DEAR GP...

Patient-written clinical assessments of their mental health professionals

What do you mean reasonably well kempt?

Subjective one-sided analysis is for everyone!
Because subjective one-sided analysis is for everyone!

This is a collection of clinic letters, which are usually written by mental health professionals to GPs and copied in (if you’re lucky) to the patient/service user. They come from a community that is tired of having clinic letters drop through the door without a proper right to reply.

The letters here are different because they are written by the people usually written about. But they are similar in their attention to random details, the reading into gestures and behaviours, the assumptions and the judgements. The power dynamics in clinical relationships are rarely recognised, and it isn’t often they can be subverted in this way — returning the medical gaze back to the professional. The tables have been turned.

We have felt catharsis and solidarity in writing, collecting and publishing these letters, and we hope this can be extended to all of you reading this who recognise these frustrations all too well.

These letters are written without our input and treated as the authority on us, often held as a higher authority than our own words. I’ve received letters that have sent me spiralling into a suicidal crisis. I’ve received letters that have left me shouting at an empty room because I can’t shout at the doctor who wrote it.

- Alex
Clinic letters are often dehumanising, and the professional’s own subjective analysis is privileged over anything the patient might say. Why use words like “denies” or “claims” in relation to what a patient says? Perhaps you mistook a genuine concern for an “overvalued belief”? Is the person really anxious, or are they angry? Do you have the ability to read minds or are you jumping to conclusions? How much time is lost on “compulsive information-seeking”, and how much of it is important to the person in front of you?

Why this zine?

The letters ask professionals to re-examine their perceptions and use of language. We have already heard from professionals how Dear GP has made them reconsider overused tropes and phrases used in clinical writing. We hope our zine will continue this discussion, and that those with the responsibility of writing notes will begin to understand the power their words have on our lives.

I don’t hardly recognise this lad in their letters. He sounds like a useless idiot and I am not.

- W

A note to professionals reading this zine:

Don’t avoid this. Try your best to tolerate any distress and employ your coping skills to face these letters head on. Focus on your breath and try to sit with any negative emotions you may feel. Perhaps eat a raisin mindfully. If all else fails, we recommend drinking a cup of tea in the bath to soothe yourself. Don’t have a bath? Just wait for your shower to block up with hair and sit in the dirty water that doesn’t drain. We’re told these interventions are foolproof.

Remember, your feelings are YOUR responsibility. We would not recommend sharing your feelings of distress with fellow professionals as it may encourage dependency.
Dear GP,

Thank you for referring me to this meticulously dressed young doctor. He was average build, with hair. He positioned himself unconventionally, away from the computer with a pad of A4 paper and a ballpoint pen. He displayed behaviour suggesting an over-reliance on the security and stability of the desk to make notes. He had some insight into his relative inexperience but also displayed traits of over confidence.

Overvalued beliefs included the 100% effectiveness of CBT/mindfulness and an ability to read minds. The doctor denies inflexible thinking and difficulties processing and retaining verbal
communications. On examination, difficulty in recognising and understanding the complex nature of emotion and building rapport was noted. Rather than addressing emotional content, he was somewhat preoccupied with insignificant details. He displayed compulsive information-seeking behaviours about historic events. Eye contact was appropriate for the situation, though his mood and energy levels fluctuated. His speech was faltering at times.

Medication was discussed but he preferred not to explore this, expressing insecurities and inexperience with prescribing certain medications. Unfortunately, this left some confusion as to what the best course of action with current medication might be. He was unwilling to challenge irrational thoughts and feelings around cliches and trite platitudes.

He has difficulties with ending sessions without reassurances.

Finally, he has exhibited a curious behaviour - he felt the need to write his own version of events from this session, sending them to other health professionals, without my knowledge or input. The
motivation for this behaviour is not clear, but may be an attempt to cause splits within the group of health professionals involved in this case.

I am unable to review this gentleman again due to the likely increase in risk, but there are several ways forward that may help improve functioning. More assertive approaches may be required to help overcome low levels of insight.

Twitter: @GoodNewsFromBad

Dear GP,

I saw Social Worker Y in clinic today as per our regular arrangement. We discussed that she has made contact with you several times recently despite not receiving a response, and how this made her somewhat anxious due to fears of rejection and abandonment. We were able to work together to consider how she might best resolve this situation in an interpersonally effective manner.

Y was wearing a red jumper and identified its soft texture as a means of self soothing; she expressed that she finds this particularly helpful while reading and answering emails. I also noted her leopard-print boots and we spoke about the relationship between her clothing choices and her sense of professional identity.

Y remains emotionally labile and excitable; although she is clearly committed to maintaining a mindful approach to our sessions, she struggles to contain extreme emotions.

As we were preoccupied with other matters, we did not have an opportunity to discuss Y’s continuing overvalued ideas regarding the diagnostic validity of Borderline Personality Disorder, however I am hopeful that we may make progress in this area in future.

Kind regards,

Rachel Rowan Olive
Dr H attended her appointment today. She arrived ten minutes late as is characteristic. I tried to explore the issue of her regular lateness, but Dr H became defensive and said she was rather busy. Dr H is reasonably well kempt. She has plenty of hair, no freckles and her teeth are normal size for her face. However, Dr H appears to be a troubled middle-aged woman. Her posture is rigid, she made little eye contact, and spent most of her time tapping away at the computer. Her response to questions was disinterested.

Dr H described she has been a Clinical Psychologist for many years. She demonstrated black and white thinking as she was unable to acknowledge that not all her patients like being told their personality is disordered. Dr H demonstrated a fear of abandonment and has an ambivalent attachment pattern. This is evidenced in her commentating that it was fine, because although her patients would be left on a waiting list for the next year or so without a care coordinator or any support, it surely only encouraged their independence. However Dr H has such a strong fear of abandonment, it influenced her to return to the service just one month after her departure, only this time in a senior role. Dr H did make eye contact and smile on occasion, when describing her new office and new salary and she stated at least now those pesky patients cannot talk to me.

Dr H had an unexpected angry outburst when she stated she would rather sit in her new office and let the phone ring out than respond to concerned parties (GPs and the like) calling on behalf of patients who were left with no support when she quit her previous role. Dr H denied impulsive or manipulative behaviours. However, she admitted occasionally impulsively replying to an email, but only when the person emailing copied her manager in. She shows signs of splitting, highly valuing management, but devaluing other professionals. Dr H denied self-destructive thoughts. She appeared rather naive in her ability to manage crisis listing having a bath, drinking camomile tea and going for a walk as strategies.

Louise
Dear GP,

Thank you for referring me to Dr. Hugh Jass Holl as I transition from CAMHS to the adult mental health department. He appeared well kempt, having recently showered and brushed his hair. His stature remained consistent throughout the meeting, hunched over a clipboard with good eye contact while he took notes.

Prior to the meeting we had confirmed that this was to be an evaluation and we did not need to go over my history. We then spent 2 hours exclusively discussing my history.

I noted he has some issues with communication, as evidenced by his tendency to diagnose me with an abundance of disorders without telling me, leaving me only to find out when I received his review of our session. Additionally, his mannerisms were rather condescending, speaking to me as though he couldn’t quite comprehend the severity of the situation. I have been in this industry for almost 5 years now, yet he felt the need to speak to me like a child. I feel as though he should try ice diving to reset his brain, as this may help him regain control of his vernacular. Medication was discussed, and despite several failed attempts to ease off the sertraline prior to today, Dr Holl was still insistent about lowering the dosage. I told him I had discussed this possibility with his colleagues who agreed that it was not a good time to remove the mood stabilisers considering the close proximity to exam season. Dr Holl became visibly irate at this. It is clear he does not like being undermined in the same manner in which he undermines his patients.

