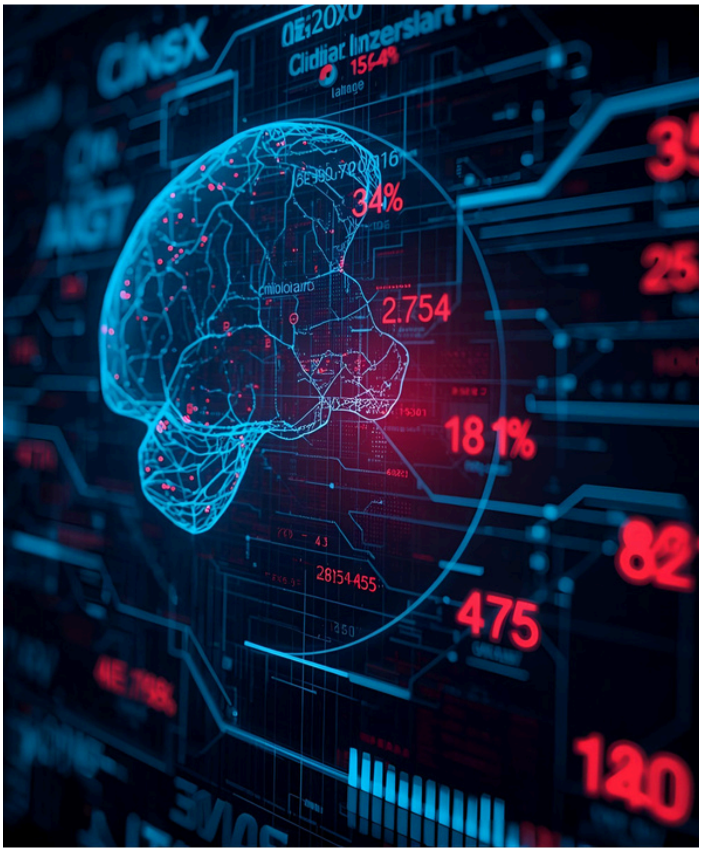
‘Guilty beyond reasonable minds? The clinical assessments of Notorious Killers.’

BY STEPHEN KING



What separates the criminal from the clinically unwell? In the courtroom, the answer can mean the difference between a prison sentence and psychiatric commitment- justice or treatment. True crime stories thrive on this conundrum. The idea that behind every murder may lie a tortured psyche, or worse, a mind completely in control.
When faced with notorious killers like Ted Bundy, who charmed and killed with apparent ease, or Jeffery Dahmer, who spoke openly about his remorse, we're confronted with the difficult question: Were they mentally ill, bad, or both? And how do we go about answering this question?

This article explores the blurred lines between mental illness and criminal sanity in line with some of history's most infamous serial killers. Drawing on psychological diagnoses, family history and courtroom outcomes, we will examine how clinical psychologists attempt to make sense of these senseless acts. What tools, criteria and ethical challenges do they face when the stakes are this high?



Ted Bundy: The Disturbing Face of Sanity

Ted Bundy has long occupied public interest: a law student who was articulate and charming, however, committing a long series of murders across the U.S. in the 1970s. Aside from his brutal crimes, what makes Bundy particularly unsettling is the contrast between his public persona and his actions; he appeared to be intelligent, composed and crucially, sane. From a clinical psychology perspective, Bundy's case raises pressing questions about culpability. Though never officially diagnosed, many clinical psychologists believe him to have had Antisocial personality disorder (APD) which is defined as "the ongoing disregard for the rights of other people, as well as the consequences of actions" (American Psychiatric Association, 2013).

This definition aligns with the atrocious acts he committed, highlighting his lack of empathy and disregard for social norms. However, Bundy himself was insistent that he was in control of his behaviour, rejecting the insanity plea. Though a bold decision, this was just one example of the audacious self-confidence Bundy displayed during court. From acting as his own lawyer to charming journalists, he performed with the composure of somebody disturbingly self-aware, adding weight to the argument that he knew right from wrong.

Bundy's case illustrates a key challenge that clinical psychologists face- do all mental disorders impair a person's ability to distinguish right from wrong? APD, which many suspect he may have had, does not necessarily imply a lack of legal culpability, nor can it be used in support of an insanity plea. Due to its stability in patterns of displayed behaviour, it isn't seen as a severe mental illness that impairs one's ability to understand and control their actions- both criteria that are central to the legal definition of insanity.

As such, individuals with APD, like Bundy, may still be seen as fully capable of distinguishing right from wrong and behaving with intent. This makes the disorder relevant in a clinical psychologists' assessment of an offender, but rarely a basis for a successful insanity defence. This, along with Bundy rejecting the insanity plea, led to his sentence of guilty beyond reasonable doubt.

Andrea Yates: When mental illness meets the law

In 2001, Andrea Yates drowned her five children in the bathtub of their Texas home — an act so horrifying it stunned the world. But unlike Bundy, whose behaviour suggested calculated intent, Yates's case forced the legal system to confront the devastating effects of mental illness on culpability. She had been diagnosed with postpartum depression and postpartum psychosis (American Psychiatric Association, 2013), conditions that can cause delusions, paranoia, and hallucinations — often involving the belief that harming oneself or others is necessary or even morally right.

Yates had been in and out of psychiatric care for years, with repeated hospitalisations and suicide attempts. Her husband and doctors were aware of her declining mental state, but the full consequences weren't realised until it was too late. During her trial, Yates initially pleaded not guilty by reason of insanity.

However, the jury rejected the plea, in part due to the testimony of forensic psychiatrist Dr. Park Dietz, who incorrectly claimed that Yates may have gotten the idea for her actions from an episode of Law & Order. That episode didn't exist, and Dietz's testimony was later discredited (Resnick, 2007).

Yates was convicted of capital murder and sentenced to life in prison. But on appeal, her conviction was overturned due to the false testimony, and in 2006, she was found not guilty by reason of insanity and committed to a high-security psychiatric hospital (CBS News, 2006).

Her case demonstrates the complexity of assessing legal insanity. The standard isn't simply the presence of a mental illness, but whether the disorder was so severe that it impaired the person's ability to understand the nature or wrongfulness of their actions at the time (Bartol & Bartol, 2018). In contrast to Bundy, Yates was consumed by psychosis — she believed she was saving her children from eternal damnation. For clinical psychologists, this distinction — between choosing to kill and being compelled by delusion — is fundamental but rarely clear-cut.

Where does Clinical Psychology stand?

For clinical psychologists, the task of distinguishing between criminal intent and psychiatric impairment is both essential and fraught with complexity. Bundy and Yates sit on opposite ends of a spectrum — one disturbingly in control, the other consumed by psychosis — yet both demand careful psychological evaluation. These cases underscore how vital clinical assessments are in shaping legal outcomes, and how difficult it is to diagnose under pressure. When the stakes are this high, the insights of clinical psychologists are not just helpful — they are indispensable to justice.

‘REWIRING THE BRAIN’: HOW THERAPY AND MEDICATION CAN REWIRE YOUR BRAIN

BY BHOOMI DHARIWAL

Rewiring the brain is a captivating concept grounded in the scientific reality of neuroplasticity - our brain’s remarkable ability to reorganize and adapt throughout life (Kukreja., & Manoharan., 2025). This science breaks the myth that our brains are ‘set in stone’ after childhood and underpins why therapies and medications can play such a powerful role in healing and transformation. In practical terms, rewiring means that our neural circuits can change their structure and function in response to experiences, injury, mental illness, or intentional interventions. Modern therapeutic approaches and pharmacological treatments take full advantage of this phenomenon to help people recover abilities, gain resilience, and improve mental health.

