NHS
Kent and Medway
NHS and Social Care Partnership Trust

Kent Journal of Psychiatry

Dedicated to psychiatry trainees and trainers

December 2018 - Volume 1 - Issue 2

Brilliant care through brilliant people

Kent Journal of Psychiatry is a psychiatric journal with emphasis on the publication of research by psychiatry trainees and their mentors. This traditional source of new medical knowledge is under pressure due to the logarithmic growth of journal submissions; this journal attempts to redress this balance.

The editors will offer support to young authors in the presentation of their findings. This will be followed by rigorous peer review. The procedure will enable the journal to fulfil a valuable educational and developmental role in addition to presenting high quality research to a wider readership.

Kent Journal of Psychiatry is a free online publication which appears on a quarterly basis. It offers the best of new research from innovative young thinkers on the front line of mental health care.

Editorial board

Contents

Kent Journal of Psychiatry - Instructions for authors

Types of accepted articles and their specifications are given below. Word count for the main manuscript includes only the main body of text (not including tables, figures, abstracts or references). All pages should be numbered. Manuscripts should be double-spaced, submitted as a word document. All abbreviations should be spelled out the first time they are used anywhere in the manuscript. British spelling should be used.

Types of articles the Kent Journal of Psychiatry will accept

Original research or audit

Abstract to be no longer than 250 words.

The text should not exceed 3500 words, with the following structure: introduction, methods, results, discussion.

In case of original research the Journal will expect to see evidence of ethical approval, or explanation of why formal ethics committee approval was not sought.

Reviews or meta-analyses

Abstract to be no longer than 250 words.

The text should not exceed 5000 words, with the following structure: introduction, methods, results, discussion.

Case reports or case series

Abstract to be no longer than 250 words.

The text should not exceed 2000 words, with the following structure: introduction, methods, results, discussion.

In case of case reports or case series the Journal will expect to be provided with signed written consent of patients, or in case of incapacity, the next of kin. Patient details should be anonymised.

Opinion papers

Abstract no longer than 250 words.

The text limited to 5000 words, with the following structure: introduction, methods, results, discussion.

Letters to the editor

No abstract, text limited to 500 words.

Book reviews

No abstract, text limited to 500 words.

References

All manuscripts should be referenced in Vancouver referencing style. Use of a reference manager such as EndNote or Mendeley is recommended.

Manuscript/tables/figures

All should be provided in a single word .doc or .docx files. The main manuscript should be double-spaced in Times New Roman or Arial size 11 font.

On page 1 should be the title page with the title of the article submitted clearly stated. Authors in the relevant order, their place of work and the contact details of the corresponding author should also be detailed on the title page.

On page 2 the abstract should be placed.

On page 3 the main manuscript should begin.

This should be followed by references.

Tables and references can be either embedded within the manuscript or added as appendices at the end.

Completed manuscripts should be sent to aamer.sarfraz@nhs.net alongside a covering letter for consideration in the Journal.

An email of acknowledgement will be sent once submission has been received and feedback will be given if it needs amendment or is rejected.

The role of meditation and mindfulness in psychiatric treatment

Dr Victoria Clark (ST6)

St. Martins Hospital, Canterbury

Psychiatric wellbeing:

Psychiatric wellbeing encompasses feelings of contentment, enjoyment and self-confidence. It includes maintaining healthy relationships and engagement with the world around us. It is impacted on by our physical and spiritual wellbeing, creating a lens through which we perceive the world.

As a psychiatrist, I find that many of my patients are caught in a cycle of negative thinking based on their interpretation of the world which has been skewed by their traumatic past. They are unable to see the reality of the surroundings that they now occupy, or to be in their present moment due to distress caused by their negative thought patterns. Psychological distress is driven by unwillingness to see things as they really are. It isn't until true reality is acknowledged and accepted that change can happen. Mindfulness can facilitate this process.

Daily experiences provide repeated external, as well as internal, stressors triggering chronic physiological stress reactions involving the nervous and hormonal systems. This reduces immunity and can cause physical illness, as well as mental strain (1). If the stressors are not acknowledged with acceptance, then distraction techniques are often employed, such as the use of drink or drugs. These distractions are used as an attempt to drive the associated thoughts and feelings deep into the unconscious. This often leads to psychological distress and ill health as the body and mind are interdependent. A key aspect to managing stress with a mindful approach is acceptance of how things are, rather than how we want them to be.

Mindfulness teaches us to be less judgemental of ourselves, encouraging self-compassion which is a difficult mind-set to develop. Mental illness is often driven by a negative self commentary which is so embedded that it is often not acknowledged as a problem to be addressed.

Meditation and mindfulness

Mindfulness is the overarching term for a way of being; paying attention to the present moment without judgement while acknowledging thoughts, feelings and bodily sensations. Mindfulness can be applied throughout daily life with meditation providing intense periods of mindful practice. This trains the mind to be present during the rest of the day. We now have evidence to support that which has been known by practitioners of the Zen tradition of mindful meditation for thousands of years; that meditation and mindfulness maintain physical and mental wellbeing. This evidence will be discussed in this article.

Effects on mental health

The space provided between thought and reaction, developed by meditation, is useful in the management of emotional distress. Emotional pain is ever-present; it is our reaction which is important for our psychological wellbeing. Becoming mindful teaches us to take control of the negative stories that we tell ourselves, causing psychological distress, including anxiety and depression. Mindfulness teaches us to be aware of the actual reality of the moment and to avoid attaching ruminating thoughts which tend to be anxiety-laden. Awareness and acceptance of the present moment experience allows change and healing. It is often painful to face the present moment which leads to a desire to run away and distract ourselves, but this is a temporary fix.

There is often fear attached to the experience of the emotional pain, compounding the wish to avoid it. Turning towards the emotional pain takes courage but can lead to a change in the experience of the pain when the associated thoughts around it are shrugged off. In the example

of sadness linked to the ending of a relationship, mindfulness encourages us to sit with the feeling of sadness with acceptance and a non-judgemental attitude. Losing the associated fearful commentary (how will I cope without him? What will people say?) alters the experience of the pain and allows change.

Mindfulness develops inner resources for dealing with stress. The stresses may not be removable but our reaction to them is adaptable with mindful training. Being mindful creates a space between the thought and the reaction which teaches us to respond to stressors rather than automatically reacting to them. A key aspect of mindful practice is noticing the stressor along with the bodily response to it, and having the ability to let go of the associated thoughts and feelings without negative interpretation.

There is now plenty of evidence supporting mindfulness as a means of managing emotional distress. Kuyken et al (2) designed a randomised controlled trial which compared mindfulness and meditation to antidepressant use in 123 people with recurrent depression. After 15 months, 60 per cent of the participants taking medication had relapsed compared to 50 per cent who had received mindfulness training which showed it to be as effective as medication in this group. The training was also found to be more effective in enhancing quality of life and equally cost effective.

Mindfulness also teaches us how to avoid time pressure stress, grounding us in the present reality and focusing us on the wonder of everyday activities. Unity of the mind and the body can lead a state of 'flow', a term coined by Csikszentmihalyi to describe a state of consciousness in which a person is completely absorbed in his or her actions and experiences. This appreciation for everyday activities improves our quality of life and emotional wellbeing. It encourages us to simplify our lives, reducing the distractions and allowing focus on the things that are important to us.

Effects on physical health:

Loss of the mental commentary due to mindfulness can be helpful in reducing the distress caused by physical pain which is often connected to emotional pain. By having a 'welcoming' approach to pain with acceptance, the change in attitude can significantly alter the experience. Evidence of the reduction in pain experience with the practice of mindfulness was shown by a study by Kabat-Zinn et al in 1985 (3). This group showed that a 10 week programme based on mindful practice for stress reduction led to statistically significant reductions in the present moment pain experience of patients, increased activity and improved psychological symptoms associated with physical pain. Several subsequent studies have shown similar results. Grant and Rainville (4) showed that Zen meditators have lower pain sensitivity, both in and out of a meditative state, suggesting an adaption to their processing of painful stimuli. Work by Brown and Jones (5) showed, by using brain scans, that areas of the brain associated with the anticipation of pain (prefrontal cortex) were less active in meditators when exposed to pain.

The concept of the 'double arrow of pain' explains how pain is often exacerbated by the thought processes associated with the pain such as the worry of anticipated pain. Mindfulness teaches us to lose the associated negative thought processes which come with pain, focusing solely on the sensation and noticing how it is felt. Just paying attention to the feeling with a welcoming attitude can lead to a change in the experience of the feeling and a recognition of the transient nature of feelings. This is thought to be the mechanism by which mindfulness and meditation cause a reduction in the distress experienced with painful sensations. 'Pain is inevitable, suffering is optional', is a phase which helps with understanding this concept. Resistance to the pain often leads to the suffering. Meditation is also associated with relaxation which can reduce pain.