While I personally found the meeting rather constructive, Dr Holl

—I noted he has some issues with communication, as evidenced by his tendency to diagnose me with an abundance of disorders without telling me—Mia
clearly didn’t feel the same. In his write-up he acknowledged that I was still majorly suffering from debilitating mental illness, but then suggested I be discharged without explanation. He evidently struggles with reading the emotions of others, as when I became upset due to the lack of justification for my discharge, he wrote down that it was simply due to the emotional stress of the day. Perhaps he should be transferred to another patient to see if they can make any progress with him.

In terms of an action plan, I recommend that he utilises radical acceptance, as I doubt he will be making progress with his abilities anytime soon and it is important that he comes to term with that.

Yours Sincerely,
Recently Discharged 18 Year Old
“Moderate to High Risk”

Misgendered and Mistreated
Dear GP,

I met with CMHT member, Mr Y Bother, today, a diminutive man in his late 50s. Having described his job as a “bit of a care-coordinator that-sort-of-thing” (query: delusions of grandeur?) I had seen him a few times before and was interested to see he was attired, still, in his favourite C&A outfit of pale beige trousers, short sleeve brown check shirt with white socks and brown slip on shoes. He had made an effort showing a good standard of self-care; spiking his fringe up with hair gel to add height.

I started the appointment by trying to address his discomfort with using the telephone as a medium of communication. He stared out of
the window and was reluctant to engage so I moved on to ask if he had been the one to send random letters. He was proud to admit that he had and this did concern me as he had cheerily over-ridden any spelling or grammar functions provided, preferring his own version of medical terminology and sense. (Query: delusions of grandeur again?)

Throughout our brief appointment he sighed and fidgeted continuously (query: tapeworm? Asthma?)

He did offer me a sheet of paper, upon which were written some words such as: STONE – feels cold, hard, icy to touch. Which I imagined were the pre-instructions to the game scissors, paper, stone that he practiced while listening to the phone as a musical backdrop.

I am confident that the diagnosis I originally conferred upon this CMHT member of BPD (BORED of PATIENTS DISORDER) is, indeed, the correct one.

“I am confident that the diagnosis of BPD (Bored of Patients Disorder) is indeed the correct one”

I feel there is little point in seeing him again in 2/52 though I am happy to provide him with a list of useful telephone numbers/ places where he may seek help: Asda, B&Q, local library are all open after 5pm (some even 24 hours) and the staff are kind and courteous.

Yours sincerely

Elk
Dear GP,

I met with Doctor X today, as planned. He was smartly dressed, with trousers and a shirt, though a tie was notably absent. His hair was styled well with hair gel. Eye contact remained poor throughout.

Doctor X appeared irritable and hostile throughout the appointment. He was also late, though he alleges this was through no fault of his own (see previous notes regarding other late arrivals to appointments).

An attempt was made to discuss possible treatment plans, especially regarding medication, but unfortunately Doctor X failed to engage. He has strong delusional beliefs regarding Emotionally Unstable Personality Disorder and the effectiveness of medication. He was unable to accept medication works well for me. I tried to gently challenge this pattern of thinking, but Doctor X denies my unique expertise regarding what does and does not help me.

“Doctor X denies my unique expertise regarding what does and does not help me”

Doctor X refused to discuss the possibility of a misdiagnosis. Doctor X also refused to explain how I met the criteria for the diagnosis given to me in a previous appointment. He became defensive quite quickly and this deteriorated to full blown misogynistic behaviour.

It is my professional opinion that Doctor X does not lack insight and therefore his behaviour is purely psychological. Doctor X fails to accept responsibility for the standard of care he provides, and I am therefore recommending that he be discharged back to your care to ensure the safety of myself and other service users.

If you have any concerns regarding Doctor X, please be advised that I am contactable during the working hours of 1pm and 3pm, Monday to Friday. If you leave a voice message, I will endeavor to return your call within 28 working days.

Yours sincerely
Patient A

Twitter: @NewMummyLife
Dear GP

Re: Miss Mindlessness

I met with the above named professional on 15 April 2019.

On arrival she was carrying a book entitled DBT The Gold Standard Treatment for Because Psychiatrists Discriminate, a bowl and small wooden mallet. She was dressed in what appeared to be a cheerleader outfit and greeted me with what seemed to be a forced half smile, addressing me as DEAR MAN.

At regular intervals during our appointment, she took a raisin from her pocket and smelt and licked it before returning it to her pocket, stating that it helped her to “live in the moment”. At times I noticed her heavy breathing and the use of words such as GIVE, FAST, and DEAR MASTER that were not in keeping with the context of our conversation.

She was very eager to talk about how she had regulated her overwhelming emotions of being unable to meet the Government’s happiness targets, stating that she had distracting herself by flying a plane, collecting shells and thinking about sex.

Although she appeared to be disappointed when I refused to take part in the role play that she had suggested a few minutes before the end of the appointment, overall I found her to be an extremely positive, if not, irritatingly optimistic lady with a WISE MIND. For this reason I am now discharging her.

Yours sincerely

A Service User
Dear GP
Re: Dr L. Psychiatrist.

I met the above named gentleman in clinic today. He was escorted by Ms Assistant Psychologist. This appointment was arranged as part of an existing package of care; the Near Endless Assessment To Absolve Risk Guilt in Health (NEAT ARGH).

You may recall two earlier letters detailing two previous meetings since early this year. One with Mr Anonymous Telephone-Triage, in which I outlined this gentleman’s unwillingness to introduce himself and his difficulties with impulse control surrounding his need to have his questions answered immediately.

The second with Mr I. A. M. Manager, which you may recall, took place out of hours, due to a cancellation. You may recall that I. A.M. became irritable at times, due in part, he explained to being unable to “do justice” in an assessment to someone with such “complex needs”.

“He has difficulties with impulse control surrounding his need to have his questions answered immediately”

Dr Psychiatrist was a little late for his appointment, although he made no excuses for this, and was at pains to explain that he was aware of the previous NEAT ARGH meetings. He appeared reluctant to believe that I work in the NHS and was very interested in the concept of commuting to a place of work, and how long this takes.

He was smartly dressed, jovial and polite in approach, although a little bombastic. He made good eye contact. His speech was normal in rhythm but a little loud in volume. Mood was subjectively and objectively slightly elevated.

Mr Psychiatrist has overvalued beliefs in the concept of borderline personality disorder as a valid diagnosis and appeared to be using one of the self tests on me that can be found on less reputable websites, in order to support his beliefs. When challenged he appeared to engage with the idea that the diagnosis is a contested
one and agreed to change the subject. I have concluded that despite his expressed opinion of his appreciation of honesty in his patients this was an attempt to humour me and his belief in the diagnosis remains intact.

