the columns

correspondence

Psychotherapy meets neuroscience

I read with interest the 'opinion and debate' article by Peter Fonagy 'Psychotherapy meets neuroscience' (*Psychiatric Bulletin*, October 2004, **28**, 357–359). While I am in agreement with the points he makes and the illustrations he uses, I think he has overlooked what is very likely to be the defining technology in the future of psychiatric treatment: neuroimaging. There is already a smattering of papers that have addressed the possible convergent brain mechanisms that underlie psychotherapeutic response and drug responses in the same disorder (for example in social anxiety disorder, e.g. Furmark *et al*, 2002). These studies are bound to increase in future years. So far, they seem to suggest that different brain regions are involved in psychotherapeutic response compared with drug response, although they may target a common final pathway such as the amygdala.

Another area of growing interest which will presumably turn into publications in the next few years is the exploration of the underlying neurochemical mechanisms of psychotherapy. For instance, our own group is currently conducting a study in which we give cognitive–behavioural therapy (CBT) for panic disorder and when patients have made a full recovery we test whether the therapeutic benefit of this intervention can be undermined by depleting brain 5-HT using the tryptophan depletion paradigm. Our preliminary data (Hood *et al*, 2004) suggest that tryptophan depletion does elicit a return of vulnerability to the panicogenic actions of a flumazenil challenge. Some earlier data from the Oxford group (Smith *et al*, 1997) using tryptophan depletion in those recovered from depression support the view that CBT effects may be mediated through serotonergic action, since they found a depressive relapse in a couple of patients who had recovered on CBT whom had never had any drug treatment for their depression.

It was pleasing to read a psychotherapist promoting a positive view of the interaction with neuroscience and I am very happy to offer my support for any biological studies he would like to conduct in this field.

FURMARK, T., TILLFORS, M., MARTEINSDOTTIR, I., *et al* (2002) Common changes in cerebral blood flow in patients with social phobia treated with citalopram or cognitive–behavioral therapy. *Archives of General Psychiatry*, **59**, 425–433.

HOOD, S. D., NAHS, J. R., BELL, C. J., *et al* (2004) Early results from a tryptophan depletion study in panic disorder patients treated with cognitive behavioral therapy. *Journal of Psychopharmacology*, **18**, A22, MB13.

SMITH, K. A., FAIRBURN, C. G., COWEN, P. J. (1997) Relapse of depression after rapid depletion of tryptophan. *Lancet*, **349**, 915–919.

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Professor Fonagy's article (*Psychiatric Bulletin*, October 2004, **28**, 357–359) is concerned mainly with the 'elucidation of pathogenic mechanisms', so that the 'structured manualised psychotherapy techniques of the future will be designed to specifically address empirically established developmental dysfunctions'. And for the purpose 'Non-biased non subjective measures of outcome are urgently required'. To achieve this, he invokes 'scanning techniques that allow the simultaneous imaging of two individuals interacting' (i.e. in the form of electronic signals).

Having in this way identified a 'biological deficit' (i.e. in the function of the subject's brain) 'psychotherapy can be available to provide a set of techniques that the mind can use to overcome a biological deficit'.

Freud recognised that human language could not be construed as a product of 'natural laws' governing the behaviour simply of 'material particles and forces'. Rather, every utterance in a language involves some process of interpretation by each auditor, and may be as much the expression of an unconscious intention of the speaker to deceive or mislead a listener (and perhaps even the speaker himself too) as simply to inform the other. To make these problems even more difficult in this field, untruths and errors may themselves point silently – as we all know – to unacceptable or disturbing truths and intentions to which consciousness is therefore barred.

Even the possibility of electronic systems or devices which might enable the display of evidence of such conflicts (especially in a symbolic or coded form) could surely not be called a therapy, or even humanitarian. The pursuit of understanding the origins and meanings of human mental conflict and suffering must indeed be humanitarian, perhaps one might even say humble?

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European Working Time Directive

Charles Dixon (*Psychiatric Bulletin* (Correspondence), November 2004, **28**, 426) echoes the sentiments of many psychiatric trainees who have to comply with European Working Time Directive (EWTD) rest requirements. On the one hand reduction in working hours is seen as a welcome modernisation in the life of a junior doctor, on the other hand, at the expense of senior house officer (SHO) training, delegation of tasks traditionally performed by medical staff means that front-line psychiatric practice becomes increasingly multidisciplinary.

The apparent ease with which the SHO has become dispensable from the assessment of the patient in accident and emergency (A&E) must have grave implications for psychiatrists at all levels. Nurse-led teams assessing A&E patients out of hours already call upon the services of the on-call psychiatrist if faced with the possibility of the use of the Mental Health Act 1983, following their initial, often very comprehensive assessment. If there happens to be a medical complication, there are plenty of A&E staff close at hand to give advice.

Psychiatrists, in order to avoid being perceived as supernumerary in the initial screening of the patient presenting to A&E, must ensure they are represented on

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columns

the teams carrying out these assessments. If the EWTD means that this can only be achieved by implementing a shift system we can see our future, and this is to be supported over and above a reduction of SHOs' night commitments. Not only is this significant for SHO training, but it is of paramount importance in defining the role of the psychiatrist in the multidisciplinary team.

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Who wants to be a specialist registrar?

