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A meeting point for neurology and psychiatry?

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Correspondence

Psychotherapy via Skype: a therapist's experience

There are some who think that psychodynamic psychotherapy has not or will not move with the times. Perhaps because of this attitude and it not being seen as a cost-effective treatment, services have recently been decommissioned in the National Health Service (NHS).¹

There is an ever-increasing number of people delivering psychotherapies over the internet. You only have to google 'internet psychotherapy' for a plethora of websites to appear providing you with access to online material and 'face-to-face time' with a therapist. There is, however, very little research into the delivery of psychodynamic psychotherapy via the internet. The vast majority of studies to date have investigated the effectiveness of cognitive-behavioural therapy delivered by modern communication,² predominantly self-guided or by telephone, but even this research is scant. An article by Fishkin *et al*³ discusses how for several years the China American Psychoanalytic Alliance (CAPA) has provided treatment, training and supervision via the internet using Skype, which they have found to be a practical and successful alternative to traditional methods, and which has been instrumental in improving access to training and therapy for Chinese mental health professionals.

I was almost halfway through my year-long psychodynamic psychotherapy sessions with a patient when he told me that he was moving to a different city and so would no longer be able to attend. We were both disappointed; sessions had been going well and we had developed a good relationship. The patient suggested 'meeting halfway' but this was not practical and we concluded that his therapy with me would have to end.

At my next supervision I delivered the news to my supervisor who, much to my surprise, suggested carrying on via Skype. When I mentioned this to the patient at our next session he was very happy to give it a go.

Before the first internet session, I had tested it out with a friend to ensure I had the right lighting and environment at my end. The patient would be in his own home. I was quite intrigued by the fact that the patient, who had reliably been about 10 minutes late for the majority of our face-to-face sessions, was also 10 minutes late for his Skype session, and for many of the subsequent sessions too. It took a few minutes to get going but it was actually surprisingly easy to adjust.

The patient instantly appeared more relaxed and appeared to speak more openly and frankly with me, which continued throughout our Skype sessions. Was this a consequence of him being in the comfort of his own home, or perhaps not being in the same room was less intimidating?

Something that was quite disconcerting was trying to make eye contact; the positioning of the cameras meant that for both of us, looking directly at the other's face on the screen would mean that eye contact was not being made. I would sometimes try to compensate for this by looking directly into the camera but this felt false and I would not be able to tell whether he was returning my eye contact. However, by discussing these difficulties and the nuances of Skype, this did not appear to hinder our sessions.

Silences and active listening suddenly became a new experience to negotiate. Any prolonged pauses would cause me to worry that the connection had been lost, and clearly this was also the patient's concern as we would both on occasion say, 'Are you still there?' Similarly, I also found myself nodding in an exaggerated manner and making louder and more frequent listening noises to convey to the patient that I was still connected, both technically and mentally.

A few sessions were blighted by technological problems: the sound would not sync with the picture or it would cut out altogether, the patient's face would become a hazy blur and sometimes the connection would be lost several times, making for a rather disjointed session. There did seem to be a correlation between these technically difficult sessions and psychotherapeutically challenging sessions. From my notes of these particular sessions, I detected in the countertransference a sense of frustration, often before any technological difficulties ensued; however, this is likely to be only coincidence.

For the final session we met in person again, which felt like a more appropriate way to end. I had not seen the patient in the flesh for over 6 months and so felt slightly apprehensive as to what it would be like. It actually felt 'normal', which I believe is a reflection of the effectiveness of the Skype sessions at maintaining and building on our already established therapist-patient relationship. This phenomenon is also mentioned by Lana Fishkin³: part-way through the analysis with her patient she was able to meet him in person in China. Both she and the patient commented that it did not feel different from their Skype sessions.

Overall, I think that being able to continue our sessions via Skype was incredibly useful for both the patient and me. It meant that those that we had before he moved were not a waste of our time and of course this had a positive financial implication for the psychotherapy service too.