“Mr Psychiatrist has overvalued beliefs in the concept of borderline personality disorder as a valid diagnosis”

We discussed medication and he is a strong advocate of initiating anti-psychotics or mood stabilisers, alongside beta blockers and promethazine, in order to manage the symptoms of “BPD”. He denies the validity of any recent research that medication is not useful for those given this diagnosis. He was reluctant to

Mr Psychiatrist then asked Ms Assistant Psychologist to advocate on his behalf, and she explained there is a significant waiting list for care coordination, and even longer one for “psychology” but they were able to offer psycho-educational groups including mindfulness and emotional regulation. It is unclear at this time whether it is necessary to attend these prior to accessing the waiting list but I will keep you informed of any updates.

I will see him again in six to eight weeks for the next stage of the NEAT ARGH programme although I understand he may have found a permanent position elsewhere, if so I will see his replacement.

Yours sincerely
A. Anonymous
Dear GP,

At your request I recently saw Dr X in the outpatient clinic at CAMHS. She attended the appointment alone, and was well groomed. She was wearing a dress and jacket that were appropriate for a woman of her age. She appeared rushed, and she arrived for the appointment slightly late, which may be indicative of problems with her executive functioning, or may demonstrate a reluctance to engage with the service.

“She arrived late which may be indicative of problems with her executive functioning, or may demonstrate a reluctance to engage with the service”

I met her with the assistance of two colleagues, my parents, and Dr X attempted to split the team several times by addressing my parents rather than myself. Her level of eye contact fluctuated during the appointment, and by refusing to acknowledge my presence properly, she appeared to manipulate the situation to suit her need for power and attention. Throughout the appointment her presentation appeared false. I noticed a lack of warmth and empathy in her manner despite some occasional superficial smiles, which causes strong concerns regarding her ability to relate to others. She refused to discuss how her behaviour affects others, including those she works with.

Dr X further split the team by insisting on seeing me separately to my colleagues, to which we agreed in an attempt to encourage greater engagement from her. Upon my colleagues leaving, she aggressively asked lots of questions, and attempted to manipulate the situation further by saying she believed I had been abused in the past. She seemed unaware or indifferent to the inappropriateness of her behaviour at this point, not realising that I was unprepared to discuss such issues with her, especially at our first appointment. When I refused to speak about such personal issues, she grew increasingly hostile and appeared outwardly annoyed.

She was willing to discuss antipsychotic medication options only, and had little insight into how her beliefs around their effectiveness may impact others negatively. Interestingly, she claimed that the
main side effect which is in fact quite rare, would be alarming seizures. I believe she may have purposely attempted to intimidate me with her description of the side effects, and that she deliberately failed to mention other side effects such as weight gain and sedation. She appeared frustrated when I assured her that we could discuss the options for medication at a later date but that I wasn’t prepared to make any decisions at that time.

“I would offer a preliminary diagnosis of BPD (Bad Psychiatrist Disorder)”

Dr X is currently unwilling to discuss potential diagnoses, however I would offer a preliminary diagnosis of BPD (Bad Psychiatrist Disorder) although further evaluation would be necessary to confirm this and any potential comorbid problems such as ADD (Abysmal Doctor Disorder). Due to her difficulties in communicating and inability to empathise, I recommend that she not be allowed to work with any living organism, and certainly not human beings in distress. If you require a letter to state as such, I am able to oblige.

Yours sincerely
Patient Y
Dear GP,

I met with Psychologist A as scheduled. She is a mild-mannered young woman and appears to be neat and tidy, showing an ability to care for herself without assistance. She spoke quietly and calmly, but has a worrying over-reliance on relating all topics of discussion back to therapy worksheets found online, which caused her eye contact levels to be low throughout. The glazed, faraway look that occasionally came over her suggests a concerning lack of engagement with the system.

“she has a worrying over-reliance on relating all topics of discussion back to therapy worksheets found online”

Psychologist A presents with certain fixed-mindset issues that make it difficult for her to consider viewpoints that add nuance to what she believes herself to be an expert on. Gentle disagreement and the presentation of new evidence cause visible discomfort, and the suggestion that two experiences could be interlinked was met with scorn and disbelief. She appears to have difficulty understanding the complexity of the effects of dissociation on daily life, despite claiming to have a degree in what she calls ‘worrying illnesses’.

We discussed coping strategies, but little progress was made in this area, as she considers meditation and swimming to be the answer to all known and unknown distressing emotional experiences. Suggestion that more exploration may need to be done in this area was shut down. I attempted several times to explain paranoia and delusions to her, but she refused to engage, preferring to tell me ‘not to worry about it’. I am concerned that she believes the M in CAMHS to stand for ‘managing perfectly well’.

I wrote this letter as a humorous way to work through the anger and frustration I felt/feel as a teenager going through the CAMHS system. Although it discusses an individual practitioner, the letter isn't supposed to be a personal attack, but rather a means to examine structural problems in the CAMHS and wider NHS mental health systems.—Eleanor
She appears to have particular issues with trust and boundary-setting. She became agitated when another member of staff informed her about a personal choice I have recently made in my life, as I had not ‘consulted her first’.

I attempted to schedule future sessions with Psychologist A but I was informed last-minute that this would not be possible, as she has decided to relocate to Manchester. I am concerned about the potential implications of this move on her high stress levels, but as she will have left our service, I am unable to do anything about it.

Yours sincerely,
D. Zarster

Twitter: @_erithacus

“I am concerned that she believes the M in CAMHS stands for ‘managing perfectly well’.”
Dear GP

Thank you for referring me to Dr H for psychiatric assessment. I met with Dr H in her clinic this morning. Dr H is a middle-aged, overweight lady who was dressed appropriately for the occasion. She was late to attend our meeting, and was able to offer no explanation for this. Dr H reports having completed a medical degree and having extensive experience as a consultant psychiatrist. Eye contact was variable throughout the assessment; Dr H generally appeared able to sustain appropriate eye contact while talking, however there was virtually no eye contact while others spoke. Speech was normal in rate and tone, however she showed some preoccupation with overvalued ideas. Dr H was labile in affect throughout.

Dr H initially presented as warm and caring, however was able to display a dismissive and patronising demeanour with minimal encouragement. In conversation Dr H demonstrated significant preoccupation with the belief that I am psychotic, a belief not related to my current presentation, my present diagnosis, or in accord with the opinions of the many other mental health professionals to whom you have previously referred me. In relation to this Dr H displayed some preoccupation with antipsychotic medication and became noticeably distressed on questioning regarding this. Ultimately she was persuaded not to initiate inappropriate psychotropic medication with significant encouragement from myself and the community psychiatric nurse who accompanied me throughout the assessment.

“Dr H displayed some preoccupation with antipsychotic medication and became noticeably distressed on questioning regarding this”
Dr H displayed poor understanding of social norms during our meeting. Beginning by informing me that she had “read your notes, so I feel we know each other well already” she continued to make remarks suggestive of poor social understanding throughout. Dr H also showed minimal awareness of the need to develop rapport before discussion of sensitive topics, asking me intrusive personal questions regarding historic traumas. She appeared surprised and offended when I declined to offer detailed responses, suggestive of a deficit of empathy.

On one occasion Dr H appeared unaware of my presence, discussing me with the nurse accompanying me and speculating as to the reliability of my account of my history with mental health services and the likelihood that I may have been “exaggerating” the traumatic events in my past.