From personal experience I support A. Naeem's opinion 'thinking about higher training during senior house officer (SHO) years can reap rewards' (*Psychiatric Bulletin*, November 2004, **28**, 421–424). I appreciate the importance of valid research but during SHO training I focused on developing my clinical skills and the MRCPsych examinations. As a consequence, I had no publications and was not shortlisted for specialist registrar interview.

I am currently waiting for research projects to proceed through ethics committee approval, one of the aims being to improve my shortlisting chances. However, from colleagues' experiences it seems possible that 1 h spent replying to this article may have the same desired effect.

Another concern surrounding the shortlisting process is the emphasis that seems to be placed on research and publications, while other important factors such as communication skills and clinical ability that cannot be quantified in a standardised manner on paper take a back seat. As a consequence, the system filters out too early valuable clinicians with these subjective skills but who possess less research prowess.

I do not think the quality of counter-transference you experience on looking at someone's curriculum vitae can compare to that on interview. It is these feelings you invoke in the interviewer (positive or negative) that are likely to be replicated in interactions with patients throughout your career. Perhaps it is these subjective qualities that patients will appreciate just as much as extensive research. I acknowledge the shortlisting process needs to be standardised, however, perhaps selectors could increase the numbers they shortlist.

The answer to the question: who wants to be a specialist registrar? Well, I do and I think I have a good chance once someone meets me face to face.

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Are the College 'norms' for general psychiatry dated?

The Royal College of Psychiatrists Occasional Paper 55, published in October 2002, *Model Consultant Job Description and Recommended Norms*, is the most up-to-date current document available that sets the standards recommended for the mental health services consultant workforce in general psychiatry. One would have hoped that it would command some credence in planning the consultant workforce, yet to our dismay, recently at our local planning away day between consultants and senior managers questions were asked by the senior managers about its utility. A cloud of confusion and ignorance was created and basic questions were asked about what does a consultant psychiatrist do and what should or should not be his or her role.

An interim report in August 2004, produced by the National Steering Group formed under the auspices of NHS Modernisation Agency, the Royal College of Psychiatrists and National Institute for Mental Health in England, has issued some 'Guidance on New Ways of Working for Psychiatrists in a Multi-disciplinary and Multi-agency context'. Appendix 3 of the document lists a summary of the hypothetical options discussed by the Royal College of Psychiatrists and in option 2 and option 3 there is mention of delegation and distribution of responsibility among other professional disciplines. Unfortunately, the document, gives guidance and talks of general principles only.

The general psychiatrist had already begun to disappear in the mist of functionalisation of services. Now the future feels even more uncertain. The College needs to respond rapidly with an updated version of its recommended norms for the new forms of general and specialised psychiatrists.

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Impact of a nurse triage system on junior doctors' workload

We were interested in the article by Moore & Willmott (*Psychiatric Bulletin*, October 2004, **28**, 368–370) that discussed the impact of a nurse triage system on junior doctors' workload. We were involved in piloting a very similar nurse triage system at Solihull Hospital, which has a psychiatric unit based in a district general hospital.

At the time of our study the senior house officer rota was a 1:6 'on-call' system covering the four in-patient wards, accident and emergency and general practitioner referrals, and liaison referrals within the hospital.

The nurse triage system was introduced at the beginning of February 2004. Nurse practitioners were to be the first point of contact for all referrals and ward calls in order to offer advice, screen referrals and assist the doctor with certain administrative work. During the trial a nurse practitioner was not present for every on-call shift, which therefore allowed us to evaluate the impact of a nurse practitioner on junior doctors' workload. Between 17 February and 17 May 2004 the six senior house officers recorded the time and nature of the calls they received and whether there was a nurse practitioner working with them. During this period there were 44 on-call shifts with a nurse practitioner present, 39 where there was not and 8 where it was not recorded.

The average number of calls received by the junior doctors was not significantly different with a nurse practitioner present (7.25) or without (6.76) (*t*-test P=0.53). The type of call received was recorded in four categories: referrals/advice, admissions, psychiatric ward calls and inappropriate calls (wrong mental health team/specialty etc.). The type of call received did not differ significantly depending on whether or not a nurse practitioner was on duty (*t*-tests, P=0.93, P=0.61, P=0.51, P=0.17, respectively). When a nurse practitioner was present, junior doctors did not receive 5 h continuous rest (the minimum required to be compliant for an 'on-call' rota under the new deal) for 34% of on-call shifts, compared with 26% when the junior doctor was working alone. There was, however, no significant difference between these results (χ^2 P=0.10).

Our results would appear to confirm the findings of Moore & Willmott that a nurse triage system had no significant impact on reducing junior doctors' workload. We felt though that having an experienced nurse on duty offered junior doctors support during assessments, improved multidisciplinary relationships and provided specific guidance for those who were newly appointed. However, these benefits must be balanced against the risk of trainees missing out on essential learning experiences in acute psychiatry as described in the recent letter by Dixon (*Psychiatric Bulletin* (Correspondence), November 2004, **28**, 426).

A carefully planned nurse triage system in fact could not only be a valuable part of service provision in the light of changes in junior doctors' working hours, but also lead to an overall improvement in care received by psychiatric patients out of working hours. Clearly there needs to be further evidence published to ascertain if

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