Neuroplasticity is more than just a term - it’s the literal remodeling of your brain’s pathways. Imagine the brain as a bustling city filled with roads and intersections. Over time, traffic patterns (our habits, thoughts, and movements) carve deep grooves into some roads, while others stay underused or become overgrown. With neuroplasticity, therapy and medications can spark construction crews to build new roads, repair old bridges, or even turn existing alleyways into highways, reshaping how the city, and your mind, functions. The first mechanism at play is structural plasticity, where actual physical changes like new neural connections or the sprouting of new dendrites occur in response to stimulation. Functional plasticity allows other brain regions to pick up the slack if one area is damaged, similar to how a detour route forms after a street closure. Synaptic plasticity, frequently observed in learning and memory, deals with strengthening or weakening specific circuits based on repeated use (Gage, 2004).

Therapy is a primary tool for harnessing plasticity (Kolb & Muhammad, 2014). Cognitive behavioral therapy (CBT), for example, doesn't just teach you to think differently - it alters the circuitry involved in emotion and decision-making. With repeated practice and guidance, brain imaging reveals measurable changes, a kind of neural fingerprint of the new skills and coping strategies people acquire. Everything from learning a new language to systematically confronting phobias makes use of this process. In the setting of neurological injury, such as stroke or trauma, rehabilitation therapy uses 'use it and improve it' principles, encouraging repeated, goal-directed practice to push the brain to reassign tasks across damaged and healthy regions (Kolb & Muhammad, 2014). This method is not about brute force - it's about targeting specific outcomes with intentional practice, which guides the brain's under-construction zones toward optimal rerouting. Physical activity, generally, is now known to increase helpful growth factors like BDNF, which acts almost like fertiliser for neurons, allowing new connections to flourish and old ones to recover (Kumar et al., 2023).

Medication can also facilitate rewiring, often by priming the brain's environment for change (Cramer et al., 2011). Treating depression with selective serotonin reuptake inhibitors (SSRIs), for instance, not only corrects chemical imbalances but elevates neurotrophic factors that support neuron growth and connection. Consistent use of these medications has been shown to boost neurogenesis, particularly in memory-critical areas like the hippocampus. In recovery from injury, medications that stimulate neurotransmitter production or increase cortical excitability can temporarily boost the brain's readiness to learn and change, making concurrent rehabilitation exercises more effective. There's an important partnership at play —while medication prepares the brain's soil, therapy plants the seeds and tends the garden, guiding changes toward functional gains.

Some treatments combine the effects of therapy and direct brain modulation (Cramer et al., 2011). Noninvasive techniques like Transcranial Magnetic Stimulation (TMS) use targeted magnetic pulses to excite or calm specific neural networks (Bandaru & Sivarajah, 2025). Repeated sessions can strengthen or weaken problematic circuits, offering relief in conditions like depression or chronic pain where traditional therapy and medication may have stalled. Analogies help underline these ideas: rewiring the brain can be compared to renovating a house while living in it. Therapy is like rearranging furniture, breaking down partitions, or fixing faulty wiring, while medications provide the materials and tools to make this work smoother and more likely to stick.

The process of actual 'rewiring' involves long-term potentiation (LTP) - making synaptic highways quicker and more efficient through repeated use, as well as the creation of completely new pathways via synaptogenesis (Kukreja., & Manoharan., 2025). Dendritic branches grow, bringing more communication points and, in some areas, entirely new neurons can be formed. These changes can be seen on brain scans and, even more importantly, manifest in real-world improvements: a patient regaining speech after a stroke through hard work in therapy, or someone overcoming persistent anxiety after a course of CBT and medication. The most successful results often arise from the synergy of methods, with medication amplifying the effects of guided practice or therapy, each approach reinforcing the other's gains (Kumar et al., 2023).

Examples are everywhere. In depression, therapy teaches new coping strategies, while medication helps reverse stress-induced shrinkage in emotional and executive brain regions (Gage, 2004). Patterns of overactivity in negative-thinking centers and underactivity where motivation resides can normalize as symptoms improve. After a stroke, targeted exercises retrain movement, harnessing undamaged brain regions to compensate, sometimes propelled by medications that boost dopamine or other chemical messengers. In obsessive-compulsive disorder, behavioral exposures rewire ingrained loops, breaking the cycle of compulsion and fear. Even healthy aging benefits, with exercise, social engagement, and learning warding off cognitive decline by maintaining brain plasticity.

Despite this massive potential, there are boundaries. Severe neural damage, late-stage neurodegenerative diseases, and advanced age can limit the degree of structurally meaningful recovery. Still, remarkable progress can be made with persistence, and the science of neuroplasticity challenges assumptions about what's possible at any stage of life. The topic also raises ethical conversations about enhancement versus therapy and questions about fairness and access.

Looking ahead, the future of brain rewiring lies in customization. Emerging technology allows for detailed mapping of individual neural architecture, letting clinicians craft interventions targeted to a person's unique brain patterns. Ongoing advances in wearable technologies and digital therapeutics mean that access to neuroplastic interventions may expand to a global audience, making rewiring possible not just in clinics, but also at home.

The science of neuroplasticity and the combined power of therapy and medication reveal a hopeful message:

the brain is adaptable, resourceful, and ready for change given the right support. Whether facing psychological distress, recovery from physical injury, or just striving to learn something new, understanding how to nurture and direct this flexibility can mean the difference between stagnation and transformation. As research continues and techniques become more precise, the capacity to intentionally rewire the brain for health and fulfillment will likely only grow, offering opportunities for healing and growth that past generations could scarcely imagine.

THE END OF THE SSRI ERA? PSYCHEDELICS AND THE NEW HOPE FOR DEPRESSION TREATMENT

By Amelia Savage

Everybody knows depression. It is a disorder that afflicts 280 million people globally (World Health Organisation. 2023) and is characterised by symptoms such as anhedonia, insomnia and suicidal ideation, among others (Diagnostic and Statistical Manual of Mental Disorders 5th ed,. 2013). Yet, despite the global burden this disorder has created, progress in developing novel antidepressants has been rather stagnant since the discovery of selective serotonin reuptake inhibitors (SSRIs) almost 40 years ago (Bullmore. 2018). Therefore, it is time to start considering alternative treatments to this debilitating disease and recent findings suggest that psychedelic drugs may be an effective way of doing so. Whilst it must be acknowledged that these kinds of drugs have been used in spiritual practices for centuries by ancient civilisations such as the Mayans, located in what is now southern Mexico (Principe. 2022), it is only within the past couple of decades that they have been considered a promising route of psychological treatment in mainstream western healthcare.