In both my and the patient's opinion the therapy had been successful. This was also reflected in the outcome measures (the CORE outcome measure tool): the patient showed a significant improvement in all domains of well-being, symptoms, functioning and risk, which was also sustained at a 6-month review. What impact the use of Skype had on the level of improvement is, however, uncertain: the effectiveness of psychodynamic psychotherapy via Skype compared with being in the same room with the patient is an area for further investigation if this method is to be taken seriously.

I believe that there is a role for Skype or other distance communication technologies in delivering psychological therapies. I think my successful use of Skype was facilitated by having already developed a rapport and a good relationship with the patient over several sessions in person, although Fishkin *et al*³ did not report any negative sequelae of not having met their patients in person before starting therapy. The use of such modern forms of communication could, and does, have a role in improving access to psychotherapies for people living in remote areas and also for people who might be housebound. The role of online therapy delivery is expanding and is likely to

continue to do so. For this expansion to be successful further investigation into its effectiveness is warranted.

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Teaching undergraduate psychiatry in a forensic setting

Typically, medical students do not learn about psychiatry in forensic settings. Depending on their interests and their medical school, they might have access to special study modules or elective placements in their final year. We introduced undergraduate psychiatry placements at our regional forensic service in New Zealand and surveyed the experiences and attitudes of our students over the past 2 years. The placement includes experience of medium-secure in-patients, community, prison and court liaison services.

McGauley & Campbell¹ asked whether medical students needed to know anything about forensic psychiatry and concluded that forensic psychiatry taught students about managing chronic illness, working with complex patients, understanding stigma and security, learning about personal and organisation dynamics and experiencing multidisciplinary, cross-disciplinary and multi-agency working. Such issues are relevant to all psychiatric specialties and some areas of medicine.

The University of Otago Medical School, Dunedin, was the first to be established in New Zealand. There are about 270 students each year. Students study psychological medicine throughout the 2nd year, and 8-week attachments, divided between two different areas of psychiatry, are compulsory in the 4th year. Students attend placements as part of the clinical team and complete logbooks of experiences, including team working and ethics. They see patients and learn about the assessment, formulation and management of common mental health problems. They regroup for weekly medical school teaching and undertake an examination with written and practical components.

We designed an online survey, which the medical school emailed to our 15 students who had spent their psychiatry placement with our forensic service; 73% (11 students) responded. They were asked about the expectations and experiences they had had, the disorders they had learnt about, what they had enjoyed and what could have been improved.

Interestingly, 27% were anxious about starting their placement. Most students thought that they would be learning mainly about 'legal issues' and seeing patients in prison. Some had 'no idea' what to expect. All respondents gained experience of seeing patients with schizophrenia, bipolar disorder, drug and alcohol problems and the problems associated with psychological trauma and head injury. Over

70% also gained experience of seeing patients with personality disorders. Depressive and anxiety disorders were less commonly encountered, with around half of students gaining experience of these. We learnt that about 27% of respondents felt unsafe at some point during their placement and subsequently introduced a first-day security and safety induction and distributed a leaflet explaining the nature of forensic services and the placement, which we were told was useful.

All students were positive and stated that they had enjoyed their placements. Over 70% rated the placement as 'excellent'. They appreciated seeing patients in a variety of settings which included in-patient, community, prison and court, and gained experience of a variety of mental health problems. Some students remarked that the placement was one of the best they had done in their undergraduate training to date. Forensic settings can therefore provide useful and enjoyable experiences to students as they learn about psychiatry as undergraduates.

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Recruitment into psychiatry is working, but we are responsible for maintaining the momentum

It is no secret that psychiatry has always struggled to recruit adequate numbers of doctors. This has led to the Royal College of Psychiatrists launching its Recruitment Strategy, implemented by a recruitment team. Their targets are to increase recruitment to core psychiatric training, achieving a 50% increase in applications and a 95% fill rate by the end of their 5-year campaign. It is therefore most encouraging to learn that those foundation year (FY) doctors who are exposed to psychiatric placements are almost ten times more likely to embark on a career in the specialty. *BMJ Careers* reports¹ that 15% of those FY2 doctors who undertook psychiatry placements applied for core psychiatry training, as compared with a mere 1.8% of those with no psychiatry exposure during their Foundation Programme. At last, a reason for quiet optimism, perhaps.