There is emerging evidence that meditation can positively influence the physiological aging of our bodies. Wallace et al. (1982) (6) found that a group who had meditated regularly for at least five years, when compared to a control group, were 12 years younger physiologically. This finding has been replicated in other studies.

Conclusion:

Mindfulness and meditation do not just prevent ill health, they can also elevate our functioning. Many of the greatest achievers practice mindfulness and use the skills that it develops to their advantage. An example is Jonathon Rowson, the British Chess Champion who describes how mindfulness allows him to remain calm and centred whilst competing. He is able to 'just play' the game without worrying about the result. Sridevi et al (7) looked at how meditation affects personality growth and found a significant increase in positive personality traits, including increased confidence, conscientiousness and less anxiety.

In summary, there is now extensive evidence supporting the positive impact of mindfulness and meditation on our physical and mental health. This way of being improves our quality of life, allowing us to live in the true reality of the present moment.

References:

1. Segerstrom SC, Miller GE. Psychological stress and the human immune system: a meta-analytic study of 30 years of inquiry. Psychological Bulletin. 2004; 130 (4): 601-630.
2. Kuyken W, Byford S, Taylor RS et al. Mindfulness-based cognitive therapy to prevent relapse in recurrent depression. Journal of Clinical Psychology. 2008 Dec; 76 (6):966-78.
3. Kabat-Zinn J, Lipworth L, Burney R. The clinical use of mindfulness meditation for the self-regulation of chronic pain. Journal of Behavioural Medicine. 1985 June; 8 (2):163-90.
4. Grant JA, Rainville P. Pain sensitivity and analgesic effects of mindful states in zen meditators: a cross sectional study. Psychosomatic Medicine. 2009; 71:106-114.
5. Brown CA, Jones AKP. Meditation experience predicts less negative appraisal of pain: Electrophysiological evidence for involvement of anticipatory neural responses. Pain [Internet]. 2010 Sept; 150 (3): 428-438. Available from doi:10.1016/j.pain.2010.04.017.
6. Wallace RK, Dilbeck M, Jacobe E, Harrington B. The effects of the Transcendental Meditation and TM-Sidhi program on the aging process. International Journal of Neuroscience.1982; 16: 53–58.
7. Sridevi K, Rao P, Krisha V. Temporal effects of meditation and personality. Psychological Studies. 1998; 43 (3): 95–105.

Cognitive analytic therapy: The multiple roles of a reformulation letter

Jinny McDonald (ST4)

Elizabeth Raybould Centre, Dartford

Background

Cognitive Analytic Therapy (CAT) is a mode of psychotherapy which has been derived from a strong theoretical and evidence-based background. It is unusual in that this potentially rigid background is combined with high levels of flexibility and patient collaboration within the consulting room. It is my belief that the CAT reformulation process links these seemingly opposing characteristics and is thus key to the nature of the therapy. Reformulation is defined as 'formulating again' or 'formulating in a different way, altering or revising'. Virtually all psychotherapy schools anticipate an early formulation of a patient's situation. This distils detail of the patient's circumstances to a coherent narrative and anticipates ways in which therapy may offer improvements to those circumstances via a more or less generalised approach to their indicated problems. Most schools of therapy see this as offering a guide for work in future sessions and research suggests that therapy is often more effective if deviations from this broad plan are minimised. (1)

Ryle, the founding father of CAT, examined psychodynamic formulations in some detail and established that the majority of perceived problems were identified within the first few sessions and tended to be recurrent themes through the remaining sessions. He also noted (2) that the traditional role of 'expert therapist' to 'naïve client' accentuated dependence and failed to recruit patients' potential to participate in their own recovery. Ryle (3) examined the use of written documents in dynamic psychotherapy and remarked that written communication from the therapist could speed up the process of communication in time-limited therapy while offering patients a useful bridge between sessions. He added that such communications could maximise objective distance from problems and extend patients participation in the therapy. It is unsurprising, considering these views, that Ryle started to share his written formulations with patients. These documents were not initially written with this aim in mind and so shortfalls became clear which primarily reflected a lack of empathy-developing warmth and a distance from the patients' own perspective which limited potential collaboration. This led to the development of the 'reformulation letter' which carries much of the information of a traditional formulation but is written from an empathic and provisional perspective so as to become a shared document with the patient. (1)

CAT is a short-course treatment, generally 16-24 sessions, which calls for speedy identification of a collaborative description of the patient's sources of difficulty. These are identified from the perspective of non-functional relationship patterns and the procedures that continually reinforce these patterns. The patterns are described in narrative form in a 'reformulation letter'; the aim is to reach this point in around 3-4 sessions. This is a tentative document that should show empathy towards a patient's experiences while suggesting possible primary relational causes of problems, their possible impact on future sessions and offer a realistic summary of the progress that could be made during the course of therapy. This is followed by the shared construction of a diagram that summarises these relationship and procedural problems. Thereafter the therapy can move towards 'recognition' of these patterns within the patient's daily life and then 'revision' of the problems by establishing alternative patterns of behaviour which would cease to reinforce the patient's difficulties. The final (or penultimate) session sees a further exchange of letters between the patient and therapist which summarises the progress that has been made and offers signposts to the future. A

follow-up session is generally offered three months later.

This describes a tight framework which is necessary due to the short nature of the course – wandering 'off-piste' into psychodynamic realms is not a real possibility within such a time period. It indicates the central role of the reformulation as a means of recognising a shared presentation of problem behaviours which serves as a source for finding solutions. However, within this structure, the patient and therapist can choose any appropriate means to fulfil their aims of exploring current practices and their modification. This gives CAT an extraordinarily free-flowing nature for a short term treatment – I feel that the reformulation is key to this nature as it offers a vital starting point for recognition and revision within a very adaptive format. (4)

The key role of the reformulation letter means that there are a number of important functions and characteristics that should be considered when writing the document. These are discussed below.

Early orientation for a patient:

A CAT reformulation is a descriptive process (4) rather than the therapist's interpretation of the patient's circumstances. This places the patient firmly in the role of 'expert' while the therapist is effectively translating the patient's descriptions to a coherent and generalised format. The reformulation is developed as a partnership where the patient offers information and has responsibility for confirming or correcting the accuracy of the resulting document. The reformulation is then used as a shared starting point for future sessions and updated or modified as necessary. This openness to modification means that reformulation can be started at an early stage of therapy and helps the patient to feel more in charge of proceedings rather than leaving him 'afloat without a destination' for a long period. This allows movement into the 'recognition' of behavioural patterns and thus their revision.

Expressing empathy with the patient:

The primary recipient of a reformulation is the patient. However, just as Bakhtin, as cited by Evans (5) describes the fact that 'every utterance has an addressee', there is a further audience of invisible addressees in the therapist's mind. This reflects the fact that the letter is addressed to the patient but still retains some of the functions of a traditional formulation. This adds a 'self-to-self' role for the document where the therapist is structuring his own perspective to find clear narratives within the patient's detailed story. Similarly it helps him to develop a direction of treatment and consider possible obstacles that may arise. A third addressee of the reformulation letter may be the therapist's supervision group. This introduces a potentially 'judgemental' view of the reformulation which can have an inhibitory effect on the writer. It also means that the letter must be comprehensible to individuals who have not been present within sessions. This multiple audience is challenging but discussion within a supervision group prior to presentation of the letter can lead to a more thoughtful product which bears better witness to the patient's emotional experiences (6). Ideally this is couched in simple and reflective language within the patient's zone of proximal development, as noted by Vygotsky and later cited by Ryle (7). It supports the therapist in his recognition of the patient's emotions – both painful and joyous.