“Dr H also showed minimal awareness of the need to develop rapport before discussion of sensitive topics”

With regards to risk, Dr H shows an interesting approach to risk management. After discussion of ongoing self-injury and a detailed suicide plan she was observed to write “no risk of self-harm or suicide”, suggesting poor insight into the nature and extent of the risks discussed. This conversation raises concerns that Dr H may go on to allow vulnerable patients to come to harm as a result of inaccurate recording of risk.

I recommend a strategy of watchful waiting with regard to this lady’s risk behaviours, and referral to a fitness to practice panel should the situation deteriorate.

I will be unable to meet with this lady again, and recommend referral to a different consultant should you feel the need for further investigations.

Yours sincerely

A.T.

Alex
HTT Discharge Letter

Reason for referral

On the INCORRECT DATE... AGAIN, [redacted] attempted suicide after attempting to [redacted]. She was interrogated, bullied and transported in a metal cage following prolonged solitary confinement in the 136 suite and discharged with an coerced agreement to be followed up by [redacted] Home Treatment Team.

Mental Health Diagnoses (including ICD10 codes)

Working diagnosis – F329- Severe Depressive Episode

Summary of treatment and progress

During this second episode, it was highlighted with [redacted] that she would benefit from treatment being medicated for her depressive episode. She very eloquently raised her concern about taking treatment MEDICATION for her mood at a professional meeting regarding [redacted] and after 7 separate psychiatric assessments, [redacted] remains clear about her decision not to try treatment MEDICATION for her condition.

Please note: Some symptoms were ignored, invalidated and discarded in order to fit the patient neatly into this box and adhere to the model of treating specific disorders.
**Risk**

Ongoing risk of self harm – Moderate
Risk of suicide – Moderate
Risk of self neglect – Moderate
Risk to others – Low

**Crisis Plan, including relapse indicators**

[Redacted] has access to the CMHT between 9 and 5 p.m. on [An irrelevant phone number] **BECAUSE SHE CAN’T USE PHONES.**

In absence of her care coordinator [Redacted], [Redacted] can’t speak to the Duty work **BECAUSE SHE CAN’T USE PHONES.**

Out of office hours, [Redacted] can’t access the Crisis and Support Line on [Redacted] **BECAUSE SHE CAN’T USE PHONES.**

If there is an immediate risk of harm to self or others, [Redacted] can attend her nearest A&E Department where she can access the Liaison Psychiatric Service, and [Redacted] will be signposted to the appropriate service. **Except her experience of being detained under section 136 make it extremely unlikely that she would ever even consider this.**

So all in all – no plan

**Follow up and actions for GP**

Regular physical health checks **I have had none at all!**

Yours sincerely,
A probably well-intentioned Mental Health Nurse

Aisha Brooke
@AishaCampaigns
Dear GP,

Dr BS was seen for assessment on the 17th August 2017 following your referral. She was dressed appropriately for the appointment. That is to say, she wore clothes that we neither garish in colour nor suitable for a tropical retreat. Although appearing moderately flustered as she presented me with her sweaty hand to shake, she was reasonably well kempt. Initially, she spoke with flattened affect and there was no observable passivity phenomena.

Her lack of insight was clear from the beginning of the assessment and she seemed unclear about its purpose. Mistaking me for a school admissions officer, she asked for my advice as to how to get her daughter into a particular secondary school, querying whether private tutors were needed. When informed that this was not the purpose of the assessment and that NHS funding for such assessments is scarce, she responded “but it’s my first choice school!” with the conviction of a petulant child.

I was concerned by the rate at which Dr BS became inappropriately aggressive. I would expect that a woman who works with vulnerable people for a living would have a somewhat elevated capacity for empathy. However, Dr BS failed to exhibit it, repeatedly shouting “why are you crying?” at a distressed patient. This seems to be suggestive of personality difficulties (unspecified at present) and an inability to control emotions. Further evidence of personality difficulties became apparent when Dr BS engaged in manipulative behaviour, failing to record a patient’s trauma history.

Dr BS displayed behaviour that is inappropriate for a woman of her age and stature, struggling to contain her laughter when discussing the topic of sexual activity. She seemed somewhat bemused by the concept of a teenager engaging in sexual activity outside of a committed, long-term relationship, tutting under her breath between giggles. A slight developmental delay cannot be ruled out.
It appears that Dr BS presents with distorted cognitions of the delusional type. When confronted with clinical letters highlighting a patient’s ten-year history of dissociation, she claimed “we don’t use that word here” with strong conviction, effectively denying the existence of Dissociative Disorders. Claiming to be speaking on behalf of a whole mental health trust is further evidence of delusions of grandeur. Contrary to evidence from clinicians and a patient reporting no history of absence seizures, Dr BS insisted that a diagnosis of epilepsy better explains dissociative symptoms.

Although her records show a history of personality difficulties before she began taking psychiatric medication, it is of my opinion that they are caused by her medication. However, I gave Dr BS a repeat prescription for it and recommend that she continue to take it as prescribed.

“Claiming to be speaking on behalf of a whole mental health trust is further evidence of delusions of grandeur”

Throughout the assessment, I observed an inability to retain information. Despite being informed by a patient that her ancestry is White British, Dr BS insisted that said patient, in fact, “presented as biracial.” She also identified said patient by the wrong name on multiple occasions.

In essence, Dr BS presents a longstanding pattern of clinical misjudgements, posing a risk to patients. Despite this risk, I will be discharging her from this service due to her “challenging behaviour” and refusal to cooperate. She is aware that she can be re-referred to this service if she proves herself to have greater insight into her disposition.

I advise that Dr BS should avoid operating any heavy machinery.

Do not hesitate to get in touch with me if you have any question

Twitter: @Chloe_Apt
Here are some quotes we’ve collected from actual mental health letters. This is what we’re up against!

“casually dressed & obese"

“She does not look too underweight, so I have trouble understanding her loss of periods”

"observed carrying a shopping bag"

"spotted in a pet shop"

Claire was dressed in black without retardation and made a good rapport. She spoke fluently about her problems and smiled on occasions. During the interview she revealed a number of social competences and is clearly organised and quite resourceful. (the last sentence lost me a PIP appeal)

“suggestive hair”

“unconsciously wilful”

“Poppy came to the appointment in a Halloween costume”

(I’m goth, I dress like this everyday)

“Hair cut in latest style & colour”
"Patient is a Caucasian female dressed smartly in navy blue with stripes and carrying an umbrella"

“she has long stringy hair and when she smiles her teeth are somewhat too large for her face”
Dear GP

Thank you for referring me to see Dr Robotnik at the Spring Yard Mental Health Clinic.

Dr Robotnik was dressed in red without retardation and made a good rapport. Form of thought appeared normal, although eye contact was poor as he seemed to be preoccupied with a clock mounted on the wall behind me. During the assessment he revealed a number of prejudices towards my class and gender.

Dr Robotnik was initially reluctant to offer a diagnosis, despite acknowledging the severity of my difficulties. Towards the end of the assessment he favoured a diagnosis of social anxiety, which he further clarified by stating “There’s a lot going on with you.”

Discussion of treatment exposed Dr Robotnik’s ignorance of SSRI Discontinuation Syndrome. He intends to consult Dr Mario before writing to me with a detailed schedule for switching medication and managing withdrawal symptoms.

“Discussion of treatment exposed Dr Robotnik’s ignorance of SSRI Discontinuation Syndrome”

In my opinion, Dr Robotnik is someone who appears to have had a very privileged life, sheltered from hardships that would allow him to develop the empathy required for an appropriate bedside manner.