According to the Alcohol and Drug Foundation (2025), psychedelic substances are defined by their tendency to alter an individual's sensory perception, emotions, and cognition, including the potential to induce hallucinations. For the purpose of this article, the focus will be on a specific psychoactive substance known as Psilocybin, a type of drug that is colloquially known as ‘Magic Mushrooms’ as this is most commonly used in therapeutic settings. Biologically, Psilocybin itself is relatively inactive in altering cognition or perception. This is because it is metabolized by the liver into psilocin, the compound responsible for its psychoactive effects. Psilocybin closely resembles the neurotransmitter serotonin and acts as a serotonin receptor agonist, resulting in changes in mood, perception, and cognition (Principe, 2022). Clinically, this psychedelic-induced reaction is thought to have an antidepressant effect. Psilocybin has been shown to alter cerebral blood flow to the Amygdala and Posterior Cingulate Cortex, regions of the brain thought to be hyperactive in individuals with depression, thereby reducing this hyperactivity and improving mood. Furthermore, depressed individuals often exhibit hyperconnectivity within the default mode network (DMN), which is associated with depressive rumination. Psilocybin has been found to decrease cerebral blood flow to this region, helping restore brain activity to a healthier baseline which therefore reduces depression symptoms (Ling et al., 2022).

In their systematic review of the use of Psilocybin in depression treatment, Watford et al. (2022) found that all six studies reviewed reported significant improvements in depressive symptoms following Psilocybin administration. Notably, these effects persisted for several weeks after the final treatment session. Additionally, emerging evidence indicates that psychedelic-assisted therapy may be particularly effective for individuals with treatment-resistant depression (those who do not respond to conventional interventions such as SSRIs). For example, Carhart-Harris et al. (2017) conducted a study in which participants with treatment-resistant depression received two oral doses of Psilocybin (10 mg and 25 mg) spaced one week apart. The researchers observed marked reductions in depressive symptoms up to five weeks post-treatment, and follow-up assessments at six months indicated that these improvements remained significant. Therefore, Psilocybin may represent a promising and durable alternative for individuals who have not benefited from existing antidepressant therapies, consequently filling a gap in current medical treatments.

However, despite a lot of supporting literature for this novel treatment, one must consider the possibility of publication bias. This is the phenomenon whereby studies reporting null or adverse outcomes may be underrepresented in the literature, as positive findings tend to generate more academic and public interest. In an effort to address this issue in psychedelic research, Marrocu et al. (2024) conducted a meta-analysis involving over 800 participants across multiple psychedelic therapy studies. They specifically chose to focus on ‘negative responders’ in this study, which are those that experienced a clinically meaningful decline in psychological well-being following psychedelic treatment. Whilst such adverse outcomes were rare, 16% of the sample population did experience prolonged negative effects as a result of the treatment. Additionally, further analysis revealed that a third of ‘negative responders’ had a pre-existing diagnosis of a personality disorder meaning that this may be a risk factor for poor outcomes of psychedelic drug therapies. Overall, the significant mental decline that can be caused, albeit rarely, by drugs such as Psilocybin highlights the need for further research in the field before it can enter mainstream medicine.

To conclude, as the limitations of existing antidepressants become apparent, the search for alternative methods of treatments has never been more urgent. Psychedelic drugs such as Psilocybin offer a promising solution, with recent research indicating their effectiveness in causing a long term reduction of depressive symptoms, especially within treatment-resistant populations. However, while the therapeutic potential of Psilocybin is compelling, it is essential to approach this emerging field with caution. Concerns such as publication bias and adverse outcomes in vulnerable populations must be taken seriously. Ultimately, Psilocybin and psychedelics in general may well represent the dawn of a new era in depression treatment, but further research is still required before it can be safely administered into mainstream healthcare.

One Size Does Not Fit All – Rethinking Mental Health Services for Autistic Individuals

By Julia Zurawska

For most of my life, I felt different from those around me, but I didn't understand why. I struggled to make friends, felt constantly overwhelmed and used masking to fit in. My mental health declined rapidly in my teenage years and despite years of therapy and medication, nothing seemed to help. It was only when I was diagnosed with autism at university, that things finally began making sense, including why traditional mental healthcare hadn't worked for me. This experience is unfortunately common for autistic people, as the current mental health system is not designed with us in mind.

While autism is not a mental health condition, almost 80% of autistic people experience mental health problems in their lifetime. These are most commonly anxiety and depression, but autistic people also have higher rates of psychosis and eating disorders (Lever & Geurts, 2016). Also, it's common for autistic people to face stigma and discrimination, which can increase feelings of isolation and poor mental health. As a result, autistic people have a diminished quality of life, struggling to access employment and at much greater risk of suicide than the general population (O'Halloran et al., 2022). Despite these unsettling figures, mental health services are often unhelpful for autistic people and may even cause additional distress.

Being autistic can bring unique challenges to accessing mental health services. Alexithymia is a common trait in autistic people, which makes it difficult to identify and express emotions (Bird & Cook, 2013). This can make therapy difficult as underlying emotions are often explored in common treatments such as Cognitive Behavioural Therapy (CBT). Another challenge is that much of the early research on autism involved white males, so diagnostic tools may be less sensitive for women and people from other ethnic backgrounds, leading to underdiagnosis (Williams, 2022). Shockingly, 80% of autistic women are diagnosed after the age of 18 and are often misdiagnosed with other conditions such as Borderline Personality Disorder (McCrossin, 2022). Having undiagnosed autism can lead to more mental health difficulties, difficulties forming relationships and feeling alienated. Therefore, it is important that people can be diagnosed with autism, so they can better understand their needs and access the appropriate support.

Even more challenges are found in accessing mental health support as an autistic person. Worryingly, less than a fifth of autistic people have reported positive experiences with mental health services (Autistic Mutual Aid Society Edinburgh, 2018). Some people even reported being denied mental health support, as their autism diagnosis made their case too 'complex'. A common fear among autistic people is that they will not be understood by mental health professionals, especially if this has happened in the past. Professionals themselves may lack knowledge about autism and not be aware of how they can best support autistic patients (Corden et al., 2022). A lack of appropriate support can make people feel isolated and hopeless, or like they are being 'difficult' which may further deteriorate their mental health.

It is clear that mental health services are failing autistic people – but what can be done about this? Making reasonable adjustments to services is key to making them more accessible and effective. Firstly, the environment should be considered to avoid distractions and sensory overload. This may involve reducing clutter, dimming lights and avoiding strong perfumes. Autistic people may experience communication differences, so the way staff interact with them is important. This could involve utilizing clear and concrete language, highlighting that eye contact is not mandatory and allowing more time for individuals to process information. Lastly, it is vital that staff in mental health services receive adequate training on autism, to understand how this can affect mental health and accessing services. Of course, the best way to meet an individual's needs is to ask them what they require, as no two autistic people are the same. This is not an exhaustive list of accommodations for autistic people, the 'Good practice guide for mental health professionals' by the National Autistic Society is a useful resource for anyone wanting to know more.

Fortunately, services within the NHS are becoming aware of the difficulties autistic people face in accessing care and are tailoring their approach accordingly. Autistic people have a greater risk of developing anorexia nervosa and have worse recovery rates and long-term outcomes than their non-autistic peers (Lepananen et al., 2022). The South London and Maudsley NHS Trust has developed a specialised pathway for autistic people within their in-patient eating disorder service. All individuals referred to the service are now screened for autism, to allow for identification of autism and appropriate adaptations to be put in place. At intake, patients complete a sensory screener, and a communication passport is created to make staff aware of their sensory and communication needs. In addition, a sensory-friendly menu was created for autistic patients, making mealtimes more predictable and less anxiety-inducing. Since the implementation of these adaptations, hospital stays for autistic patients have been reduced from 16 to 13 weeks (Tchanturia et al., 2021). Furthermore, staff also found these changes increased their confidence and knowledge in supporting autistic people with eating disorders (Li et al., 2024). This shows that simple changes to services can be highly effective in improving outcomes for autistic people.