However, if we are to succeed in helping the College achieve its targets, it is clear that supervising clinicians have an important role to play. Archdall *et al*'s qualitative study assessing medical students' perspectives of psychiatry post-attachment,² makes it patently clear that positive role models are a key factor in influencing eventual career choice. Respondents valued enthusiasm, eagerness to teach and motivation in those they were attached to as the most important qualities. It is highly likely that similar factors come into play with respect to influencing foundation doctors in choosing to pursue a career in psychiatry. Therefore, it is critical that those of us who are fortunate enough to supervise students and recently qualified doctors are fully conscious of our powers to positively influence recruitment. With great power comes great responsibility, as the saying goes, so the future of our specialty lies in our own hands.

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Why choose psychiatry? Report on a qualitative workshop

As trainees, we thought that examining the views of trainees who have already chosen psychiatry might add to our understanding of the factors involved in career choice.

In November 2009, the London Deanery School of Psychiatry hosted its annual trainee conference themed 'Recruitment – Everybody's Business'. There we facilitated two identical, optional qualitative workshops entitled 'Choosing psychiatry as a career – influencing the next generation'. Each workshop was attended by 30 individuals, and facilitated by 5 senior trainees and 4 medical students who took verbatim notes. Framing questions were used to identify key themes regarding positive and negative influences on career choice.

Of the 184 delegates, 86 (47%) were male and 106 (58%) reported Black and minority ethnic backgrounds. Two of us (M.P. and K.F.) used thematic coding until saturation of themes emerged. We report these themes briefly here.

Participants described the doctor–patient relationship, the human narrative ('psychiatry is about stories, rather than abstract algorithms'), and the rapidly evolving nature of psychiatry ('you can do things which are ground-breaking') as attractors to the field. They emphasised the importance of conveying the high work satisfaction and good work–life balance, job flexibility, and 'colourful colleagues [who make it] fun' to medical students.

Factors that nearly discouraged trainees from a career in psychiatry included stigma and negative attitudes towards the profession from colleagues. Several trainees described unhelpful experiences during their foundation years: being 'ignored by a consultant surgeon after disclosing an interest in psychiatry', and how physician colleagues 'did not have a positive thing to say about the specialty'. Medical student participants as a subgroup also commented on the effect of negative attitudes from other professionals ('boring job', being seen as 'less of a doctor' and 'becoming mad as a psychiatrist'). Such inter-professional stigma towards psychiatry has been reported to negatively influence choice of psychiatry as a career.^{1,2} Intra-professional stigma and 'negative attitudes and behaviour' were observed among teachers, who were reportedly 'a bit embarrassed about being psychiatrists'. A further theme was the lack of professional confidence and evident role uncertainty among psychiatrists: 'Psychiatrists have big issues with the specialty they've chosen – we don't feel confident we're as valuable as other medical specialties; we're not sure what our role is and what we contribute'.

When trainee psychiatrists were asked what they could do individually and collectively to inspire the next generation,

the main emphasis was on high-quality teaching and clinical placements, making time for experiential teaching, and helping students to feel part of the team. The importance of positive modelling by psychiatrists^{3,4} was also noted, for example, being 'passionate about psychiatry'.

Changes in attitude and perception, both within and without psychiatry, along with improved student placements, role modelling and teaching quality must occur if we are to address low recruitment and, in the words of one of the participants, 'make the specialty something to aspire to, rather than something into which people drift'.

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What about old age psychiatry?