Yours sincerely,

C.J.

Twitter: @ClaireJadis
Dear GP,

Thank you for referring me to Dr A, who I saw at U.P. Schitt Creek mental health centre this morning. Dr A is a balding, middle aged man who appeared reasonably well-kempt. He claims to be educated to medical degree level and have specialist psychiatry training. Eye contact was poor throughout. His affect was congruent with his mood which he described as “very well, thank you”.

Dr A remained distracted by his computer throughout the appointment but eventually endorsed starting anti-psychotic medication. He denied side effects. However he appeared irritable and confused when challenged on this, insisting these were “well tolerated” and “very good medication”. He was ultimately not able to specify what side effects I could expect.

I advised that I would be leaving the appointment after Dr A answered his mobile phone and had a conversation with his car mechanic. My colleague has suggested he might benefit from MMMP therapy (Mindful Management of Mobile Phones).

Dr A’s insight into his deficiencies are poor and I remain concerned about his ability to manage.

Yours sincerely,

W. T. F.

Twitter: @1ittleVictories
Dear GP,

Thank you for referring me to see this unpleasant middle-aged psychiatrist. My initial impression was that Dr Y displayed concerning levels of hostility and a reluctance to engage, failing to acknowledge my presence for a considerable period of time after I entered the room, and allowing other staff members to provide all basic human courtesy.

“Dr Y displayed concerning levels of hostility and a reluctance to engage, failing to acknowledge my presence for a considerable period of time after I entered the room”

Dr Y has a mobility impairment, and I have decided that this irrelevant detail is a useful piece of information to communicate, despite it having no bearing on the reason for assessment.

Only one hour was available to assess Dr Y, and I had no access to any history pre-dating her recent entry to local services, and limited opportunity to exchange information with her thanks to the presence of two extraneous staff members. However, I feel fully justified in overturning the opinions of previous patients, who have assessed her continuously over
many months and had access to a full history and specialist external opinion from a nationally-respected expert.

My clinical opinion is corroborated by secret background information I am not going to detail, which won't at any point be referenced in Dr Y'S notes, from a person I'm not going to name, from a Trust I have invented.

While I have failed to extract any useful information from Dr Y thanks to my asking few relevant questions and spending most of my time justifying the treatment I had decided on before entering the room, and although I have fabricated or confabulated answers to many questions I didn't ask, and despite having presented no clear evidence, I am confident in adding a firm diagnosis of personality disorder.

Moreover, in addition to standard policy of refusing treatment to individuals with ASD, I do not treat people with physical disabilities, and am therefore discharging her.

Yours sincerely,

Mental NOS
MentalNOS MDD AvPD ASD BAD BPD SZ NPD GAD SAD CD StPD RCMentals
Dear GP,

I saw Dr Whatever 2 weeks ago. She was clean and tidy and wore normal clothes. She is quite intelligent in many ways but her main problems seem to be about how she reacts to other people and not understands them which I will explain below.

Dr Whatever seems to get a bit fixed on minor things sometimes for example she commented on the way I sat and how I spoke etc. I don't know why this mattered to her. She also seems to sometimes read into things a lot which come across a bit suspicious/paranoid. For example when I phoned a couple of times in between appointments and she came to the idea I was doing it for attention, instead of the more obvious reason that I just wanted to check some details. In general she had problems trusting and understanding me.

Dr Whatever was a bit avoidant at times. For example she did not return my calls ever and one time even ignored me to my face. I don't know if she is just anxious or has trouble with her responsibilities.

Dr Whatever was quite unkind to me in a letter she sent and she didn't seem to have insight how her comments are hurtful. So I have to think about the risk she might cause to others, so my recommendation is that she gets help with her difficulties and behaviours I have talked about above, so that she can be more appropriate and not cause harm.

Yours sincerely,

W

---

I’ve been under mental health services a long time and also a lot of my childhood was in care. So I’ve seen many many reports + letters like this, even sat in meetings were it was said to me face. It can be so hurtful.

Of all them times tho, the worst ever was this one psychologist I seen about 2 yrs ago. She was absolutely horrible how she wrote about me. It made me feel WORTHLESS. I even thought at the time how will she feel if I done the same back. So the letter is about her.
Dear GP,

I saw the above named middle-aged, overbearing, unspecified doctor in the A&E department today. He had an overall imposing demeanor, and showed inappropriate affect, fluctuating rapidly between severe irritability and disinterest. He experiences difficulties with expressing simple verbal information such as his name, his occupation or explain what he is doing at any given time.

He mostly seem oriented to time and place but somewhat disconnected from reality at times, unresponsive to pain, dizziness, risk or emotional despair.

He denies the need for support for ongoing difficulties with taking blood. He displays delusions regarding curtains and their soundproofing properties. While able to take a history, he is unable to process the information to adjust his behaviour, showing strong inattentiveness to the large box of overdose material nearby.

“He displays delusions regarding curtains and their soundproofing properties”

On discharge, I have identified an ongoing risk toward others, and suggest a treatment course of A Taste of His Own Medicine, including a limited number of sessions being stabbed in the arm and hand repeatedly with a needle, within a trauma-promoting specialist service. This would be most effective, if emotional despair was induced first, followed by many hours of wearing the same clothes, not knowing where he can go to the toilet and not having implements to brush his teeth.

Twitter: @52Outsides
Dear Dr W

I met with Dr Young this morning.

He presented as rather confused, and exhibited a poor awareness of physical boundaries. He chose to sit extremely close to me and leant towards me increasingly closer throughout the appointment. My impression was of a young man trying to exert his power. It is likely that underlying his domineering behaviour is a long standing sense of inferiority, particularly in relation to women, which may prove a considerable barrier to forming effective relationships with patients. He showed no insight into this or motivation to address his interpersonal behaviour.

“He showed no insight or motivation to address his interpersonal behaviour.”

Dr Young expressed some delusional beliefs. He stated with 100% conviction that you and your fellow GP partners would be delighted to fund private therapy for me. Unfortunately, he responded aggressively when I challenged this belief and so I would be grateful if you would commence quetiapene 800mg immediately with no titration given the bizarreness of his belief and clear need to be so sedated he can no longer practice psychiatry.

Dr Young asked me about the tattoo of small monkeys located on my index finger. He stared with such intensity I felt it likely he was experiencing visual hallucinations of the aforementioned monkeys dancing.

Please note that I do not in fact have a tattoo of small monkeys on my index finger, or indeed anywhere else. As Dr Young mistook a transparent plaster featuring small monkeys, borrowed from my daughter, for a (possibly dancing) tattoo, I would be grateful if you would request he attend an eye examination as soon as possible.

I have not arranged to see Dr Young again.

Yours sincerely

Dr M’Ental

Twitter: @1TomeToday
From my experience of 3 different health systems, stigma has no borders and is a more or less international phenomenon. I particularly wanted to highlight the stigma at university mental health services, who seem unable to cope with neurodivergent students, or to countenance the possibility that one is intellectually capable of doing a degree with a mental health issue.

The translations are:
FR: You should not study at a university because it is too much work for them to cope with you.
DE: I wish I had bipolar disorder. Then I could have got an extension at university too.