In conclusion, at present autistic people are disproportionately affected by mental health issues and do not always have access to appropriate care, which affects their quality of life. However, I truly believe that there is hope, as the understanding and awareness of autism improved in recent years, including the diverse ways in which autism can present. More mental health services need to follow the lead of the South London and Maudsley Trust to break down the barriers autistic people face and make treatment more inclusive. As the main stakeholders, autistic people should be involved in research and have a voice in improving guidelines for mental health services so they can benefit from services and thrive. Autistic people are not being 'difficult', our needs are simply not being met by mental health services because one size does not fit all.

INTERVIEW EXCLUSIVE

Rethinking Reality: Dr. Clara Humpston on Self, Schizophrenia, and Soundless Voices

Written by Caoimhe Farrelly

What is your current position here at the university, and what is your research focus on?

I am a lecturer who specialises in mental health research, and I have been at York since April 2022. My focus is almost solely on Schizophrenia-spectrum psychoses; including schizophrenia, Delusional disorder and to a lesser extent Schizophreniform [disorder] and schizo-affective disorders. These are the kind of psychotic disorders, I would say, damage and distort how reality is processed, perceived, and viewed by your brain/mind.

I do my research from an interdisciplinary perspective - I'm not limited to a particular discipline or methodology. My own background is a mix of pharmacology, neuroscience, phenomenology, philosophy and chemistry - all sorts of disciplines that some would say are quite incompatible. This has given me insight into how we can use multiple levels of explanation to tackle the same problem. Because for me, one size does not fit all; it's not just a brain or just society, it's not just anything. That's why I think my multifaceted background can really help.

Within the psychology department - what teaching do you currently do?

Since I started at York, I've been teaching a third year advanced module in schizophrenia and psychosis. Which, even from its inception, has attracted a high number of students (40 every single year, even with a waiting list). It's been really popular and really well received as well. It is really heartening to see the students being so engaged and really keen to take part in discussions and ask questions. Some of them even enrolled on the new Masters of Psychology of Mental Health, where I teach a module on severe or serious mental illnesses. So that's not just schizophrenia, but also includes bipolar disorder. I'm not a specialist in bipolar, I have some knowledge of it, so I'm happy to teach bipolar and schizophrenia. But granted, it's probably more schizophrenia than bipolar, where my interest lies.

I also teach psychopharmacology, so that's how psychiatric drugs work, to first year medical students at the Hull York Medical School. Which is by invitation, because they somehow found out that I had a background in psychopharmacology.

So I think I'll just keep doing all of these things every single year, which is a lot. Especially when it comes to marking and feedback, but I really love it. Nothing pleases me more than hearing my students say 'you inspired me to do a PhD' or 'you inspired me to do further education'.

You've challenged the conventional notion of auditory hallucinations with the idea of 'soundless voices.' Could you walk us through this concept and what led you to it?

It's actually one of the very first, earliest conceptualisations of auditory verbal hallucinations, particularly applying to schizophrenia as opposed to other disorders. So when people think of hearing voices or auditory hallucinations, they assume it's as clear as everybody else talking. However, this is only the case in a minority of patients. But mostly, it's almost thought-like. It's in this really bizarre in-between space between thought and perception. So it's not truly a thought, neither fully inside your head or absolutely silent. But every one of us has an inner voice, which is like a soundless voice; In patients, the sense of agency is lost. So it's like inner dialogue has lost the sense of self.

Soundless voices was actually first coined by Breuler, who also coined the term schizophrenia as well. Even before Breuler, the definition of a hallucination in general was created by a psychiatrist called Esquirol, and it was never so much about perceptual qualities, but was more about a strong conviction. So you believe strongly that you've been given a message, you heard something, you perceive something rather than the current DSM diagnostic criteria where hallucinations have to have reality based auditory qualities.

Phenomenology work and really talking to patients led me to this conclusion. You have to ask the right questions, because for current clinical practice, it's a tick box exercise, which is really sad in my view. In these psychiatric assessments, they ask binary questions like 'do you hear voices?'

when it's never as simple as that. Because these methods are binary, the follow up question would be, if the patient said yes, 'are they as clear as I'm talking to you now?' And that's a crucial distinction, which is often not dealt with effectively. Most patients will be unsure how to respond, then suddenly it's not schizophrenia anymore, it's something to do with personality disorders etc. So it's deemed a pseudo hallucination. Suddenly your experiences don't count anymore. So it's really, really bad. And I think that's partly because most clinicians don't focus on phenomenology.

You've also written extensively on disruptions of first person authority in psychosis. How do you conceptualise the relationship between altered self-experience and the phenomenology of hallucinations?

I think in terms of the phenomenology of hallucinations and delusional thinking, this disruption of first person authority (also sometimes called a basic self-disturbance) is a fundamental distortion or transformation in not just what you perceive, but how reality, your thoughts, your perceptions, and your actions are given to you. For example, when I'm talking and you are looking at me, you wouldn't necessarily wonder or doubt, 'is that me?' 'Is it really me?' 'Who's doing the talking here?' 'Am I really seeing Clara here?'. This really basic first person authority is what everybody takes for granted. It's not absent entirely, but strangely and heavily damaged in schizophrenia. That to me is the most fundamental aspect of the condition.

In fact, epidemiology and neuroscience have shown that basic self-disturbance have this symptom, they have a higher specificity towards schizophrenia spectrum diagnosis; whereas delusions and hallucinations can occur in a multitude of other conditions as well, like brain damage, brain injury, Parkinson's, Alzheimer's, eye disease. So it's not specific enough for schizophrenia.

So even throughout the 50s and the 60s, soundless voices and so-called first rank symptoms, i.e. thought insertion (believing that a thought in my head is not mine) or thought broadcast (my thoughts can be projected on the screen for everybody to see) all revolve around ego boundary disruption. This invisible permeable boundary between what's yourself and what's other people.

It's really a neglected heritage in psychiatry research, but I'm proud to say some of my own work has contributed to this revival. Self-disturbance was listed as one of the key features of schizophrenia in a paper that was endorsed by the pioneers of this field. It actually cited my papers as evidence that self-disturbances define schizophrenia more than hallucinations and delusions.

Your 2022 paper discusses "ontologically impossible" states of experience in schizophrenia spectrum conditions. Could you clarify what you mean by this term, and its relevance to psychopathology classification?

That's my own term actually! Ontology is a philosophical tradition that studies existence.

Ontologically impossible means it cannot possibly be true or exist in this commonsensical, boring, mundane reality. So an example would be very bizarre delusions or hallucinations that defy the laws of physics, logic, and the so-called corporeality (bodily limitations). So some patients with schizophrenia would say they can feel a planet in their stomach, which is clearly not ever going to happen. But it's very real to the patient, almost like a revelation.

And that comes from the Conrad model of beginning schizophrenia - a delusion dawns on you and reveals the ultimate truth i.e. I do have the moon in my body or my head is replaced by something else. And that's usually more interesting than this boring, everyday reality for patients.