We welcome the article by Oakley *et al*.¹ creating a robust training programme more focused on developing medical expertise will go a long way to addressing the identity crisis currently ravaging psychiatry. However, we were concerned about the proposed structure of postgraduate training with regard to the dearth of old age psychiatry experience. Currently, it is possible to undertake one, and in some cases two, 6-month old age placements at any point during core training. The proposed training reduces this significantly to one 4-month placement as a CT1. All other subspecialties are represented by 6-month placements between CT2 and CT4. It is unclear why old age psychiatry has been excluded from this. Although old age experience at an early stage in training is important, this can only serve as a basic introduction to the specialty and will not allow for the development of expertise and excellence as emphasised in the Tooke report.²

It seems perverse that the authors recommend increasing the total duration of training while reducing the time spent in old age psychiatry. To exclude old age psychiatry from CT2–4 placements suggests non-parity with other psychiatric specialties. We fear this may harm recruitment to the field, as it becomes a distant memory by the time choices for specialisation are made as a CT4. It neglects to tackle the situation of trainees who are undecided about old age psychiatry and would benefit from further experience to aid their decision, or those who have, early on, settled on a career

in old age psychiatry and wish to consolidate their experience in preparation for ST5. The authors raise the issue of 'functionalisation' of general adult psychiatry and the risk that trainees may have very little exposure to in-patient treatment. That problem is resolved in the new proposals by two specific general adult placements each of 6-months. The new proposals do not equitably consider training issues raised by functionalisation in old age psychiatry.

Old age psychiatry is a multifaceted subspecialty incorporating aspects of psychiatry, physical medicine and neurology. This marries well with the authors' suggestion of incorporating more of these two disciplines in psychiatric training. Offering an older adult placement as a CT2–4 may help to maintain the momentum of focus on these skills, and enhance the expertise of all trainees.

- 1 Oakley C, Jenkinson J, Oyebode F. Psychiatric training for the next generation. *Psychiatrist* 2013; **37**: 25–9.
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Authors' response: We are encouraged that our paper has sparked some debate of these important issues. We agree with Conn & Husain¹ that conducting emergency assessments out of hours is a crucial component of training in psychiatry. We also support the Section of Neuropsychiatry's view that evaluation of the practical aspects of implementing a more integrated curriculum would be beneficial.

We understand the arguments put forward by Burza & Hilton about the value of old age psychiatry and their assertion that it has non-parity with other specialties in our proposed scheme for postgraduate training in psychiatry. It was not our active intention to reduce trainees' exposure to old age psychiatry but this was a product of the challenge of trying to accommodate neurology, psychopharmacology and psychotherapy which currently are not routine placements. However, we intend our paper to stimulate discussion and would hope that this, and other perspectives, could lead to further shaping of a proposal for psychiatric training for the next generation.

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A meeting point for neurology and psychiatry?

Oakley *et al*¹ highlight an important training gap in the current curricula of both psychiatrists and neurologists. Among other interesting considerations, the article proposes that 'in the first

year of training, a 4-month placement in neurology becomes an integral part of core training [. . .] to consolidate clinical examination skills and provide experience in the interface between neurological and psychiatric disorders'.

Historically, there is a tradition of cross-fertilisation between neurology and psychiatry, exemplified by the recent renaissance of the 'bridge' disciplines, neuropsychiatry and behavioural neurology.^{2–4} Standards of clinical practice and applied research have benefitted from specialists trained in the assessment and management of behavioural symptoms resulting from pathologies of the central nervous system. In some countries, including the USA and Germany, the opportunity of exploiting these reciprocal benefits is already formalised with integrated curricula at postgraduate training level.²

In the UK, compared with their predecessors, psychiatry trainees have fewer opportunities to gain neurological and medical experience before specialisation. It has become increasingly difficult to move between specialties and there is little incentive for trainees to attain MRCP qualification. Over the past few years, the evolving discipline of neuropsychiatry has made some initial steps to bridge this gap.^{3,4}

Based on these observations, the Royal College of Psychiatrists' Section of Neuropsychiatry agrees with the direction of the proposal by Oakley *et al* and encourages further discussion to translate valuable principles into practice. From the psychiatry trainee's perspective, achieving the College's core competencies (including working with patients with cognitive difficulties, neurodegenerative conditions) would be greatly facilitated by formal exposure to placements in neurology. The increasing necessity to optimise allocation and utilisation of healthcare resources would favour a revised curriculum, where the psychiatry trainee is provided with opportunities to learn about underlying neurological changes in traumatic brain injury, epilepsy or movement disorders. Trainees could also acquire the ability to diagnose conversion disorder based on physical signs (DSM-5).