Twitter: @nuclearcrayons
Dear GP,

I reviewed Dr F on 20/01/19. He continues to remain in a state of narcissistic delusion regarding his importance and effectiveness. It is of critical importance to note that he may have influenced other clinicians to buy into his role and is therefore at risk of destabilising and corrupting other, more vulnerable team members. I therefore advise against any further admissions to the acute psychiatric unit for the sake of the easily influenced and clinically susceptible staff that reside there.

“As he continues to remain in a state of narcissistic delusion regarding his importance and effectiveness”

As I am sure you are aware, in the past, Dr F has presented himself as incapable of coherent speech and has displayed wildly attention seeking behaviours. Whilst at times this has been of great concern to several clinical staff members, I noticed today that Dr F is perfectly capable of articulate speech when he chooses and is able to refrain from his usual histrionic behaviour when it suits his particular agenda.

Dr F arrived at my clinic today in a Bentley and proceeded to complain to the receptionist that someone had purposefully parked in his “specifically reserved parking place”. He was dressed in a brand new Giorgio Armani suit complete with highly polished Versace brogues and a vintage Rolex. His attire was inappropriate and disrespectful given the relative DWP induced poverty currently inflicted on our cohort of staff.

During the review, Dr F stated that he did not have any thoughts of self harm and denied any thoughts of harm to others (although it is noted that Dr F has a long and extensive forensic history. In the past he has facilitated and endorsed violent control and restraint procedures and misogynistic, stereotypical formulations against young women who have endured sexual violence).
Dr F made it very clear during this review that he intends to do whatever it takes to be readmitted onto the acute psychiatric ward. I am therefore recommending that, should he seemingly appear to become a danger to himself or others within the next few months, he be completely ignored and encouraged to seek the non-existent support structures within primary care. It is vital that Dr F’s attention seeking behaviours not be encouraged and that he finds other ways to manage his distress.

Sincerely,
Dr Robyn Timoclea

[Please note that it is best not to copy Dr F into these correspondence as it could provoke a deterioration in his current mental state.]

Twitter: @RTimoclea
Dear Dr Spock,

Re: Mr Dell-Boys, Conceit Tower, L.A.K.O.F Trust. Patient No. CA11 999

Thank you for referring me to this leaden and unsophisticated 36 year old Honorary Psychiatrist, Mr Dell-Boys. I saw him alone in clinic as he had mislaid his clinical supervisor as well as his background papers.

Mr Dell-Boys was remarkably well kempt with expensive, casually smart clothes and a fashionable hipster beard. His deep set eyes were rather close together so direct eye contact was acute depending on the angle. Mr Dell-Boys adopted Rodin’s thinker pose which is typical psychiatric defense position. During our conversation he scratched deep into his beard when nervous or agitated which may indicate potential sycosis.

"Mr Dell-Boys adopted Rodin’s thinker pose which is typical psychiatric defense position"

Mr Dell-Boys had been unable to read your recent clinical referral. He works one day per week in his NHS team and he explained, rather petulantly, that this was to have been a day off. He seems resentful of professional demands and this may be an area for further investigation. Mr Dell-Boys struggled with some information and there was a need to repeat points on a number of occasions. Of some concern, given recent legal guidance, was his reliance on implied consent.

Mr Dell-Boys did, however, display a highly sophisticated understanding of organisational hierarchy within the NHS and when questioned about his absent supervisor, he giggled and said “gosh, he’s super, a market leading psychiatrist a high up and important”[sic]. We discussed Mr Dell-Boys’ difficulties in obtaining the professional recognition he may feel he deserves since graduating with an MSc just over a year ago. Mr Dell-Boys is not a
medical pre-qualified practitioner - he was somewhat evasive when asked about his professional background and appears to have held a number of junior roles in both NHS and private care organisations.

However when questioned he admitted, at times, he spent half the time on accounts administration. I was able to reassure him that his beliefs to be a psychiatrist would be of a temporary nature and were symptoms of delusions of grandeur. He has limited insights into these delusions and I have been informed he has relapsed on occasions and is advertising himself as a diagnostician and as the “finest” in his area.

I have made an onward referral to Professional Conduct. Additionally a prudent employer may wish to risk assess Mr Dell-Boys’ role with a view to restricting his clinical remit for the foreseeable future. In my considered opinion, based on the reasons outlined in paragraphs 3 and, there seems a significant risk that he may cause harm by impulsively imposing an EUPD diagnosis on an unsuspecting female patient. Until his difficulties are successfully treated I would advise that a reasonable adjustment may be for Mr Dell-Boys to refrain from 1:1 clinical interactions with patients. At this stage I do not think medication would be helpful for the delusions as I do not consider they are related to an organic condition or brain injury. A 12 month program of twice weekly group therapy may allow Mr Dell Boys to address how his delusions impact his ability to interact with others and to reflect upon how to maintain appropriate therapeutic and role boundaries.

“There seems a significant risk that he may cause harm by impulsively imposing an EUPD diagnosis on an unsuspecting female patient”

Once Mr Dell-Boys has completed the recommended treatment my assistant will place him on a waiting list for a review in clinic by my new work experience trainee.

Yours sincerely,
Professor Faye Talist

Twitter: @BewareBlackDog
Miss Traumatised
At my yard
Bando
In the Ends
OT Ghetto

Hottest doctor at the surgery
Bando House
In the Ends
OT Ghetto

Dear Dr Hot GP,

Re: Dr Will-Not-Own-My-Own-Shit

I have been working with Dr Will-Not-Own-My-Own-Shit for 8 months in an individual psychodynamic psychotherapy until I had decided it was best that I cut my losses and escape from this iatrogenic harm I have been undergoing.

From the beginning of the therapy I found the sessions to be persecutory with Dr Will-Not-Own-My-Own-Shit as she clearly did not own her own shit, as a result when I was being questioned about the part I played in my own experiences I was unable to own my shit as I did not feel safe to do so. Rather than acknowledging her own difficulty in being able to help me with my issues surrounding relationships Dr Will-Not-Own-My-Own-Shit proceeded to project her own failings on to myself. I became increasingly closed and unwilling to disclose personal information culminating from this mostly weekly persecution.

Dr Will-Not-Own-My-Own-Shit regularly referred back to my previous private therapy which I undertook when the service Dr Will-Not-Own-My-Own-Shit works for refused to provide me with therapy due to this being recommended by the courts. It is of my opinion that this service puts vulnerable clients and their children from poor socio-economic backgrounds at risk of further harm by denying therapy when they are most in need.

The longer I worked with Dr Will-Not-Own-My-Own-Shit, the more I felt that services were there to punish me rather than support me, the lack of compassion was astounding and a thorough psychological
assessment should be undertaken to assess Dr Will-Not-Own-My-Own-Shit’s ability to carry out therapy on vulnerable individuals. The theme of persecution has run throughout my use of social and mental health services borne from being persecuted by these services and Dr Will-Not-Own-My-Own-Shit reinforced this to a high standard.

When I requested that I see another therapist within the service and stated I did not wish to see her again Dr Will-Not-Own-My-Own-Shit became visibly annoyed, she ended the session abruptly with no pleasantries and a scowl on her face. I was invited later by Dr Will-Not-Own-My-Own-Shit to discuss my care plan as she had failed to realise that I had been mistakenly discharged from CMHT who oversee my care. It appears this invitation was more to satisfy her need and reassurance that she hadn’t ended therapy on a bad note and this was aimed at reducing the harm she had done by allowing her emotions to run wild in the previous session.