Sometimes people can have solipsistic delusions, meaning 'I am the only one in the world', 'only my mind can tell what reality is'. Solipsism is the idea that there's nobody else, I am the ruler of the universe and the only one that exists. I also wrote about the paradox that's intrinsic to such experiences and to me forms part of the core of schizophrenia psychopathology, as opposed to other disorders, which is how it contradicts self-disturbance. Because if you were truly the only mind, what's to prove that you are actually there. So to be solipsistic, paradoxically, requires the presence or the observation of something else, which defeats the whole point of being the only entity in the universe. I would say these are out of this world experiences, language can't do it justice. This has implications for measurements and experiments. Is it because patients can't do these tasks or is it because their mind is literally somewhere else?

You often combine brain science with philosophy in your work. That's not something we usually see together. How does this help you understand what it's really like to live with schizophrenia?

Some people will say neuroscience and philosophy are not compatible. One is very empirical, it's numbers, it's brain structure, it's very physical. And philosophy or phenomenology is very, in some people's opinion, very subjective, fluffy and even fairytale-like. Some don't believe there is value in combining the two because it's not possible. Even patients themselves are sometimes divided on how they see their own condition, because there are people who tell them there is no biological basis to mental illness, which is clearly not the case.

I don't think we can ignore one or the other. Brain science and philosophy can inform and improve each other. For example, self disturbances also come from the brain; not necessarily a particular region of the brain, but perhaps because of how the brain processes information as a whole. The brain sits in an intersubjective world, so how our sense of self and reality are formed (and how this can be impacted by others and society) in the brain is important to understand. As Karl Jaspers says, the 'soma and psyche as an inseparable unity'.

You've given public talks like "Rethinking Schizophrenia." If you could change one thing about how the public sees schizophrenia, what would it be?

The public has a lot of misconceptions about schizophrenia. I recently did a school outreach talk and a teenager said 'doesn't schizophrenia make you dangerous?'.

Schizophrenia is mysterious, so it's very hard (because of these ontologically impossible reports and experiences) for the public to see themselves in that position, holding those beliefs. When people don't understand something, they tend to romanticise or stigmatise it.

The public needs to see schizophrenia as a condition, and see the human side of it. Schizophrenia doesn't automatically make anyone a mad genius or a violent unpredictable serial killer. It affects different people differently. So we need to look at the person as the centre of everything we do when trying to understand and help this person.

It's easier to reduce stigma around depression as most people have felt sad or low before, but not everyone has experienced hallucinations or delusions, so it's a lot harder to empathise and put yourself in those shoes.

You teach and mentor students at the University of York. What advice would you give to someone who wants to research mental health but doesn't know where to start?

Firstly, have a good undergraduate degree, not necessarily psychology (mine was in pharmacology) it could be in neuroscience or even a combination of all these subjects.

You have to have a lot of perseverance, resilience, and determination. It's not an easy ride by any means and it can be extremely difficult to keep focused and not give up, especially when things don't go to plan. I did not get a 1st class but my BSc project getting published really helped my career. Degree classification isn't everything, looking up authors from publications, attending conference networking can get you where you want to go. I met Tony David and Robin Murray, some of the most famous psychiatrists in the country, as an undergraduate. Tony David is still my mentor 20 years later, and we still speak often about our careers. Never be shy, reach out to academics who inspire you and you want to work with.

If you never try, you never get!

How do studies like yours help improve diagnosis or therapy for people with psychosis? What can change when we understand symptoms in more depth?

My hope is to bring back self-disturbance to the core of schizophrenia diagnosis as I believe it's very specific to schizophrenia if measured properly. The DSM is still quite opposed to phenomenology in some cases, but The ICD 11 mentions self disturbance as a feature of schizophrenia, partly due to work by myself and my colleagues.

Human experience should always be on the centre stage. Once we start speaking to patients properly and giving them the due care and attention, we will gain incredible insight. For example, I have close colleagues in Norway, who are conducting a clinical trial for treating self-disturbance through psychotherapy.

There are far more we have in common with patients than we think. We all value the same things; family, friends, stable jobs, we all want a happy fulfilling life. Society's treatment of the mad is a mirror to the minds of the 'sane', people hide from the gaze of the 'mad' because they're scared to see themselves in their eyes.

Do you have any ongoing research projects?

I'm working with YNiC on an MRI study, looking at traits in nonclinical individuals related to self-disturbance and relationships with measurements of self disturbance, and brain functioning and structure in terms of connectivity and covariance.

I'm also submitting a grant next year to study Schizophrenia outcome predictions using a Norwegian birth cohort and patient registry. It has been tricky to get funding for this, which highlights how important resilience is.

I am also a proud member of the Hallucination Consortium - I brought an international conference to our department a couple of years ago!

PSYCHOLOGY IN ACTION: MY EXPERIENCE WORKING AS A MENTAL HEALTH HELPLINE VOLUNTEER."

BY GRACE SPARK

Content Note: This article contains themes of mental illness, suicide, and discrimination. A range of support resources is listed at the end for anyone affected by these topics.

Work experience — it's a must for anyone hoping to pursue a career in clinical psychology. Myself being such a person, I spent a large portion of first year browsing handshake and the psychology opportunities and placements board. Eventually I came across an advert for a charity looking for volunteers to help run their social media page which aimed to support individuals struggling with their mental health.

The role involved creating and sharing positive or helpful resources, as well as staffing a 24/7 chat box. Working for a support line is a great way to improve your interpersonal skills, creativity and your ability to come up with solutions or advice quickly during sensitive situations. The charity I worked with required us to complete a series of online courses about suicide prevention and how to reduce the stigma around mental health. It was cool to be given the opportunity to access these resources, and I learnt a lot from them.

The volunteering itself was incredibly rewarding, and it felt nice to know I was supporting people in need. Taking a more hands on approach meant I gained a new perspective on people's everyday experiences with mental health. For those who want to apply for a clinical based job or course at the end of their degree, you will know it's important to find work experience which can supplement your academic knowledge, and this role really did that for me. Overall, I cannot recommend working with a helpline enough to anyone considering a future in clinical psychology, or any sort of field working with vulnerable or disadvantaged individuals.

Now, I'd like to use the second half of this article to discuss an important issue which became deeply important to me during my time volunteering.

There's a stigma around mental health, and I am sure that most people are aware of this. I knew it, even before I started volunteering. But having gained the experience I have now, I look at this topic from a new perspective.

magine this: it's time for my first shift, and of course I'm nervous. I have spent days reading and re-reading the charity's guidance booklet, compiling resources, and practising what I might say. Would I be helpful? Would I say the right thing? Poised at my laptop, I waited for the first notification in the chat box. It started with:

"I'm sorry to bother you, I know it's silly..."
It was the first of many messages, all sharing a common belief — that their struggles were a burden, unimportant, or not serious enough to deserve help.

"I know everyone gets depressed sometimes" ... "So many people have it worse" ... "I shouldn't feel this way" ... "I usually just deal with it on my own" ...

I asked myself, is this feeling really so common? A quick deep dive online confirmed that yes. Yes, it is.

According to the most recent report released by the Mental Health Foundation, 75% of people experiencing mental health concerns don't access the help they need. Why? Well, with mental health being so diversely experienced, there are many possible factors. Men are statistically less likely to seek help, as are members of marginalised groups like LGBTQ+ or BAME and access can also depend on where you live, how you were raised, and other systemic barriers. While I fully acknowledge the impact of these factors, this article will focus specifically on self-stigma as a barrier to accessing mental health resources. The one thing I sincerely hope to achieve by writing this article, is that if someone experiencing poor mental health reads it, they will feel empowered and more comfortable to explore the support available to them. Because mental health resources are more accessible than you may think, and they are for everyone.