Accurate communication:

Reformulation is a non-judgemental process that appreciates the patient's narrative from his personal perspective. It is written to be read to the patient which leads to a number of potential problems. The therapist may be 'overly gentle' in such letters, aiming to avoid psychological pain to the patient, and thus fail to fulfil the traditional requirements of a formulation to move a patient

forward along a therapeutic pathway (1). Alternatively the letter may be written in a harsh but accurate style which can be painful to the patient. This then leaves the patient in a hurt and powerless state where they flounder, unable to think. It is, however, important to realise that communication transcends the words that are used. The nuance that is carried within phrases can have a powerful effect even if the words deny its existence (4). An example of this would be the statement that a patient 'not boring or needy' which would lead to him being imbued with those attributes despite the clear negative. This emphasises the importance of reading a letter aloud beforehand, ideally to others, to try to understand the 'non-verbal' messages that are implicit in its presentation

Tentative nature: (4)

Beyond the collaborative and empathic nature of a CAT reformulation is the potential for demonstration of an inquiring and reflective viewpoint. This requires the reformulation to have a provisional and overviewing character. The reformulation relates the patient's past experiences to his current problems. This is not a 'known' relationship but relies on standing back and wondering about possible patterns in behaviour and emotions. This viewpoint models the metacognitive process that CAT seeks to develop (8) to help the patient to construct a 'meaningful story from incoherent distress'. It demonstrates, similarly, an uncertainty that is often counter to a patient's black-and-white modes of thought (4). It reinforces the role of the patient as sharing or owning the therapeutic process rather than being a passive subject. This perspective, of wondering reflection, is therefore a vital tone to convey throughout the letter so as to reinforce flexibility in both emotional and cognitive terms.

Identification of target problem: (1)

The patient's target problem is different to his described symptoms as it is more pertinent to address the unifying underlying cause of these symptoms. Generally it is found that a number of problems will resolve if a few deep drivers are modified. This enables a narrower treatment focus and their identification ensures that the therapist and patient are in agreement as to the treatment target. It is vital that the patient and his therapist work together to develop a clear and simple target that underlies his daily difficulties. Thus, feeling continually low in mood and angry may, on discussion, provide a target problem of 'difficulty in making good enough relationships'.

The source of target problems: (1) (4)

Establishing the aetiology of target problems in CAT has developed from evidence-based studies of psychodynamic therapy. Ryle noted that a limited number of procedures were repeatedly observed through courses of therapy. This led him to the concept of 'target problem procedures' represented by snags, dilemmas and traps. Thus early reformulations concentrated on these procedures, examining them from the perspective of a sequential chain of appraisal, emotional response, aim, action, consequences and re-appraisal (2). Ryle's use of Kelly's Repertory Grid techniques (7) then led him to realise that the effects of therapy could be observed through changes in relationships with both others and self. He thus added dyadic 'reciprocal roles' as another potential source of psychological problems. He proposed that both inappropriate reciprocal roles and target problems are maintained by procedures that continually reinforce them so that they are not revised to more productive endpoints. Both poles of reciprocal roles (eg abuser and abused) are learned through experiencing one pole of such a relationship (9). Children can be observed internalising relationships as they first 'quote' the words of carers, eg 'all better now' and later develop this as a template for self-soothing. This thus becomes an internalised 'self-to-self' relationship (7). A limited range or

dearth of positive reciprocal roles can lead to psychological difficulties and the formation of unsatisfactory relationships in adulthood.

Predicting therapy: (1)

The reformulation letter is of value as a point where the initial therapeutic direction is considered as well as anticipation of potential obstacles. This helps to minimise inappropriate 'therapy drift' which has been observed to have a negative effect on treatment. It is also an opportunity to detoxify potential therapist-patient difficulties. It is a point where the period of treatment required for a pragmatic level of improvement can be considered. This tends to range between eight, sixteen or twenty-four weeks.

Conclusion:

This essay tries to show the central role of reformulation in CAT therapy and the challenges of expressing the requirements in the reformulation letter. CAT is unusual in having extended the nature of the psychotherapy formulation to play a part in the shared space between the therapist and the patient. This has led to a degree of internal conflict which has been largely solved by the recognition that honesty and collaboration outweigh any requirement for formal and dogmatic evaluation of the patient's situation. Thus reformulation becomes the skeleton of a short-course therapy allowing adaptive flexibility and continuous modification of shared understanding within sessions. My personal experience has helped me to observe the effects of reformulation on the patient and our therapeutic relationship. The recognition of the patient's perspective in such an empathic and supportive manner appears to foster the therapeutic alliance. The presentation of the letter often leads to a relaxation in tension as it confirms the shared nature of the therapy and trust is engendered as it becomes clear that that the therapist does not have a hidden and suspect agenda. The letter should set the scene and offer a plan for future sessions allowing the recognition of a common goal. In all, the exchange of letters offers a transitional object to the patient which appears to cement the therapeutic bond between patient and therapist within an act of care and shared generosity.

Bibliography:

1. Denman, C. What is the point of a formulation? In Mace, C (ed.) The art and science of assessment in psychotherapy. London: Routledge. 1995 p159-174
2. Ryle, A. Consciousness and psychotherapy. British Journal of Medical Psychology 1994; 67: 115-123
3. Ryle, A. The value of written communications in dynamic psychotherapy. British Journal of Medical Psychology 1983; 56: 361-366
4. Ryle, A and Kerr I B. Introducing cognitive analytic therapy principles and practice. Chichester: John Wiley and Sons Ltd 2002. Chapter 3,4, 6.
5. Evans, M. A trainee's guide to terms and concepts in standard CAT . [internet] 2013 Available from: http://catalyse.uk.com/index.php/training-supervision/cat-glossary/ [Accessed 2nd February 2015]
6. Kerr, IB and Ryle, A. Cognitive analytic therapy. In Bloch, S (ed.) An introduction to the psychotherapies. Oxford: Oxford University Press; 2006. p267-285
7. Ryle, A. Cognitive analytic therapy: developments in theory and practice. Hoboken; John Wiley and Sons Ltd. 1995.
8. Ryle, A. Cognitive analytic therapy and borderline personality disorder: the model and the method. Hoboken, John Wiley and Sons Ltd. 1997
9. Ryle, A. (1975) Self-to-self, self-to-other: the world's shortest account of object relations theory. New Psychiatry, 1975 April: 12-13

Humanities in psychiatric education? Wherefore art thou?

Dr Vinodini Vasudevan, MRCPsych, HST psychiatry, KMPT
Dr Maxwell Picard, MRCPsych, consultant psychiatrist, KMPT

In a post-graduate (and pre-graduate) curriculum packed with important subjects vying for attention and import, what place do medical humanities have, if any? In this article we consider the primary arguments for, and against, medical humanities as part of medical education, and how it might be most effective.

What the devil is medical humanities anyway?

This is a devilish question. That we ask this question at all may be because we are doctors and have a need for a clear definition that fits well within our system and is easier for us to work with. The question that then arises is whether humanities can be defined? Is it too much of an abstract concept to be defined within the confines of a diagnostic system?

The study of the humanities has its initial roots in the classical period. Apollo himself was the god of music, poetry, and medicine. The scholars of antiquity understood well the relationships between art and health. Medical education and education in the arts took place side by side (1). Da Vinci, for instance, was able to see this relationship.

The separation of humanities from medicine is relatively new. Perhaps a strict definition of medical humanities is not required. Perhaps it is not even advisable. What medicine does need, always has needed, and arguably always will need, is examination of how medicine fits in with the "big picture" of human experience. The core strengths of medical humanities are the imaginative non-conformist qualities and practices.

Why medical humanities?

Crawford et al argue that though medical humanities as a discipline has made advances, more integration is needed in the future as health humanities (2). This may be in the form of allied health professionals, patients and carers, those traditionally marginalised from medical humanities becoming involved. This will help health humanities to evolve, share knowledge and teach future generations of practitioners (2).

It has been argued that humanities should be part of any medical educational curriculum to help develop better patient relationships. A counter argument is that medicine must be evidence-based and medical humanities is not sufficiently so to warrant inclusion, at least on a compulsory basis. We are now scientifically documenting what was known intuitively in the past, as evidencing the place of therapies using art and drama in easing psychiatric suffering, which gives medical humanities some legitimacy.

Medical humanities offer different ways of thinking about human culture, behavior and experience to in turn influence health care practice. The most relatable example may be of developing better patient relationships as mentioned earlier. One way of doing this is being able to validate how the patient feels and being able to read in between lines. This then brings us to skills around empathy. If we agree with the principle that empathy is part of good clinical practice, we must ask then ask whether empathy can be learned or if it is an unmalleable trait. If (and it remains an "if") empathy can be cultivated then it has been argued that there is a role for Humanities in the curriculum. (3)

Even if empathy can be improved in some, it does not mean it can be improved in all. Would the introduction of medical humanities be effective for every potential or active doctor in improving empathy, would it improve the empathy of the already empathic, or would it be a remedial intervention for those with observed poor empathy (which in itself could be due to a variety of causes, such as innate psychopathy or burn out and poor

morale)?

These questions are, at present, unanswered. The answer, as always, will depend on evidence. However, this area is not easy to research and will ultimately require long term dedicated outcome-based research. Nevertheless, we must not conflate absence of evidence about efficacy with evidence of ineffectiveness. We must speculate initially and confirm afterwards, and even without good evidence we can fall back on the Royal College of Psychiatrists Motto "Let Wisdom Guide". O'Donnell puts it well when he based medicine deals with populations; clinicians deal with individuals" (4).