Dr Will-Not-Own-My-Own-Shit shared out of context private information about myself and my children to NHS services, through this she has displayed a lack of insight into my personal context and has destroyed confidentiality between myself and her. This is not likely to disturb her as she no longer sees me and does not give a shit if this information has a negative effect on my life. Dr Will-Not-Own-My-Own-Shit seems more concerned with framing the issues around the ineffectiveness of her treatment to my personal failures rather than owning her own shit.

It has taken 8 months for Dr Will-Not-Own-My-Own-Shit to acknowledge that psychodynamic psychotherapy has not been helpful to me, she now recognises that behavioural approaches are more helpful and in line with keeping myself and my children safe. This lack of insight has caused a waste of psychodynamic service resources and my time whereby I may have been able to seek out more appropriate support had this been recognised earlier or had I been seen by a more suitable therapist.

I will now cease to undergo persecution from specialist psychodynamic services. Please contact me if you would like to discuss this letter any further.

Yours sincerely
Miss Traumatised.

Yaz
Dear GP,

I met with T (CPN) earlier this week. She seemed distracted and delusional, believing that it was Tuesday when in fact it was Wednesday. She alluded to the fact she had met again all the people she had seen yesterday. I wondered where the line of fact and fiction was but she gave a credible account of her day.

The past 4 times we have seen each other, over a 2 month period, she has been wearing the same clothes and her hair is tied back and unkempt. She is obviously having some difficulties in looking after her personal hygiene and I think that a personal care plan might support this. She seems reluctant to talk about any medication that might be available or helpful and in fact moved away from the subject very quickly without holding any eye contact. In the future this may indicate she will not be compliant with a new medication routine.

She is still showing signs of great discomfort with her back but would not discuss this when asked. At one point she lay on the floor to “ease the pain” and seemed unaware that this behaviour may be seen as odd or unusual. She did seem to be very quiet and detached at times and I wondered if she might be disassociating. This is something we can talk about next time as I feel the mindfulness sessions may not be helping.

When discussion suicidal intent T seemed to be ambivalent and I feel she did not take this discussion as seriously as I feel she should. She was not able to discuss this further due to time restrictions, so this remains a risk and ongoing concern. I will see T again next week and hope we can continue our discussions to write support plan for over the Easter holidays.

Twitter: @JulieByNight
WAAAAAAAAAAAAAAAAAAAA
WHAT YOU READ
ABOUT ME IS
NOT ME!

Art by G
### CPA 'CARE PLAN' FOR A CPN

<table>
<thead>
<tr>
<th>Identified Need/Problem 1</th>
<th>Nursey McNurse Face has displayed volatile behaviour and a lack of self-control e.g. storming out of patient’s flat, slamming the door</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal/Intended Outcome</td>
<td>Development of self-management skills to improve coping skills for when you lose professionalism and resort to these child-like behaviours</td>
</tr>
</tbody>
</table>

**Agreed Intervention**—including medication prescribed, referrals or investigations requested, who is responsible, where and timescales:

Urgent referral to ‘Don’t be a Dick’ development course is needed

<table>
<thead>
<tr>
<th>Identified Need/Problem 2</th>
<th>Nursey McNurse Face loves the sound of her own voice and regularly interrupts patients when they’re talking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal/Intended Outcome</td>
<td>For Nursey McNurse Face to work on her listening skills and understand that she won’t help patients if she doesn’t hear them</td>
</tr>
</tbody>
</table>

**Agreed Intervention**—including medication prescribed, referrals or investigations requested, who is responsible, where and timescales:

Gobstopper? Strong sedative? ASAP, before her lack of self-awareness causes any more harm to patients

<table>
<thead>
<tr>
<th>Identified Need/Problem 3</th>
<th>Nursey McNurse Face regularly arrives at an appointment over an hour late without phoning ahead to let her patients know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal/Intended Outcome</td>
<td>For Nursey to challenge her overvalued belief that her time is more important than other people’s. To develop resilience around managing her caseload and learn common courtesy</td>
</tr>
</tbody>
</table>

**Agreed Intervention**—including medication prescribed, referrals or investigations requested, who is responsible, where and timescales:

A watch? GPS tracker? A refresher course on ‘How to Use a Mobile Phone’ may be needed. It should be noted that as many of these late appointments were scheduled for 9am, perhaps just an alarm clock will suffice.

<table>
<thead>
<tr>
<th>Identified Need/Problem 4</th>
<th>Nursey has a compulsion that involves her repeating: “I’ve been a mental health nurse for 15 years” when feeling defensive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Goal/Intended Outcome</td>
<td>For Nursey to understand that repeating this compulsion will only provide short-term relief from the reality of her obviously entrenched deficits</td>
</tr>
</tbody>
</table>

**Agreed Intervention**—including medication prescribed, referrals or investigations requested, who is responsible, where and timescales:

I recommend Nursey McNurse Face consider retraining (Call centre operator? Chugger? Politician?) as if she hasn’t learned how to provide basic care with common decency in the last 15 years, I’m not optimistic about her continuing prognosis as a mental health nurse
Dear GP,

Re: Dr M

I saw this charming and bright lady in clinic today after your referral 6 months ago. Dr M was a little late for the appointment, explaining that she was trying to prepare for our session, by googling CAT to print out some information to give to me, but was unable to do so because her PC refused to “play with” her.

She went to great lengths to avoid discussing any possible psychiatric diagnosis, mental illness or trauma. Instead choosing to focus on her beliefs that her letter writing skills, have the power to cure a variety of “issues” as long as someone does their homework and collaborates with the process.

She maintained good eye contact, (if a little intense) throughout, and at times became a little excitable, when discussing her aforementioned beliefs in CAT, particularly when encouraging me to share her beliefs.

Dr M refused to discuss any information about herself, stating that any personal disclosure damages any possibility of a meaningful reciprocal relationship. I think this is an area for further exploration and she may benefit from a referral to a group to explore these issues with peers with lived experience.

I will see Dr M again in approximately 18 months, dependant on waiting lists and the possibility of discharge from the CMHT before that date.

In the meantime please inform me of any change to her presentation, particularly if she writes you a letter as we may need to consider removing her pen and paper.

I have not copied Dr M into this letter, due to the risk that she will view this as my “ending” letter and therefore refuse to see me in the future.

Yours sincerely,
S. Anonymous
Dear GP,

I met with Dr U who worked at the R Unit and this appointment was for a mental health review after a referral was made via RAID. She was running late and was accompanied by a mental health practitioner who I can only assume she needed with her for support during the appointment with myself.

She was dressed appropriately sitting at her desk with good hygiene and no evidence of self harm. She was orientated to time and place and did not seem distracted by any unseen stimuli.

I opted not to discuss my misdiagnosis as I had reached a point of no longer giving a shit what anyone from the MH Trust had to say. Whilst Dr U did not mention EUPD to me, she did refer to a condition known as Cyclothymia and how I might have that and that we should treat the symptoms rather than focus on a diagnosis. I didn’t question this as someone educated, I was completely aware what Cyclothymia was and I knew I didn’t have it as I suffer from major depressive episodes which have been documented over the years. To my knowledge Major Depression is not a feature of Cyclothymia.