Equally, care pathways which are currently far from efficient or cost-effective could be streamlined if the neurology trainee received exposure to the principles of conversion disorders and common behavioural symptoms and their management.⁵

Finally, we feel that the same principles should apply to colleagues dealing with neurodevelopmental conditions, where formal training of child and adolescent psychiatrists would benefit from incorporating core elements of the paediatric neurologists' curriculum. In other countries (e.g. Australia, New Zealand) additional training in paediatrics and neurology is available through dual training programmes and additional certifications.

It is important that we examine psychiatric workforce development needs in the context of advances in neurosciences research and our developing knowledge of brain functions and brain disorders. The members of the Section of Neuropsychiatry express their wish that the proposal for a more integrated curriculum gains priority in the agenda of postgraduate educational committees, where the practical aspects of its implementation should be evaluated in the light of economical and logistical implications.

Declaration of interest

Submission made on behalf of the Executive Committee of the Royal College of Psychiatrists' Section of Neuropsychiatry.

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Psychiatrists are not surgeons

Reading the article by Archdall *et al*¹ took us right back to our student days, where we both remember our emerging interest in psychiatry often being lambasted by those around us. Not so reassuring to see that some things never change.

What was most striking then, and it appears still now, are the beliefs that 'you can't cure anyone if you do psychiatry', 'you can't help people'. While we admit it has been a few years since either of us have worked in acute medicine or primary care, unless there have been some radical developments, we were not aware that conditions such as asthma, diabetes, arthritis or coronary artery disease could be easily cured either. Yet chronic physical illness is what the majority of medical students will end up managing in some form or another.

This research made us wonder whether we as psychiatrists paint a rather grave, dare it be said hopeless, picture of what our specialty involves when students spend time with us. Because surely the reality is that psychiatry has no lower a 'help' rate than other specialties that deal with both acute and chronic illness?

We did not go into medicine solely to cure people; we went into medicine to help ease suffering, in whatever small way that may be. And yes, that may be a listening ear instead of a scalpel or a pill, but no less is the satisfaction for us or relief for the patient.

So what is the answer to this? How do we help students see psychiatry for what it is, rather than this hopeless and helpless version that keeps being quoted back to us? We suggest addressing this stigma head on, acknowledging that we are seen as separate and different, and take students to see the good that we do.

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Psychiatry tasters are needed early in foundation training

As a core psychiatric trainee with an interest in recruitment whose decision to enter psychiatry was influenced by completing a Foundation Year 2 (FY2) post in the specialty, I read the article by Kelley *et al*¹ with interest. The study showed a significant association between undertaking a Foundation Programme placement in psychiatry and entering core psychiatric training. One problem of the study, acknowledged by the authors, is that it did not look at the career preferences of the participants. As the authors admitted, it is likely that many of the doctors completing foundation placements in psychiatry already had a prior interest in it, and were therefore more likely to express a preference for, and be allocated to, programmes containing a rotation in psychiatry. Further research is therefore needed to evaluate further the influence of a foundation placement in psychiatry on eventual career choice, before we can infer that there is a causal link.

Given that the application process for core training begins in November, only those doctors completing an FY2 post in psychiatry within the first rotation of their FY2 year would experience psychiatry before applying for specialty training. This serves to highlight the potential value of tasters in allowing FY2 trainees to gain some experience in psychiatry before the application period.

Although I am in agreement that an increase in the number of foundation placements in psychiatry is important, I also believe that it is important to focus on attracting medical students to psychiatry at an earlier stage and ensuring that we do all we can to provide high-quality undergraduate training and placements in psychiatry, so that newly qualified doctors already have an interest in psychiatry before entering foundation training and have already thought about it seriously as a career choice.