The question of content

What content should "medical humanities" have is an important question, and it is best answered by changing the question. Medical humanities is (potentially) a vast field, which can go on to include anthropology, history, theology, mythology, sociology, philosophy, and every mode of art one could conceive of. It would be impossible to train doctors to be "experts" in medical humanities.

Whilst we should be mindful of the content of medical humanities, specific content is not the key. Medical humanities invokes different and novel ways of thinking about medicine, or the experience of medicine (and health) that might (and usually does) get lost in the day to day demands of clinical practice. Realistically, the aim of medical humanities is not to know the content of one area, but to stimulate thinking and feeling.

Events like attending plays/dramas/ relevant films/role playing/simulation training may be added to the curriculum as these are the modalities from which humanities as a subject has arisen and evolved into (3). With reflective practice becoming established in medicine, appropriately selected events can be tied to senior clinicians' personal development plans and continuing professional development points.

Humanities should be part of clinical work, as suggested by Bloch S, "they (clinicians) need to be struck forcibly by the relevance of the experience, with explicit mention of the clinical issues illuminated by a particular short story, painting, film and so forth" (3).

From a practical view, adding another subject to an over subscribed curriculum is fraught with problems. Recent advances have given medical humanities its own space in its own right, with journals, conferences, and there is also an interest in how much it can help biomedical fields. A recent summary of the future of medical humanities in the U.K. described the current state as medical humanities being able to establish itself only by appearing as the "domain of pleasant (but more or less inconsequential) meets – lurking hopefully, poetry books in hand, at the edges of the clinical encounter's 'primal scene'. This is obviously a caricature, but with some truth. What then will critical medical humanities look like? Fitzgerald et al explore the cross over areas between medical humanities and biomedical sciences to see if both can hold the patient as the center of care (5).

Voluntary, compulsory, or something In-between?

Aside from considering what medical humanities education should look like, there is another issue. Should it be compulsory (and possibly subject to examination) or voluntary? Neither is a particularly attractive option. Making medical humanities compulsory is not easy, for it requires above all engagement and the cynical, tired, and busy are not easy to engage. On the other hand, if it is purely voluntary, it is not only more easily marginalised, but the very persons it might most usefully help (those somewhat shut off from the broader aspects of the human in medicine) are the ones least likely to participate.

We would argue that it suggests the nature of content should be one chosen

by the student (voluntary content) whilst the analysis, speculation, and reflection that accompanies the content should be required (compulsory). This fits with 'reflective practice' becoming not only the norm but required.

The flip side

Psychiatry lends itself to speculation, reflection and "thinking outside the box", and is arguably the most fertile ground for medical humanities. Yet even here, there is debate and disagreement.

There are some who feel that not all psychiatrically unwell patients are able to describe their symptoms or themselves narratively and if students are taught to understand only this concept, then patient care will be compromised. Angela Woods speaks about blind spots in the dominant medical humanities approach to narrative, including the frequently unexamined assumption that all human beings are 'naturally narrative' (6). She also analyses this further keeping in view philosopher Galen Strawson's influential article 'Against Narrativity'.

Then there are some that feel that as fields of literature and art struggle against better funded counterparts, they are trying to fit under the umbrella of medical humanities by "insisting that literary fiction promotes empathy (7) and that learning languages prevents Alzheimer's." (8)

We spoke about how arts and literature can help psychiatrists, but what about the harm it could possibly cause?

Lets think about how mental illness presents in art, and literature. It might improve understanding of mental illnesses in the general population, but there are also instances of very rare conditions such as multiple personality disorder feature in popular films and books and it would be easy for the general public to form the impression that it is a condition more common than schizophrenia. Baldin recently discussed this topic and wondered if psychiatrists should write fiction. He concluded that "Psychiatrists are dealt a rough hand by fiction", and that it would be helpful both to address stigma, and for psychiatrists themselves (via reflection) to write fiction (9).

Conclusion

Successful medicine brings about desired change in the patient. Though literature can make a person rethink their world, not all of it is life altering in a positive way and some literature and poems can actually have a negative impact. Rothfield argues that whilst literature can be used therapeutically, it opens the field to criticism when dealing with less obvious change. For example, certain pieces of work raise important questions because they may be difficult and upsetting, maybe even depressing, but do not actually go on to cure depression. He gives the example of Franz Kafka, a German writer who fused realism and fantasy, whose work has been variously interpreted as exploring themes of alienation, existential anxiety, guilt, and absurdity. Just because a piece of work elicits a certain feeling in people, does not necessarily translate into people making a change based on the discomfort (10).

Despite the criticisms, and the paucity of evidence on medical humanities, medicine is still left with a number of perennial problems. Frequent complaints of poor communication, lack of understanding, being either too "medical" or lacking "humanity". The reasons for these are complicated and layered, but they are problems still. We can also add in frequent burn out, high levels of mental ill health and even suicide. Neither patients nor doctors, it seems, are particularly happy or satisfied with the state of medicine.

Education, too, is changing. With the development of information technology and Artificial Intelligence, the demands on modern medicine change too. It is not so important for a modern doctor to remember the biochemical abnormalities found in an obscure disease when this information can be found in seconds via computer systems. One could reasonably

speculate that artificial intelligence will start to encroach (and rightly so) on many aspects of medicine. Our education is changing from learning lists to problem solving skills and reflective practice.

If one considers the future, medical humanities should offer a road forward. It should be evaluated and modified, critiqued and refined. Everybody should be considering not just medicine, but the experience of medicine, and it is here that medical humanities should stake its claim.

References:

1. Schlozman S. Humanities and the practice of medicine. In Wedding D, Stuber M, editors. Behavior and medicine, 5th edition. Hoegrefe; 2010. p258–269.
2. Crawford P, Brown B, Tischler V, Baker C. Health humanities: the future of medical humanities? Ment Health Rev J. 2010;15:4–10
3. Bloch S. The art of psychiatry. World Psychiatry. 2005;4 (3):130–4
4. O'Donnell M. Evidence-based illiteracy: time to rescue "the literature". Lancet. 2000 Feb 5; 355 (9202):489-91
5. Fitzgerald D, Calland F. Entangling the medical humanities. In Whitehead A, Woods A, editors. The Edinburgh Companion to the Critical Medical Humanities. Edinburgh University Press. 2016.
6. Woods A. The limits of narrative: provocations for the medical humanities. Med Humanit. 2011;37 (2):73–8.
7. Julianne C. Scientific American. Mind. (internet) 2013. Novel finding: reading literary fiction improves empathy. Available from: https://www.scientificamerican.com/article/novel-finding-reading-literary-fiction-improves-empathy/
8. Craik F IM, Bialystok E, Freedman M. Delaying the onset of Alzheimer disease. Neurology. November 09, 2010; 75 (19)
9. Baldin, H. Should Psychiatrists write fiction? BJPsych Bulletin. 2018; Vol 42 (2): 77-79
10. Rothfeld B. Hyperallergic (internet) March 23 2015. The problem with the medical humanities. Available from: https://hyperallergic.com/177969/the-problem-with-the-medical-humanities/

What features of simulated patients are valued in teaching the psychiatric interview?

Musa Basseer Sami (ST6)
Jalil-Ahmad Ali Sharif (CT3)

Elizabeth Raybould Centre, Dartford.

Reflection on existing practice

Simulation in teaching the psychiatric interview has become increasingly important over the recent past (1). Although traditionally taught through clinical exposure of 'real patients' and similarly assessed in the real world example of the 'long' and 'short' cases, several weaknesses were identified in this method of teaching and assessment (2). Clinical exposure maybe limited to a certain type of case and thus selectively sample the curriculum, thus failing to give a broad overview. Similarly there maybe inequity between trainees or students who may have different exposures and thus different training experience. Consequently simulated patients are able to deal with both of these problems: the use of simulated patients allows for a broad sampling of the curriculum. Furthermore the use of simulated patients allows for the standardisation of scenarios, thus reducing inequalities in exposure and clinical learning (3).