Okay, let's start with a brief look at some background research on this topic. Self-stigma is defined as the internalisation of negative attitudes towards seeking psychological help, as well as lowered mental health literacy (Gündoğdu, Aslan & Ayhan, 2024). Essentially, people experiencing self-stigma may not try to understand what they're going through and often don't reach out for help. Among university students, self-stigma has been shown to reduce the likelihood of using campus counselling services (Lannin et al., 2016). The concept of deservingness is one of the main factors contributing to self-stigma, with individuals experiencing depressive symptoms often internally debating if they 'deserve to be depressed' and comparing their own experience to others, (Snell-Rood & Carpenter-Song, 2018). This is a harmful mindset which inhibits help-seeking behaviours. Consequently, even casual or non-clinical support (like the helpline I volunteered for) can feel off-limits to individuals questioning whether they're "unwell enough" to be deserving of it.

What I Saw Firsthand

In my time volunteering, I began to see how deeply rooted this issue is. Service users cited endless reasons for not seeking support sooner, but I remember a great deal of them revolving around feeling their problem was not important enough, and that smaller mental health issues must be dealt with alone, while resources should only be accessed by those experiencing the most acute difficulties. The extent of the damage self-stigma of this nature causes often seemed to go so far that many individuals delay seeking support until they reach a crisis point, such as experiencing suicidal thoughts. This delay caused manageable issues to escalate into severe conditions, making emergency intervention the only remaining option. On more than one occasion I spoke to someone who described having experienced minor (but still important!) mental health concerns in the past, which had become unmanageable by the time they sought help. Sadly, in many of these cases all I could do was urge the service user to contact emergency services due to the serious nature of their condition.

The charity I worked for did its best to share important resources: wellbeing activities, coping methods, guides and advice focusing on an array of different conditions. As much as we did try to provide support to those experiencing more advanced issues, these kinds of resources are most effective before a situation becomes a crisis. This is why it's so important to explore the resources available to you early on, if you begin having concerns about your mental wellbeing.

So what Can We Do?

Challenging mental health stigma might feel overwhelming, but recent evidence shows it is possible. Programmes within educational institutions, which on raising awareness of mental health issues (Mental health awareness campaigns), lead to positive changes in the attitudes, beliefs and intentions of young people by reducing stigma and increasing help seeking behaviours (Tam et al., 2024).

But what can you do, on a personal level?

For yourself: Don't wait. You don't need to be "at your worst" to deserve support. These resources are there for a reason, use them. And if you're ever unsure whether what you're experiencing is "serious enough," to be taken seriously and handled with care, please know — it is. I've worked with an incredible team of volunteers who are genuinely passionate about helping. We love what we do, and we want to help no matter how small or confusing you feel your experience may be.

For others: In terms of others around you, if you feel someone in your life may be going through a tough time, just talk to them! Whether it's simply a quick 'Are you ok?' or signposting them to helpful resources. It all makes a difference. Speaking openly about mental wellbeing is the first step towards reducing all kinds of stigma around mental health, whether they are self-imposed or not. It can be intimidating to make the leap and be open about mental health, but by reaching out you could help that person feel less isolated, and a little more hopeful.

Every time you ask someone how they're really doing you play a role in dismantling the stigma around mental health, you make it more normal to talk about it, meaning that people who need help might be more willing to seek it out and get the help they need.

And that's pretty powerful, I think.

Further information on mental health support:

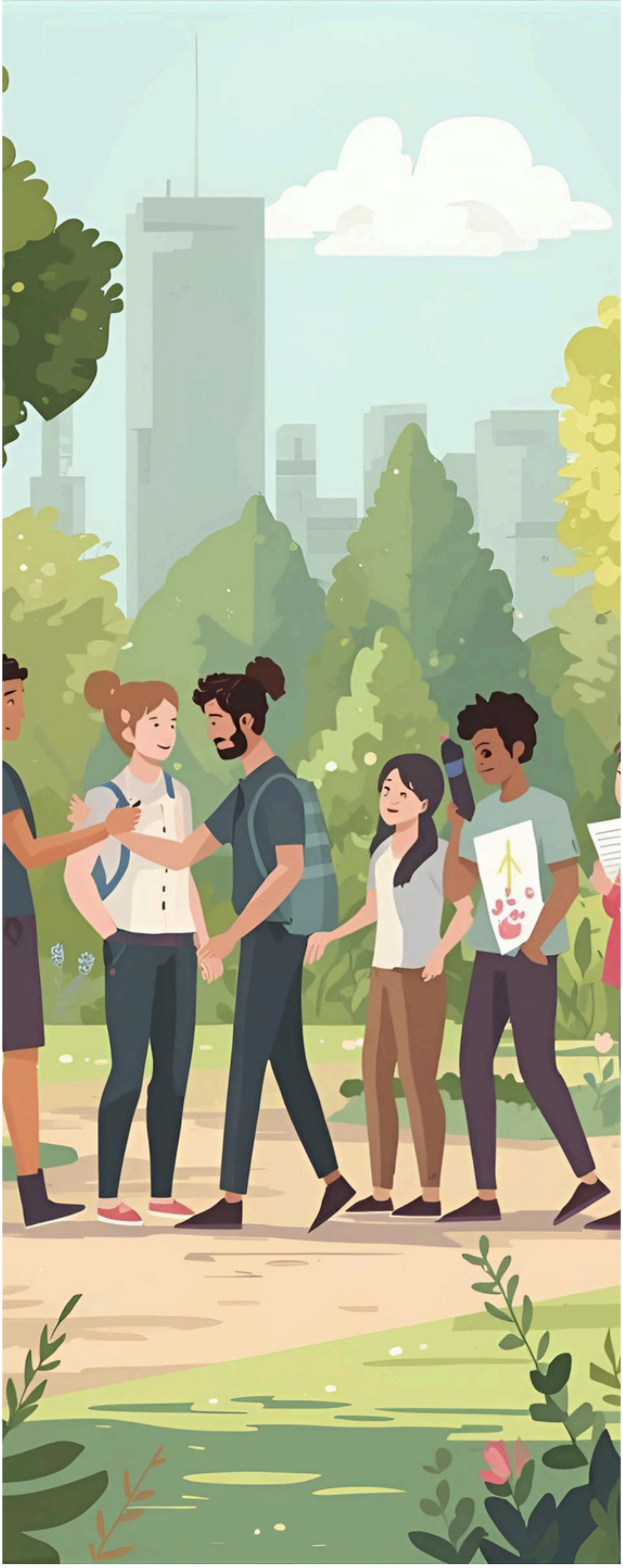
- University of York 'Open door': opendoor@york.ac.uk
- University of York Equality and diversity office: equality@york.ac.uk
- University of York student support team: https://www.york.ac.uk/students/support/student-support-team/
- Mental health awareness soc: mentalhealthawareness@yorksu.org
- YorChoice drop-in sessions, ages 14-21 (25 for SEND individuals): https://www.yorkmind.org.uk/our-services/yorchoice-young-peoples-drop-in/
- Samaritans crisis line: 116 123
- NHS 111 (select 'mental health')

Clinical Psychology in International Contexts – Volunteering in Ukraine and Jamaica

BY JESSICA HALLIWELL

Clinical Psychology is an increasingly popular field among Psychology students - and understandably so. When I think of it, I envision applying psychological theory, conducting assessments and formulations, developing interventions, and most importantly, making a meaningful difference. Many aspiring clinicians share this passion, and it's encouraging to see such capable individuals entering this competitive field. From early on, the importance of gaining work experience is heavily emphasised - almost poetically so, given how challenging it can be to secure. With that in mind, I decided to look beyond the UK, travelling to Ukraine and Jamaica...