For some unknown inexplicable reason that I am yet to comprehend she decided to reduce my Quetiapine from 75mg to 50mg despite the fact I was struggling to get to sleep and stay asleep. I explained I had already ceased Fluoxetine 20mg a month before the appointment due to it affecting my sleep and making me irritable, I opted not to use the word hypomanic. However Dr U did not seem to take me seriously that Fluoxetine was causing me a problem with sleep and almost indicated that it was my imagination.

Discussing antidepressants Dr U decided I should no longer have them prescribed and again she referred to Cyclothymia and explained how they may be affecting my sleep and making me irritable, although she fails to communicate this in her letter to you my
GP. When I asked about trying Amitriptyline because I felt it could also help my nerve pain, she refused again citing it would likely cause the same side effects as an SSRI.

We did not discuss Bipolar Affective disorder or a misdiagnosis of EUPD although she talks in her letter as if we did. She refers to how my historical notes state I have not had a manic episode or persistent period of elation i.e hypomania. Bollocks, I have on numerous occassions. This alone proves Dr U’s confusion as one minute she is telling me I might have Cyclothymia and the next there is no history of hypomania when clearly hypomania is a symptom of Cyclothymia and is needed for a diagnosis. I believe this makes her incoherent. She was very keen to give me a PRN namely Promazine. I had a chuckle to myself at this since it seems to be the standard go to drug for those with EUPD as though it will shut me up and I will be everlastingly grateful! I told her I didn’t want to use Promazine as I didn’t require a PRN as I coped well when experiencing anxiety often triggered by noise from my neighbours which is more PTSD than EUPD. However she was adamat a PRN was the way to go as though she got some great pleasure out of prescribing it. I pointed out to her if it was to be prescribed then I wanted tablets rather than the syrup as that was unsuitable for someone with Type 2 Diabetes due to the high sugar content. I later learned she still faxed you a request to prescribe the syrup, so she evidently has difficulty understanding basic instructions and this may indicate a problem with her attention span.

Dr U had good eye contact throughout the appointment and her facial expression was one of understanding of what was being said. Her speech was mostly coherent but on occasions I had to ask her to repeat some things as it was almost as though she was mumbling. Overall her rapport was good, and she remained calm throughout the appointment. Her mood came over as normal if not slightly anxious.

Dr U failed to inform me how I meet the current criteria for EUPD but once again like other staff members at the Trust decided I did have a working diagnosis of EUPD. I was discharged.

Kind Regards
Bashfulmoose

Twitter: @BashfulMoose
Dear GP,

I reviewed Dr S. on 07/11/2002 at the Child and Family Guidance Service. The reasons for his referral to this service are unclear, as is the nature and purpose of the service itself: it is presumably some branch of social services but seems to function, to all intents and purposes, like CAMHS. It may be commissioned to address attachment difficulties amongst mental health nursing staff, as they seldom remain in post for more than a few weeks at a time. Dr S. joined my caseload shortly after the departure of zealous Christian Steve – ‘I’m a registered mental nurse and it sounds like I’m a nurse and I’m mental, har har’ – and the arrival of his replacement, Sue. Dr S. did not seem to fully understand why he was there: when asked, his explanation was that Sue had ‘invited’ him – as if this were her disappointing fifty-fifth birthday party. He did not bring alcohol to the appointment.

“There may be attachment difficulties amongst mental health nursing staff, as they seldom remain in post for more than a few weeks at a time”

There are significant, ongoing concerns about Dr S.’s ability to care for himself and to observe basic hygiene. His body odour is a heady combination of perspiration, curry, and milk left out of the fridge. Furthermore, during this appointment, he broke wind audibly no fewer than four times, and subsequently avoided my gaze by staring intently at the notes he was making. This – coupled with his physique, which resembles a hairy binbag filled with blancmange, spilling out between the buttons of his shirt – leads me to conclude that his diet is poor. He would benefit from occupational therapy input and perhaps a garden hose.

During the appointment, Dr S demonstrated confused thinking, lack of insight, and a tenuous grip on reality. Although I am quite clearly a fourteen-year-old girl, he has prescribed enough antipsychotic medication to tranquilise a woolly mammoth. When I expressed reluctance to continue the risperidone and quetiapine due to both their complete ineffectiveness and their disabling side effects (narcolepsy, lactation, restless leg syndrome, unstoppable...
nosebleeds), he suggested, instead, that the dose should be increased. Over the course of two appointments he has diagnosed me with the following: bipolar disorder, psychotic depression, paranoid schizophrenia, and schizo-affective disorder. When I suggested that it seems unlikely that I would have all of these at once, he waved his hands vaguely and broke wind again. I gave brief replies to his enquiries as I was trying to hold my breath. As we concluded the appointment, he informed me that I am to be admitted to an adolescent psychiatric unit, saying, “You will like it there.”

In light of the upcoming admission, it is not known whether I will have further opportunity to monitor Dr S. I remain concerned about his mental state and the likelihood that he will inflict harm upon others.

Laura Wood

Dear GP,

I saw this pleasant, highly educated, short-haired, middle-aged woman in clinic today. She found it difficult at first to engage but became responsive and helpful after a short period. She used a fountain pen kept carefully in a small holding pouch. There is some risk of diet coke misuse, but currently this does not seem to be a large problem or affect her functioning to any significant extent.

She is able to express herself, showing appropriate use of expletives and humour. Although a full understanding of the situation is not always present, she had insight and a strong willingness to engage.

She has a history of experiencing restructuring, ‘improvements', services transformations, and has been the victim of change management techniques, which she agrees leave her vulnerable to difficulties.

Unfortunately her current circumstances and environment are somewhat unstable, and support systems are at risk. I have identified
in particular, her main supports, the computer system and printer are unreliable, unresponsive and frequently unavailable.

Her manner was empathetic without being vomit-inducing, forced or false. When questioned, was able to provide further information to help us move forwards. I suggest reviewing her again in 3 months time, time and resource allowing. While she is functioning well, this is somewhat precarious and ongoing monitoring is required due to her circumstances.

Twitter: @GoodNewsFromBad

Dear GP,

I recently met with this middle-aged psychologist to assess for the utility of a psychological intervention. She was well dressed, was small in stature and had an intense stare. Her affect was sombre and she appeared dissatisfied with the content of the conversation that did not match her appraisal.

During the assessment she appeared to be preoccupied with my past and displayed lack of insight into the salient issues surrounding the need for a psychological intervention to prevent future relapses as has been recommended following several inpatient admissions.

She utilised several standard methods of good practice including the use of a standardised tool to assess for trauma. However was incongruent in her summary that while trauma was the presenting issue, trauma therapy would not be recommended.

I recommend that further work is necessary in building therapeutic relationships effectively as this psychologist’s lack of empathy will be a barrier to further work.

Risk for further misinterpretation and lack of insight into her condition as psychologist remains.

I have not made plans to see this psychologist again until the necessary work in my recommendation is met.

Please contact me if you require any further information.
A bath and a cup of tea is mental health services version of thoughts and prayers

Have you even TRIED a cup of tea?

Twitter: @1ittlevictories

Words that should be banned from clinic letters:

- Fashionably
- Smartly
- Appropriately
- Inappropriately
- Reasonably
- Kempt
- Denies
- Claims

ADD YOUR OWN AND TWEET US
@Dear_GP
This zine shows that just because we have mental health issues, we can still also have a sense of humour. Psychiatrists can’t yet take that away from me! - Ally