As a higher specialist trainee in psychiatry one of us (MBS) been extensively involved in the use of simulated patients for teaching and 'mock exam' assessment purposes. I have organised seven workshop days since August 2013 - January 2016, which have benefitted around 60 postgraduate psychiatry trainees and 40 undergraduate students. Both workshops have taken slightly different forms: with postgraduate use of simulated patients being for the mock CASC exam (Clinical Assessment of Skills and Competencies), the high-stakes final membership exam of the Royal College of Psychiatry; whereas the undergraduate workshops have taken a more relaxed approach in order to give an introduction to the common psychiatric presentations. However what is common in both of these scenarios is (1) the use of Simulated patients (i.e. actors playing a patient with a psychiatric condition or relative) and (2) a form of formative assessment with feedback to the student or trainee on how to improve in the future. This is a well-recognised model of experiential learning often used in one-to-one or small group settings to teach sometimes complex communication skills in a safe environment (4). Involvement in these workshops has several components – including writing the scenarios, liaising with and booking the actors, drawing up the session plan, organising the candidates, examiners and actors and acted as an examiner.

As a core trainee in psychiatry one of us (JAAS) has been a participant in three workshops as a trainee and learner. The workshops I participated in have been tailored for the CASC examination.

Both students and postgraduate trainees have consistently given feedback to show they value these sessions and particularly the feedback they receive from actors and exposure to realistic situations. Overall feedback from student and trainee evaluation, although often strongly positive and very often complimentary has provided limited utility in guidance regarding how to improve or modify such workshops in the future. There is a general consensus of how students particularly value feedback given in the post-scenario briefing. Anecdotally from our observations as clinical teachers, the use of simulated patients for psychiatric teaching purposes can ultimately be a hugely valued experience. We wish to tease out in more detail the reasons for this. This will enable us to apply research findings to current practice to ensure the maximum educational value for the workshops, both undergraduate and postgraduate.

Introduction and background

Consequently this literature review aimed

to determine: which particular elements of using simulated patients are valuable in the teaching of the psychiatric interview.

By simulated or standardised patient the literature review meant: a trained participant who is trained to portray a role for the educational purpose of the session (3). This was differentiated from role-play where an untrained individual (usually a fellow student) takes on the role (3). This literature review therefore did not look at role play between students as the interactions between students are likely to be different to roles portrayed with an attempt at psychological fidelity. By psychiatric interview the author meant any aspect of the interview including history taking or communication skills.

This literature review examined both postgraduate and undergraduate contexts as this was relevant to the author's teaching practice. Within the overall question stated above - several questions arise: for example (1) what is the role of simulated patients in teaching the psychiatric interview (2) does the fidelity of the simulated experience effect the value that trainees place on the experience, (3) are there optimal ways of structuring the session and (4) what is the best way to give feedback to the student or trainee. The literature review attempted to answer these sub-questions separately in order to build an overall picture.

Only evidence from original studies including feedback, evaluation or research was included in this review. The review avoided opinion pieces or discursive commentaries in order to ensure focus on the evidence to date.

Full text articles in English: ("simulated patient" OR "standardised patient" OR actor) AND (psych* OR Mental State Exam*) AND (education OR feedback) were searched in Pubmed (Medline Database) and PsychInfo on 11 March 2015. Abstracts were screened against the following inclusion criteria: (i) articles involving original feedback, evaluation or research (ii) regarding any aspect of psychiatric interview, and (iii) including both postgraduate and undergraduate psychiatric teaching. Consequently the literature search identified six papers for review. These are discussed in further detail below.

Critical literature review

What is the role of the simulated patient interview to teach psychiatric clinical skills?

From an overview of the included papers it is clear that there are a wide variety of uses for the use of simulated patients in teaching the psychiatric interview including (i) developing skills in interview (ii) exposure to difficult to access clinical scenarios and (iii) use in assessment.

Simulated patients were used to develop a variety of skills: history taking skills (5); improving skills in informed consent (6); and risk assessment (7). All three papers reported positive results correlating use of standardised patients with positive feedback. However, this must be interpreted with caution: as the design of all three studies were pre-session and post-session self-reported confidence measures of the learners. It could be argued that teaching is always likely to improve self-reported confidence measures and such improvement does not measure objectively acquisition of the desired skill. Furthermore only one study reported the benefits in comparison to a control group of students who had "teaching as usual" (7).

A further use of simulated patient interview is developing clinical exposure to rare or potentially distressing situations in a safe environment. The simulated patient interview has thus been used in teaching a rare experience in refugee medicine (8). This was undertaken remotely through web-conference by 10 Swedish medical students with a simulated refugee from Iraq who had recently arrived in Australia. A follow-up debriefing session focussed on students response to the emotional distress of the trauma. This is the only study which compared the experience

of interviewing a simulated with a real patient, with a safe environment provided through simulation:

"Students reported that they were deeply moved by the patients' (real and simulated) trauma histories. They also reported that they felt less inhibited n questioning the simulated patient rather than the real patient."

The use of simulated patients also has a role in assessment: one study used a simulated patient interview to assess and compare differential performance of international medical graduates performed in comparison to US medical graduates in eliciting a diagnosis of clinical depression (9). A further paper also looked at performance assessment of communications skills of 1st year vs. 5th year medical students in a simulated scenario design to test skills in a psycho-social assessment (10). Yet both papers assumed that the use of simulated patients was an adequate assessment method for their study – neither showed validity nor reliability measures for their chosen method of assessment using simulation.

Does the fidelity of the simulated experience effect the value that trainees place on the experience?

The study of refugee psychiatry by Ekblad and colleagues, noted above, was the only study which directly compared learners' experience of simulated with a real patient. As noted from the quote above, the focus group noted that both scenarios were life-like and emotionally involving. This is despite the non-use of a professional actor, rather an expert professional member of teaching faculty was used to play the simulated patient. Similarly learners report positive feedback with both professional actors (7) as well as trained professionals such as psychiatric nurses (5) as the simulated patients. In the latter study, psychiatric nurses were used as simulated patients having received one hour training on simulation prior to the session in a low-resource setting in Zimbabwe. Seven out of 23 medical students who undertook the session noted in the end of session feedback they would have preferred real patients with several commenting that the nurses gave them answers too readily. It thus would appear that acting skills are an important constituent to effective teaching design, although there are no direct head to head trials of professional versus lay actors to more effectively answer this question.

Are there optimal ways of structuring the session?

Different authors have taken different approaches to structuring sessions with simulated patients. One model is to provide learners undertake the interviewing sessions with simulated patients followed by debriefing (5,7). The simulated patient activity thus becomes small group teaching of 4-6 learners in each scenario. This appears based on Kolb's experiential learning cycle – learning through doing with reflection and consequent development upon the experience (11). A variation on this model has been described where the clinical teacher undertook the interview with students observing and asking follow-up questions used in the trauma interview of a psychiatric patient (8). It is likely that this contributed to the safe environment that students reported in the session. An alternative model was described in Massachusetts where the simulated patient interview task (gaining consent for psychotropic medication prescribing) was inbuilt into a computer simulation (6). The psychiatric resident undertook the scenario, clicking on the relevant options which appeared on the computer screen as to how he would proceed with the interview. The actor was interviewed by a simulated doctor onscreen with pre-recorded options shown depending on the learner's choices. Candidates reported increased confidence in skills of informed consent and prescribing skills after the session. It is not possible to directly compare the effectiveness of these teaching approaches as there are no direct head to head studies.

There are differences in how much teaching to deliver pre-session. Whereas Piette and colleagues provided a didactic lecture to leaners, Fiedorowicz et al had embedded these teaching sessions into the curriculum and thus did not provide extra material pre-session. In the scenario of refugee psychiatry learners received pre-course material and had attended a four day workshop in transcultural psychiatry before exposure to the simulated patient. In the case of simulated patient teaching with junior students, learners were taken to meet the actors before the session, which resulted in reported reductions of anxiety during the session (10). Again it is not possible to undertake a direct comparison as there are no direct or head to head studies of one method versus another.

What is the best way to give feedback to the student or trainee

Two studies appeared to have been used as summative assessments and evaluations of different groups of learners and did not report providing any feedback to learners (9,10). All other studies reported feedback although the methodology varied. Medical students were provided feedback in a risk assessment workshop by group feedback, discussion and re-rehearsal (7). The Zimbabwean study followed a similar structure, with students also involved in feedback although re-rehearsal was not undertaken (5). It is possible that immediate re-rehearsal after feedback has an educational advantage as it allows for consolidation of learning, however no direct data was provided in order to establish this. In the psychiatry interview of a refugee feedback was undertaken through debriefing of the students to build on their learning from clinical exposure rather than to critique their performance (8). The computer simulation allowed for feedback linked to students performance directly (i.e. areas they had missed out in the algorithm) and was able to provide immediate personalised feedback with links to resources for further learning. However it is not possible to draw conclusions about the best method of feedback in the absence of direct comparisons.