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Influence of foundation job subspecialty

I read with interest Kelley *et al*'s article,¹ particularly in light of previous correspondence in *The Psychiatrist* regarding whether some subspecialties are better with foundation doctors. I am a CT3 in psychiatry, with a hope to specialise in old age. During my foundation jobs I had a 4-month rotation working with general adult in-patients. I am perhaps not best placed to comment on the influence of which subspecialty of foundation job best influences recruitment to psychiatry as a whole, given that my decision to go into psychiatry was made even before entering medical school, however, I have been struck by the

different experiences my foundation doctor colleagues (and also undergraduates on their attachments) have had depending on whether they are working in general adult or old age psychiatry.

That recruitment into psychiatry is a problem is not news and the Royal College of Psychiatrists has launched a 5-year plan to increase applicants to psychiatry.² The reasons for this have been argued as being multifactorial,³ however, a large part appears to be the view that psychiatry is an 'inferior' specialty, that psychiatrists become 'deskilled' in their medical knowledge and that, with New Ways of Working, consultant psychiatrists may feel disempowered, with less control of their workload leading to greater stress and reduced job satisfaction. There is also a feeling of psychiatry being somewhat separate from the other medical specialties. Most mental health services are run out of separate hospitals, and indeed separate trusts, and medical students and other doctors rarely see psychiatrists in ward rounds.

The viewpoint of those who have done a foundation job in old age psychiatry, however, appears to be somewhat different. Admittedly, my impression has been formed only through informal discussions about a subspecialty to which I am already committed. As the medic in the team, foundation doctors experience the more complex patients and are required to keep their skills up to date regarding the medical needs of patients, either as in-patients, out-patients or in liaison services. They are often required to liaise with teams based in the general hospital on the care of patients, who, by the nature of the specialty, often have a variety of health problems, particularly neurological, given the overlap in presentation. They have the opportunity to be involved in liaison work and therefore have face-to-face contact with colleagues in other specialties, thus preventing the feeling of separateness and isolation from other disciplines. Although emphasis is still on multidisciplinary team working, each member of the team, including the consultant, has individual roles depending on their skills and job title. They therefore see the consultant of the team being treated with the realisation that their skills are better used for diagnosis, treatment, clinical decision-making and leadership of the team while drawing on the skills of other professionals.

Barras & Harris⁴ have commented that if attrition from psychiatry is to be minimised, issues such as how psychiatric trainees integrate with other medical specialties, and how the role of doctors in the specialty is perceived need to be addressed, and I would certainly agree. What retained me in working in psychiatry at a time when New Ways of Working

and exam pressures were resulting in demoralisation, was my experience in old age psychiatry.

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Perhaps a different viewpoint is needed?

Kelley *et al*¹ raise an interesting point with regard to Foundation Programme placements and subsequent careers in psychiatry, and I applaud their aim. What they look at is whether having experience of psychiatry in the foundation years results in a placement in psychiatry at CT1 level – I would suggest this is not quite the same as influencing a trainee's decision to apply. As suggested in the discussion, I would imagine those keen on a future career in psychiatry are more likely to opt for rotations which contain psychiatry, but how many of these people are dissuaded from applying by a negative experience? Furthermore, how many people go through the application process for a CT post in psychiatry ultimately to be unsuccessful for reasons aside from not having had a taster/ FY post? Perhaps an alternative way of approaching this situation would be to survey the career aspirations of newly qualified FY1s, making note of the FY2 rotations they go through and ultimately which specialties they apply for – in addition to which one they subsequently choose. This method would look for an association between FY2 posts and applications to psychiatry, not just those who are awarded a training post.

- 1 Kelley TA, Brown J, Carney S. Foundation Programme psychiatry placement and doctors' decision to pursue a career in psychiatry. *Psychiatrist* 2013; **37**: 30–2.

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