Before I begin, it's important to reflect on the emotional context behind my decision to go to Ukraine. I vividly remember the morning of 24th February 2022 - going about my routine as usual, only to feel my stomach drop at the news of what is now termed the 'full-scale invasion' (Kimhi et al., 2023). Watching families torn apart and homes destroyed, I felt helpless just sitting in my chair, wishing there was something I could do to ease their pain.



During my time in Ukraine in 2023, I primarily volunteered with food charities, most notably one that provided freshly cooked pizzas and beverages to underserved communities in unoccupied areas. The organisation operated as two teams: the ‘West’ team (serving Lviv, Ternopil, Ivano-Frankivsk Oblasts) and the ‘East’ team (covering Odesa, Kherson, Mykolaiv, Dnipro, Zaporizhzhia, and Kharkiv). I joined the West team in March–April and the East team in July, which had varying safety risks. My main role involved cooking thousands of pizzas daily at various ‘sites’ using our converted pizza oven vans, supported by generous donations from Coca-Cola and Dr. Oetker.

These ‘sites’ often had limited electricity, shelter, and internet due to the ongoing conflict. We worked in a range of settings, including schools, orphanages, military hospitals, town halls, remote villages, and IDP shelters, many of which are located in areas classified as “no-go zones” by larger NGOs (Nesterenko et al., 2024). In these places, we were often the only accessible source of support. Beyond food distribution, I also took on additional tasks, such as teaching languages in schools, helping build shelters at internally-displaced people (IDP) centres, assisting psychological services, and hosting morale-boosting events across communities.

One major challenge was the language barrier, particularly when teaching emotional expression workshops to primary school children. Relying on interpreters limited my ability to form deeper connections, but to bridge this, I adapted lesson content using familiar Ukrainian educational formats. Drawing on national guidance, I introduced interoception and self-reflection activities that encouraged children to seek support. Phrases like “I feel scared because of war” and “I cry when I think about…” appeared frequently in their writing, reflecting their emotional distress. At one school in Kyiv, I was later permitted to teach mindfulness to older students in English - a deeply meaningful experience that reinforced the importance of building resilience through self-care, and my passion for Child and Adolescent Mental Health.

In Ukraine, I was also given opportunities to teach adult audiences, which I found especially meaningful as the only female volunteer on my team. A highlight was being invited to guest-lecture at the University of Lviv for the International Relations and Politics department. My talk explored theories, future cultural rehabilitation in Ukraine and my own journey into aid work. Knowing my audience would primarily be female-identified students, I focused on the intersection of gender, war, and peace - drawing on Burnham’s Social Graces (2012) to promote societal differences and discuss the potential short- and long-term mental health impacts of prolonged conflict on Ukrainian youth groups. Feedback from staff and students noted the clarity, relevance, and effectiveness of my session.

That experience also deepened my understanding of professional boundaries. After the lecture, I hosted an informal Q&A to hear the students’ perspectives. Questions like “When will the war end?” challenged my sense of responsibility and prompted self-reflection. Although I felt out of my depth at times, I remained warm and honest while clearly communicating the limits of my knowledge. Ultimately, this experience taught me how to maintain professionalism and self-awareness - skills that are essential in Clinical Psychology, where patients may similarly seek personal reassurance that must be navigated ethically and empathetically (Routledge, 2015).

n my third year, I sought experiences offering a multi-modal insight into Clinical Psychology - combining research, 1:1 therapy, group interventions, and service evaluation. In June–July 2024, I completed a three-week Clinical Psychology internship in Jamaica, through 'ProjectsAbroad'. I volunteered across three sites: Ebenezer Rehabilitation Centre, Mandeville Comprehensive Clinic, and Hargreaves Memorial Hospital. Jamaica's healthcare system integrates US, Canadian, and UK frameworks, which function well in theory but, in practice, revealed notable gaps, particularly in service delivery, interdepartmental coordination, and societal mental health education (Hamilton, 2024).

At Ebenezer Rehabilitation Centre, where I volunteered on Mondays, Wednesdays, and Fridays, the service model closely mirrored UK rehabilitation centres. The all-male patient group primarily presented with dual diagnoses, most commonly schizophrenia and cannabis addiction. My role included delivering psychoeducation, art and music interventions, and both 1:1 and group therapy sessions. I also supervised occupational therapy activities, such as yoga, mindfulness, and animal farming. Often acting as the primary Clinical Psychology representative in multidisciplinary teams (MDTs), I reviewed and evaluated rehabilitation plans – notably, an unusual level of independent responsibility for a student, especially compared to typical UK placements. Importantly, all safeguarding and confidentiality standards were upheld to UK clinical practice. On Tuesdays and Thursdays, I volunteered at Manchester Comprehensive Clinic, supporting Child and Adult Mental Health clinics, respectively. On Thursday afternoons, I joined the Clinical Psychology team at Hargreaves Memorial Hospital to assist with inpatient adult care. Across both sites, I shadowed psychologists and psychiatrists, conducted clinical assessments and formulations, contributed to MDT discussions, collaborated with families and carers, and supported the administration of pharmacological treatments. Throughout this internship, I deepened my understanding of international approaches to mental health and the importance of contextual awareness - an essential skill in Clinical Psychology because working holistically requires sensitivity to cultural, societal, and systemic factors unique to each patient. In Jamaica, I learned how central Christianity, Reggae music, and community are to psychological wellbeing. Hence, I adapted intervention plans, accordingly, integrating faith-based beliefs and music therapy when these aligned with patients' core values. This taught me to use culturally sensitive, accessible, and non-discriminatory language in-practice. However, I also encountered personal challenges, particularly with prevalent social stigmas, such as toxic masculinity, sexism, homophobia, and misperceptions of mental illness. Many of my male-identified patients had faced disownment by their families, and consequently viewed mental health struggles as a sign of weakness or failure. While these attitudes conflicted with my personal values, I recognised them as products of systemic judgement and lack of support. Drawing on knowledge from my third-year Clinical Psychology modules, I worked collaboratively with families to promote consistent care across settings. In one example, I introduced a modified 'microphone' technique during family interviews, using a Bob Marley "Peace and Love" bracelet from my bag: only the person holding the bracelet could speak, which allowed children to express themselves without being overshadowed or misrepresented. These experiences collectively strengthened my ability to deliver contextually- and systemically-informed clinical care.

Research was a key learning area during my Clinical Psychology internship in Jamaica. Drawing on my Advanced Research Methods module and independent study, I undertook several research tasks for Mandeville Comprehensive Clinic, including the analysis of medical trends, clinical trial outcomes, and patient feedback. One project involved thematically coding data to explore why certain groups were attending Mental Health Clinics. I found that patients prescribed antidepressants were most likely to experience adverse reactions to antipsychotic injections, suggesting potential signs of serotonin syndrome, a serious condition (Badar, 2024). Given its severity, I delivered an educational talk in the clinic's waiting room, where daily lectures are standard due to limited national health education, on recognising symptoms and seeking timely support. This direct application of research contributed to patient safety.