Conclusions

Simulated patients can be widely applied to teaching and assessing various part of the psychiatric interview. There is a variety of applications and use of simulated patients within a session. Participants consistently report increased confidence in skills after a session with simulated patients. However there is limited evidence base to establish whether the use of simulated patients objectively develops skills, or acts as a valid assessment tool. This does not mean that the use of simulated patients do not, but more specifically that there are areas which need to be researched more rigorously, using objective measures of skill acquisition in the context of learning, and reliability and validity in the context of assessment.

Thus although the current literature allows us to surmise general directions in terms of educational features of using simulated patients, specific data informing specifically the benefits of each component of using simulated patients is lacking.

Similarly there are no direct measures of fidelity employed in any of the studies included in the literature review and limited conclusions can be drawn from this. Given the results from Ekbald et al, it does not however appear that knowing the patient is simulated or an actor necessarily detracts from the value trainees experience through simulation. This is a single study of a simulated and real patient and requires further replication.

Taken overall there appear to be variations in how much exposure to give learners to the simulated patients and whether learners should take the lead in interview. This appears to be linked with the aim of the task at hand – developing interview skills (such as in our role) appears to require more direct exposure, whereas understanding clinical narrative can

be facilitated through a teacher-lead interview. Developing clinical reasoning can be undertaken through a more remote method of computer-based simulation.

This idea that the aims of the learning session will dictate the exact form of the simulated patient session is also applicable to the pre-session preparation provided and provision of feedback. For example the computer based simulation teaching an algorithmic approach to informed consent will more clearly identify areas specific areas missed in the algorithm and feed this back to the learner on screen, whereas if the task is development of interview skills, this prima facie would be better provided in a small group feedback.

Virtual patients or virtual human agents are an emerging technology in simulation based teaching (12), and can also be useful in the psychiatric settings, these could address and reduce bias by actor or trainers against the trainee, however limitations in the usage of virtual patients for educational purposes will likely be homogenous to simulated patients as mentioned below.

Additional feedback can be provided through video recording the simulated doctor-trainee patient/actor interaction, the recorded video is a useful multifaceted reflection tool, with the help of the trainer and peer feedback. (13) Video recording technology through mobile phones has become ubiquitous, and the access enables retrospective analysis of the interview, the interpersonal processes, difficult communication and the overall performance for the specific task laid out pre-session. (14,15)

Simulated patients are helpful in the acquisition or testing of specific skills in the psychiatric interview. However criticism of simulation includes difficulties in assessing interpersonal processes, concerns are surrounding the hyper-reality of the simulated empathy and emotional content between the doctor-learner and simulated patient-actor as well as the simulated transference and counter-transference.

This hyper-reality could potentially hinder building empathic alliances with real patients presenting with challenging symptomatology, where communication requires adjusting of empathic reactions and psychodynamic processes to aid in discrimination of distinct character pathology. (16,17)

This view needs to be further established through studies comparing various components of simulated patient interventions to delineate these factors in more detail.

References:

1. Dave S. Simulation in psychiatric teaching. Adv Psychiatr Treat. 2012 Jul 1;18 (4):292–8.
2. Wass V, Jones R, Van Vleuten C Der. Standardised or real patients to test clinical competence? The long case revisited. Med Educ. 2001;35:321–5.
3. Ker J, Bradley P. Simulation in Medical Education. In: Understanding Medical Education. John Wiley and Sons, Ltd; 2013. p175–92.
4. Wood DF. Formative Assessment. In: Understanding Medical Education. John Wiley and Sons, Ltd; 2013. p317–28.
5. Piette A, Muchirahondo F, Mangezi W, Iversen A, Cowan F, Dube M, et al. Simulation-based learning in psychiatry for undergraduates at the University of Zimbabwe medical school ’. BMC Med Educ. 2015;15 (23):1–8.
6. Gorrindo T, Baer L, Ph D, Sanders KM, Birnbaum RJ, Ph D, et al. Web-Based Simulation in Psychiatry Residency Training : A Pilot Study. Acad Psychiatry. 2011;35:4 (August):232–7.
7. Fiedorowicz JG, Tate J, Miller AC, Rosenbaum M. Intervention for Medical Students ’ Assessment of Suicide Risk. Acad Psychiatry. 2013;37:6 (December):6–9.
8. Ekbald S, Manicavasagar V, Silove D, Baarnhielme S, Reczycke M, Mollice R, et al. The Use of International Videoconferencing as a Strategy for Teaching Medical Students about

Transcultural Psychiatry. Transcult Psychiatry. 2004;41 (March):120–9.

9. Kales HC, Dinardo AR, Blow FC, Mccarthy JF, Ignacio R V, Riba MB. International Medical Graduates and the Diagnosis and Treatment of Late-Life Depression. Acad Med. 2006;81 (2):171–5.
10. Davis H, Nicholoau T. A comparison of the interviewing skills of first- and final- year medical students. Med Educ. 1992; (1972):441–7.
11. Kolb D. Experiential learning : experience as the source of learning and development. New Jersey: Prentiice-Hall Inc; 1984. p1-38 .
12. Shah H, Rossen B, Lok B, Londino D, Lind SD, Foster A. Interactive virtual-patient scenarios: an evolving tool in psychiatric education. Acad Psychiatry. 2012;36 (2):146–150.
13. Xie H, Liu L, Wang J, Joon KE, Parasuram R, Gunasekaran J, et al. The effectiveness of using non-traditional teaching methods to prepare student health care professionals for the delivery of mental state examination: a systematic review. JBI Database Syst Rev Implement Rep. 2015 Aug 14;13 (7):177.
14. McNaughton N, Ravitz P, Wadell A, Hodges BD. Psychiatric education and simulation: a review of the literature. Can J Psychiatry. 2008;53 (2):85–93.
15. Mumford E, Schlesinger H, Cuerdon T, Scully J. Ratings of videotaped simulated patient interviews and four other methods of evaluating a psychiatry clerkship. Am J Psychiatry. 1987 Mar;144 (3):316–22.
16. Brenner AM. Uses and limitations of simulated patients in psychiatric education. Acad Psychiatry. 2009;33 (2):112.
17. Krahn LE, Sutor B, Bostwick JM. Conveying emotional realism: a challenge to using standardised patients. Acad Med. 2001;76 (3):216–217.

Towards the future of advance directives in psychiatry

Ben Harman-Jones (Psych Trainee)
Famia Askari (FY2)
Abubakar Isaac-Momoh (ST5)
Olubunmi Adebowale (Consultant Psychiatrist)
M A Sarfarz (Consultant Psychiatrist and DME)

Elizabeth Raybould Centre, Dartford

Introduction

Initially intended to enhance patient autonomy in times of psychiatric crisis, the origins of the psychiatric advance directive (PAD) can be traced back to the days of the anti-psychiatry movement. In 1982, Thomas Szasz published his vision for the "psychiatric will" (1). Similar to the "living will", the objective was to allow patients to express their wishes for or against specific forms of treatment in the event of loss of decision-making capacity during a psychiatric crisis.

There has been large variation in PAD implementation internationally in line with the degree to which healthcare professionals (HCPs) are required by law to adhere to their contents. This has been mandatory in parts of the U.S. since 1991 (2), and approximately 50 per cent of all states now allow patients to create legally enforceable PADs (3). The U.K. has been much slower to consider this; Scotland made the legislation in 2003. The position in England is still ambiguous. It was not recognised in the 2007 review of the Mental Health Act (1983), therefore, some interpret the Mental Capacity Act (2005) in such a way that could allow legally-binding PADs (4). As a result of this ambiguity, decisions made in English PADs exist in an advisory context and ultimately HCPs must judge whether to follow them.

The interpretation of the PADs varies considerably. The simplest were those made in the U.S. in the 1990s where legal documents were created by the patient alone (5). Their uptake was very low, which prompted efforts to facilitate completion through supporting material. One study showed a resulting twenty fold increase in completion rate from the use of so-called "facilitated" PADs (6). Practice in the UK has since gone a step further and progressed the concept to the "Joint Crisis Plan" (JCP). Here, patients, HCPs and third parties such as carers agree decisions, representing the most intensive form of PAD yet seen (5).

In this review, we examine how PADs are viewed by the stakeholders who use them, trends in their usage internationally, and then compare these trends to the practice in our own trust in Kent. We then return to the literature to examine the impact PADs have had on patient outcomes, before finally examining the appropriateness and utility of PAD in modern mental health care.

Current trends in PAD usage

The views of the stakeholders who use PADs have been studied extensively, and there is a clear divide in their expectations of the benefits. Nicaise et al (5) have examined aspects of PAD classification, content and implementation. They view the PAD as a "multistage intervention" rather than a one-off document, due to its varying performance across different objectives, which are of differing relevance to different stakeholders (see Figure 1). This model forms a helpful framework with which to classify PADs, which we will use throughout this review.

