That reminds me of an anecdote on vaccination. It took several decades to know how the smallpox vaccine worked. If we wanted to wait to know the exact mechanism, millions would have died.

True. And if we contrast it with the present state that different vaccines are proposed for COVID-19, based on detailed models of cellular mechanisms of disease progression and how to interfere with them, it shows how much this field has progressed.

Going back to the reductionism, I found it interesting that you used emergentism as a way to challenge reductionism.

That was interesting. I didn't try to defend emergentism, which is a slippery idea with a complex history. I understood the position simply in terms of evolution, in which increasingly complex forms of life appear, each with characteristic phenotypic traits and associated causal powers.

I think your formulation of the biopsychosocial model is very useful. It could be very informative with concepts such as trauma.

Trauma is of course an important and interesting topic, with a long history in psychiatry and psychology. In terms of the biopsychosocial model we propose, trauma is an environmental stressor that has a direct negative impact on agency. In defining trauma in the context of PTSD, DSM and ICD regard 'helplessness' as a key feature. The position is that the most salient and important outcome in the situation (the person's own survival) is out of their control. This occurs in acute situations like trauma but also in chronic exposure to severe stressors, implicated in upregulation of psychobiological stress mechanisms and raising risk of many kinds of both mental and physical health problems.

Thank you very much for your time.

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COLUMNS

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What have we learnt from Covid?

Early on in the pandemic, many prisoners were glad to learn of their early discharge. Not long after they reached the imagined freedom of their homes, they found themselves in another prison, their incarceration now managed by an invisible viral cloud. We can learn much from this.

In March, I saw a newly released 33-year-old drug dealer. Via video, his daytime flat looked as dark as a cell. He reported anxiety, but his nightmares were worse – he dreaded return to the time he left his cousin to bleed out in a car park, calling the ambulance before he ran. That was 5 years ago, he said, but why is this coming back to me now?

Over months, peering into the homes of patients like never before, I saw how, denied of their routine contacts with the world, long-managed trauma and abuse were reappearing everywhere. Covid reminds us that all of daily life is an adaptive coping strategy; Palmer[1] dryly calculated that even a patient seeing their general practitioner fortnightly for a year would spend 99.95053272% of their life beyond the medical gaze. We should ask patients less about their symptoms and much more about what they actually do all day.

My drug dealer wasn't hemmed in by fear of some bug. He was responding to social imperatives described by Durkheim[2] over 100 years ago: the sharing of any strong emotion causes predictable changes in that group; consider the nation's behaviour after Diana's death, or that of Sir Captain Tom. My patient was kept under house arrest by the weekly banging of pots and the sudden ubiquity of fear-linked stimuli: what Daniel Kahneman[3] describes as an 'availability avalanche'. We were entranced by Boris at six, exhorting us to 'stay home, stay safe'. We hurried back to an elderly couple of wise institutions: the National Health Service and the BBC, which only months earlier Boris had considered cutting. We can discern another lesson here, at a social scale. We should spend less time exploring our

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patient's heads and pay more attention to the world around them. We have, after all, chosen to treat the only organ in the body that can vote.

Our sudden distance from our patients was no mere social distancing. Unlike the rest of medicine, psychiatry has almost no tests or devices to refine its efforts. Instead, we rely on our ears, our eyes and sometimes our noses. We started looking and listening from behind a screen. The bravest had only a mask. How odd it felt to be suddenly deprived of – and made to appreciate – those countless tiny cues, the sighs, the diverted gaze and its flinching return, and, most of all, the silences. It was not easy to gauge the pain and poignance of those quiet moments that are the stock of our trade. Like musicians, so much of our work goes on in between the notes. How do you assure someone of your understanding when you have unleashed waves of grief and tears 4 miles away?

For all the optimistic talk of 'virtual clinics' in the future, psychiatrists must be wary. Our work is not like the rest of medicine. Distance deprives us of our most important tool, a potent mix of knowledge, interest, empathy and proximity. Without this, we cannot properly grasp the thoughts, feelings and hopes of our patients.

If medical science has taught us one thing over the past hundred years, it is that human suffering is incredibly complex. Many of our responses, our resort to explanatory biological myths and diagnoses of questionable validity,[4] or the shrinking of our discharge summaries, all are signs of our instinctive retreat from the bewilderment we feel when confronted by complexity. Psychiatry is stigmatised for its apparent inability to match the 'precision' of our more bodily focused colleagues.

Although we claim to give equal weight to the biological and the psychosocial elements of our assessments, the truth is that we are drawn to the former, because they seem less challenging.[5] Covid's lesson for psychiatry is clear: psychiatry must face the true complexity of mental illness head-on. If we are seen to do this by the rest of the medical profession, our uncertainty in the face of it could become psychiatry's touchstone rather than its millstone.

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Invisible youth during times of Covid

Covid-19 continues to devastate, the elderly and those in care homes being particularly vulnerable. However, there is an unexpected population that is at great risk of morbidity due to Covid-19, the adolescent forensic population. This increased morbidity is a result of the care offered by statutory agencies being greatly diminished across all settings owing to the pandemic.

One of the first things that you learn in adolescent forensic psychiatry is that perpetrators are also victims, and it can be hard to distinguish between the two. This does not excuse the crimes they have committed but does add an extra complexity to their treatment. Young people who present with complex forensic issues are particularly vulnerable, often having histories that include early trauma, repeated loss, attachment issues, learning difficulties and mental health problems.[1] This population is notoriously difficult for professionals to engage with, for many of the above reasons but also because of the possible consequences for them and their families of talking about the criminal aspects of their lives. The reduced consistency that services currently provide has affected their engagement and the possibility of a therapeutic alliance, thus increasing risk for themselves and the public.

A further contributing factor to increased morbidity has been school closures and agencies working remotely, leading to reduced access to support and structure, which has exacerbated vulnerabilities. Challenging behaviours were previously mitigated by the provision of education and other prosocial activities; the reduction has led to increased episodes of violence.[2] This has particularly affected young people with neurodevelopmental disorders and special educational needs, with the effects likely to be long term, complicated by loneliness and a disconnection from their community.

Youth custody has had to be increasingly vigilant to ensure the safety of detainees and prevent Covid transmission. There is a need to isolate those being transferred into custody in the first 2 weeks to prevent transmission of Covid.[3] It is known that this is the time of greatest risk of suicide for young people in custody, when young people are now needing to isolate for Covid, thus increasing isolation and risk. Staff shortages, education closure and the need for Covid 'bubbles' has meant extended time alone in cells even after those first few weeks, which increases the risk of self-harm and suicide.[4] Furthermore, the pandemic has led to a backlog in the courts, and concern over community services has meant that more young people are being remanded and for longer periods. It is of note that the majority (63%) of children given custodial remand did not subsequently receive a custodial outcome in 2018.[5] These factors – extra time in cells and longer time on remand – can mean the compounding of an already traumatic experience for many in youth custody.

Young people with a combination of mental health and forensic issues are placed in secure adolescent psychiatric units to receive appropriate treatment. The effect of the Covid pandemic on staffing in these units has negatively affected the availability of support, and things that are often a lifeline for these young people, such as community access, planned leave and family visits, have been cancelled. A bottleneck has occurred, with transition back to the community being stalled

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