Another project involved binary coding that revealed an unexpected link between depressive symptoms in children and reports of persistent coughing. Although the mind–body connection is well established, this specific overlap was surprising (Martin, 2024). Further analysis using logistic and mixed-effects regression modelling, supported by psychologist feedback, suggested that children may be somatising symptoms, presenting with physical complaints to gain parental attention for their psychological distress. This was attributed to ongoing mental health stigma and the undervaluing of psychological care compared to physical health. While I initially felt out of my depth in proposing large-scale solutions, I drew inspiration from a Year 2 Social Intervention Project in which I designed a mindfulness-based school programme to reduce knife crime. Using this as a framework, I co-developed a scalable intervention for Clinic Community Nurses to deliver in schools. This experience affirmed the vital role of research in identifying systemic issues and informing practical, context-sensitive solutions in Clinical Psychology (Siddaway, 2024).

Overall, my international Clinical Psychology experiences have provided a meaningful balance of personal challenges and professional growth. They have reinforced my commitment to becoming a Clinical Psychologist, with the enduring aim of creating positive change and supporting those in need. I encourage other students to seek similar international opportunities!

MY ROLE AS AN INDEPENDENT HOSPITAL MANAGER FOR THE LEEDS AND YORK PARTNERSHIP NHS TRUST.

By Joseph Ramage

Introduction to the role

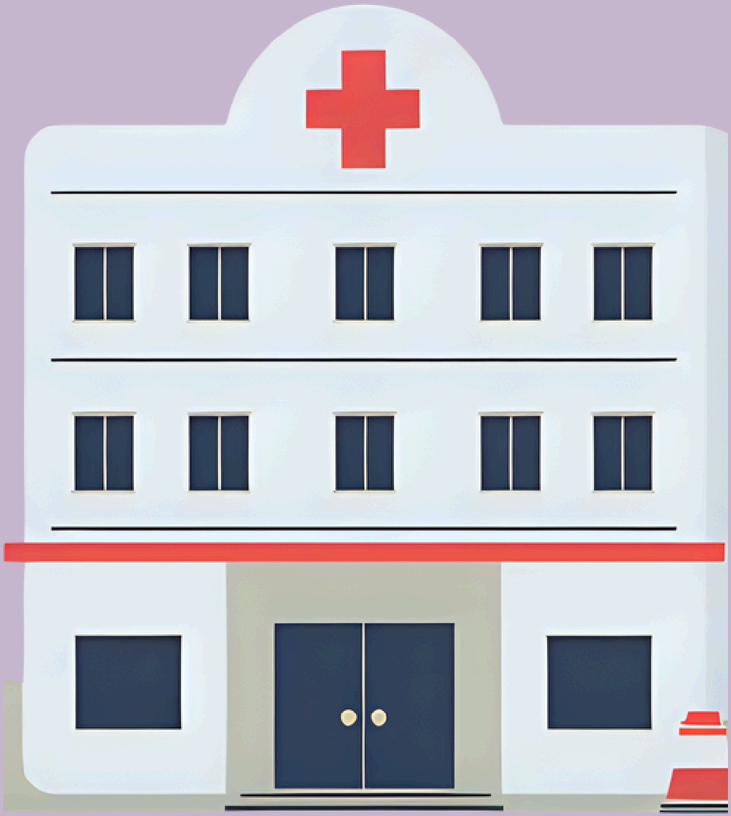
'Hospital Manager' is an official position outlined in the Mental Health Act 1983 (Revised 2007) (MHA) and the MHA Code of Practice. Many NHS trusts across the country have differing names for this position but the title I hold is 'Independent Mental Health Act Manager'.

As required by the Act, MHA Manager's are independent volunteers who are interviewed and selected to represent the trust by members of the hospital (frequently the MHA legislation team).

The purpose of the role is to act as an independent reviewer of persons detained under sections of the MHA ('sectioned'). The Act outlines very specific detention criteria, it is the job of tctive that risk to self could also entail facets such as risk of retaliative violence from others due to the service user's behaviour, or perhaps the risk associated with personal neglect. Risks to others are often conceptualised as risk of violence and confrontation, but could include specifics such as abuse, neglect or destruction of property.

Examples of challenges in the role

An example of more challenging forms of hearings may be Section 25 barring orders. This is where a person's nearest relative applies for the service users discharge but the RC blocks ('bars') this discharge as they disagree with the relative's decision. This



triggers a short notice hearing in which the professionals must justify to us the standard criteria, however with the additional point of:

Would the patient, if discharged, be likely to act in a manner that is dangerous to other people or themselves?

In terms of reasons and evidence this is a particularly difficult to justify criterion and truly tests the *necessity* of the section not just if it is *easy* or *for the best.* Dangerousness is outlined by the MHA Code of Practice as acts that cause serious physical harm or lasting psychological harm. A further challenging feature of this review process is defining the actual *likelihood* (as per the above criterion) of dangerous acts. This is particularly true in individuals who, for example, may have sporadically assaulted inpatient staff and or persons in the community but not to a so-called *serious* degree (e.g., pushing, single punches, swings that do not make contact), similarly individuals who have demonstrated some risky behaviour towards oneself however they may blur the line between ideation and intent. However, I tend to rationalise dangerousness in the wider context. There should be a note given to the fact that a dangerous act committed which did not result in serious harm does not mean that future acts under the same circumstances will not have more serious consequences.

Challenges can also come in the form of moral and ethical dilemmas. Constant reflective practice is key in order to make sure you are not being influenced by personal opinion and rather, your decisions are being made in a fair, reasonable and lawful way (as per the Code of Practice). Additionally, the heterogeneous nature of severe mental illness means that you will occasionally work with individuals with particularly challenging behaviours, a few examples from my experience include child sexual offences, stalking behaviours, fire setting, unpredictable violence and domestic abuse. So being able to manage and acknowledge this information in a holistic way that is not detrimental to your own wellbeing is of utmost importance.

Summary

I hope that through reading my article you may have a new appreciation for some of the nuances of Mental Health law and the importance of providing individuals who are deprived of their liberties with a fair, person-centred, lawful and objective review of the framework they are subject to. Thank you for taking the time to read, I hope you found the topic interesting.

There were many aspects of the Act which I brushed over (e.g., CTOs, court ordered and forensic sections etc.), if you are interested in exploring this topic further see below.

Further resources

- Mental Health Act 1983 (Revised 2007) – https://www.legislation.gov.uk/ukpga/1983/20/contents
- Mental Health Act Code of Practice (see chapters 37/38 for information regarding Independent Hospital Managers) – https://assets.publishing.service.gov.uk/media/5a80a774e5274a2e87dbb0f0/MHA_Code_of_Practice.PDF
- Mental Health Law Online (contains outlines of general MHA sections and some good examples of influential case law) – https://www.mentalhealthlaw.co.uk/Main_Page
- The Mind Charity (information regarding leaving hospital) - https://www.mind.org.uk/information-support/legal-rights/leaving-hospital/hospital-managers/
- NHS - Mental Health and the law (general easy to understand overview) – https://www.nhs.uk/mental-health/social-care-and-your-rights/mental-health-and-the-law/mental-health-act/

Ψsychout

Thank you for reading!