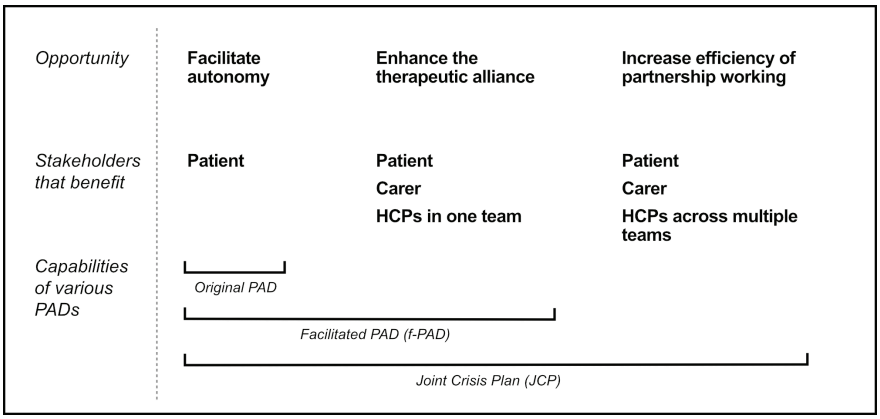

Figure 1: The "multistage intervention" model aligns the varying capabilities of different forms of PADs against the opportunities they present for different stakeholders. Adapted from Nicaise et al (2013)

They found that patients prefer legally-binding documents, and PADs are viewed positively as an advocacy tool to help facilitate autonomy in their relationship with HCPs. In contrast, HCPs appear more reluctant to subscribe to the same unilaterally beneficial view. Concerns raised include potential reduction in professional autonomy, possible use to refuse all treatment, medico-legal issues, and practical difficulties in implementation. Psychiatrists also point towards an interesting potential dilemma where the use of PADs may entrench a "worried well" behaviour with less likelihood of need to use one, whereas sick patients who need one would be less inclined to make one (7). There is also an indication that HCPs view PADs more as a tool to facilitate the care planning process rather than with the original intention of facilitating autonomy.

Several studies show that, given the choice, one half to two thirds of patients with severe mental illness would like to write a PAD if they were given the help to do so (8-12). So, in the presence of high expectation and desire by the patients to complete a PAD, are they being used? In the U.S., studies show only 4-13 per cent uptake among public sector outpatients (11, 12).

In three audits completed in Kent and Medway NHS and Social Care Partnership Trust (KMPT), from 2009 to 2014, we observed levels of appropriate PAD uptake consistent with that observed in the U.S. (Shanmugham and Picasa, 2009; Adebowale, 2013; Adebowale and Sarfraz, 2014). The results and details of the patients sampled are given in table 1.

These consistent findings raise the question of why PAD completion rate is so low. A lack of staff and patient awareness is the first observation; data from our trust shows that 79 per cent of inpatients surveyed did not know about writing a PAD. Among inpatient mental health nurses, only 49 per cent had received formal training on their use, and only 69 per cent were aware of the trust policy.

The policy (2014) recommends that all patients should be supported to develop a PAD as part of the CPA process.

While these findings may go some way to explain this low PAD uptake, we believe this is a myopic explanation. We now concentrate on variations in how the benefits of PADs make them more suited to enhancing certain parts of care than others – an issue we feel goes much further to explaining the low rate of PAD uptake observed internationally.

	2009	2013	2014
Details of patients sampled	Patients in the community under enhanced CPA	Patients in the community under enhanced CPA	Patients admitted across 2 inpatient wards
Number of patients sampled	40	50	25
Proportion of patients with a documented PAD	10%	10%	4%

Table 1: Data from three audits (Shanmugham and Picasa, 2009; Adebowale, 2013; Adebowale and Sarfarz, 2014) examining PAD usage across Kent and Medway NHS and Social Care Partnership Trust. Care Programme Approach (CPA)

The benefits of PADs

A Cochrane review examined two UK-based randomised controlled trials comparing outcomes in adults with severe mental illness depending on PAD usage (13). The authors concluded that the use of PADs led to no significant difference in care in terms of hospital admission or use of outpatient services, or compliance with treatment, indicating a lack of efficacy in facilitating autonomy. However, those using PADs required less contact with social workers, and had lower numbers of violent incidents. This is interesting

because the types of PADs used in the constituent trials were f-PADs and JCPs; consistent with Nicaise et al (5) that these more intensive forms of PAD are more conducive to enhancing the therapeutic alliance between patients and HCPs, rather than facilitating patient autonomy (see Figure 1).

Similarly, in 2006 Swanson et al reported that patients using f-PADs had a greater working alliance with HCPs than those not using them, and they were more likely to believe their mental health services were meeting their needs (6). It was also later reported that f-PADs reduced the chance of a patient undergoing a coercive intervention by 50 per cent (14).

It is therefore clear that PADs have the potential to produce benefits beyond the original intention of facilitating autonomy, a finding consistent with the multistage intervention model (figure 1).

Ethical framework of PADs

The use of advance directives in psychiatry was spawned from the use of similar documents in physical health care; specifically, their use to communicate prior decisions at the end of a person's life. There are, however, crucial and large differences in the circumstances affecting decisions made in end-of-life (EOL) care and those made in the treatment of an acute deterioration in mental state. These considerations are not necessarily reflected in PADs, the ethical foundations of which are still firmly rooted in EOL care.

The differences between decision making in EOL care and in psychiatric crisis are explored in table 2. From an HCP perspective, the value of the advance directive is generally to permit them to act in a patient's best interests when the patient is no longer able to decide for themselves. In the context of EOL care, "best interests" would usually be to not perform aggressive treatment, such as cardiopulmonary resuscitation (CPR), because the chances of a return to baseline are low (15). In direct contrast, "best interests" in psychiatric crisis may actually be to perform aggressive treatment, such as electroconvulsive therapy (ECT), because the chances of a return to baseline may be high (15).

	EOL care	Psychiatric crisis
Common dilemma facing clinicians	Not providing aggressive treatment that is unlikely to return a patient to their baseline (e.g. CPR)	Providing aggressive treatment that is likely to return a patient to their baseline (e.g. ECT)
Prior patient experience to inform decision	Not possible	Likely
Decision between capacitous/ non-capactious	Easy: Communication likely to be lost at same time as other faculties	Hard: Communication likely to be retained after other faculties are lost, leading to possibility of outward communication of disordered thought
Likelihood of override of advance decision	Low	High

Table 2 summarises the differences in decision making between EOL care and psychiatric crisis, which together may contribute to a high likelihood of override in psychiatric crisis compared to EOL care (15).

Data from KMPT showed that out of the six PADs where contents were available, three spoke about treatment preference, and three spoke about treatment refusal. These findings show a trend towards anecdotal evidence from international practice

that PADs are more often used to refuse treatment than to provide consent (16). There is clearly more to be done to ensure the decisions made in PADs are aligned to assisting HCPs in providing patient-centred care during psychiatric crisis.

There is evidence that the way in which advance decisions are interpreted varies considerably depending on the patient's reasoning behind their decisions. One survey of HCPs showed that only 22 per cent would follow a decision to refuse all medication due to paranoid delusions about them, whereas 72 per cent would follow the same decision made instead due to concerns about side-effects (17). Due to the nature of mental illness, there is a therefore a disproportionately high chance that PADs are overridden compared to other advance directives.

Discussion

The original need that PADs were introduced to meet – to facilitate the autonomy of patients upon loss of capacity in a psychiatric crisis – is underserved by the way in which PADs are commonly being used in practice. As we have shown, the uptake of PADs is much lower than originally intended, and this experience is consistent with practice in KMPT. There are a number of potential reasons for this, and unsurprisingly, failings in training and awareness are frequently deferred to as recommendations for improvement. While this is welcome, it is our view that the reasons for low PAD uptake are far more pervasive and difficult to disrupt.

In contrast to advance directives in EOL care, which are well-suited to communicating the refusal of unnecessarily aggressive treatment; to be useful in psychiatry, PADs must be able to communicate consent regarding a necessarily aggressive treatment. The assumption that the same ethical framework that advance directives for EOL care are built on is equally appropriate for psychiatric crisis is profoundly misguided. High potential override rates (reasons for which are detailed in table 2) confirm that even when a PAD is made, there is a low likelihood it will be used, hence giving insight into why perhaps the efficacy of PADs in facilitating autonomy is low. Further, perhaps HCPs assume this, explaining why uptake is also low.

This disparity is contradictory, because patients with mental health problems are likely to have a high level of insight into what it is like to suffer a deterioration, so are in a much stronger position to give informed consent than anyone is about EOL care (after all, who can claim to have experienced CPR?). Yet why are we willing to accept such EOL refusals as "competent", and not accept equally (if not more) competent permissions in psychiatry? Patients are also generally interested in using advance decisions to aid HCP decision making, rather than increase complexity of care by refusing treatment (5). Clearly, the desire to improve communication is present on both sides – and we believe that uptake and outcomes can be improved if delivery methods are modernised.

We identified evidence demonstrating that more modern and intensive forms, namely the f-PAD and JCP, are more suited as "multistage interventions", rather than being one-shot directives (5). The use of f-PADs and JCPs has been shown to correlate with lower social worker contact and lower numbers of violent acts (13) – evidence that the more intensive PADs (which are most widely used) may be more suited to enhancing the therapeutic alliance and improving partnership working (figure 1). Swanson et al (6,14) confirmed such benefits of f-PADs, with a striking reduction in the chance of coercive intervention.

Based on these observations, it is our view that the potential of the PAD in modern mental health care goes far beyond its original goal. What was originally intended to be a simple intervention is now used in practice to add layers of nuance to the CPA - as is the case in our own trust. However, we also recognise the reasons why the PAD movement

began, and believe it would be wrong for the specific goal of enhanced autonomy in psychiatry to be lost in this merger. Instead, we believe the concept may be used to both empower patients and assist clinicians simultaneously if the ethical uniqueness of psychiatric crisis is defined, recognised, and adopted, as we explain in the final section.

Recommendations

Firstly, we recommend fully embracing the best practice communication principles used in the intensive forms of PADs (f-PADs and JCPs) by fully incorporating them into CPA protocols. In our trust this would be best-placed as part of the existing enhanced CPA process (where certain aspects of PADs have already been incorporated). The potential benefits of this would be to improve the quality of the therapeutic alliance between HCPs and patients, and also to improve the efficiency of mental health services by improving partnership working.

Secondly, we are keen to preserve the potential for PADs to maximise patient autonomy. However, in order to be clinically valuable and meaningful in psychiatry, any such process must recognise the uniqueness of the challenges in psychiatric crisis. A solution may benefit from inspiration from the so-called "Ulysses contract" widely described in the literature, named after the Greek myth, where Ulysses ordered his men to tie him to the mast of his ship and not allow him to succumb to the Sirens' song, which would have meant unknowingly throwing himself to his death.

Next steps

1. Improve ability of CPA to enhance therapeutic alliance and partnership working

   a. To review the elements of our trust's existing enhanced CPA protocol and identify inclusion and exclusion of elements of the intensive PADs

   b. To recommend changes to enhance its potential to fully deliver the best practice communication principles promoted by intensive PADs

   c. Any changes will be systematically communicated to HCPs, patients and carers throughout the trust, along with this review, explaining reasoning and expected benefits

   d. To perform a retrospective audit six months after changes are made to determine if uptake rates have improved

   e. To perform a snapshot cross-sectional study to understand the views of stakeholders involved in use of the enhanced CPA protocol.

2. Explore the appetite for a dedicated process to plan for psychiatric crisis that is clinically useful and unlikely to be overridden.

   a. To invite HCPs, patients and carers from our region to a series of focus groups to discuss the issue and idea

   b. To discuss the limitations of current approaches, as detailed in this review, and to gain input on their views towards a new process that embraces the challenges of psychiatric crisis.

References:

1. Szasz TS. The psychiatric will: A new mechanism for protecting persons against" psychosis" and psychiatry. American Psychologist. 1982 Jul;37 (7):762.
2. The Patient Self-Determination Act (PDSA) 1990. United States Congress.
3. Davis JK. How to justify enforcing a Ulysses contract when Ulysses is competent to refuse. Kennedy Institute of Ethics Journal. 2008;18 (1):87-106.
4. Weller PJ. "Advance Directives and the Translation of Human Rights Principles in Mental Health Law – Towards a

Contextual Analysis", paper presented at the Quarterly Mental Health Consumer, Carer and Community Forum of the Australian Capital Territory Mental Health Community Coalition, Canberra, 12 May 2008.

5. Nicaise P, Lorant V, Dubois V. Psychiatric advance directives as a complex and multistage intervention: a realist systematic review. Health and social care in the community. 2013 Jan;21 (1):1-4.
6. Swanson JW, Swartz MS, Elbogen EB, Van Dorn RA, Ferron J, Wagner HR, McCauley BJ, Kim M. Facilitated psychiatric advance directives: a randomised trial of an intervention to foster advance treatment planning among persons with severe mental illness. American Journal of Psychiatry. 2006 Nov;163 (11):1943-51.
7. Swanson JW, Tepper MC, Backlar P, Swartz MS. Psychiatric advance directives: An alternative to coercive treatment? Psychiatry. 2000 May 1;63 (2):160-72.
8. Backlar P, McFarland BH, Swanson JW, Mahler J. Consumer, provider, and informal caregiver opinions on psychiatric advance directives. Administration and Policy in Mental Health and Mental Health Services Research. 2001 Jul 1;28 (6):427-41.
9. Noble LM, Douglas BC. What users and relatives want from mental health services. Current Opinion in Psychiatry. 2004 Jul 1;17 (4):289-96.
10. Srebnik DS, Russo J, Sage J, Peto T, Zick E. Interest in psychiatric advance directives among high users of crisis services and hospitalization. Psychiatric Services. 2003 Jul;54 (7):981-6.
11. Swanson JW, Swartz MS, Hannon MJ, Elbogen EB, Wagner HR, McCauley BJ, Butterfield MI. Psychiatric advance directives: A survey of persons with schizophrenia, family members, and treatment providers. International Journal of Forensic Mental Health. 2003 Apr 1;2 (1):73-86.
12. Swanson J, Swartz M, Ferron J, Elbogen E, Van Dorn R. Psychiatric advance directives among public mental health consumers in five US cities: prevalence, demand, and correlates. Journal of the American Academy of Psychiatry and the Law Online. 2006 Jan 1;34 (1):43-57.
13. Campbell LA, Kisely SR. Advance treatment directives for people with severe mental illness. The Cochrane database of systematic reviews. 2009 (1):CD005963.
14. Swanson JW, Swartz MS, Elbogen EB, Van Dorn RA, Wagner HR, Moser LA, Wilder C, Gilbert AR. Psychiatric advance directives and reduction of coercive crisis interventions. Journal of Mental Health. 2008 Jan 1;17 (3):255-67.
15. Olsen DP. Ethically Relevant Differences in Advance Directives for Psychiatric and End-of-Life Care. Journal of the American Psychiatric Nurses Association. 2016 Jan;22 (1):52-9.
16. Hobbs P, Hobbs P. The limitations of advance directives and statements in mental health. Australasian Psychiatry. 2007 Jan 1;15 (1):22-5.
17. Wilder CM, Elbogen EB, Swartz MS, Swanson JW, Van Dorn RA. Effect of patients' reasons for refusing treatment on implementing psychiatric advance directives. Psychiatric Services. 2007 Oct;58 (10):1348-50.
18. Adebowale O and Sarfraz M. A. Audit 715/14. 2014.
19. Mental Capacity Act 2005 (UK).
20. Mental Health (Care and Treatment) Act 2003 (Scot), ss 275, 276.
21. Mental Health Act 1983 (UK).
22. Pisaca M and Adebowale. Audit 589/12. 2013.
23. Shanmugham S, Pisaca M. Audit 190/08. 2009.

Medical education department contacts

Canterbury

Benjamin Huntley
Postgrad Admin (FT)
01227 812037

Laura Griffiths
Postgrad Admin (FT)
01227 812048

Debbie Monticolombi
Undergrad Admin (Mon-Thu)
01227 812189

Katherine Dunning
Undergrad Admin (Mon/Thu/Fri)
01227 812045

Maidstone

Angela Pendleton
Medical Education Manager (FT)
01622 224449

Lydia Fry
Postgrad Admin (30 Hrs)
01622 227390

Fax
01622 224141

Dartford

Dr Aamer Sarfraz
Director of Medical Education
01322 622222 ext. 3788 (via switchboard)

Anne Clark
Postgrad Admin (Mon-Wed 9-3pm, Thu 10-4pm)
01322 622016

Roopinder Butter
Education Registrar (Mon/Wed am, at home/Thurs)
01322 622488

Dianne Gibson
Volunteer (Mon)
01322 622037

Please call **01622 724131** if you would like this leaflet in a different language or format.

Visit us at www.kmpt.nhs.uk

Review November 2019 KM715