

Correspondence

Opt-in letters

We work in a national mental health diversion service; this gives us a good overview of a range of mental health services across the country. We are writing to draw attention to a new development in a range of adult mental health services around the country (we have had experience of this in several separate geographical areas throughout the UK) – the ‘opt-in letter’. When referring patients with an apparent episode of psychosis (for example, delusional beliefs that one is the Messiah), the response of the receiving service has been to send the patient an impersonal standard letter, stating that someone has expressed concern about their mental health and offering them the chance to ‘opt in’ to an appointment. If the patient does not take advantage of this opportunity the case is then closed. We are extremely concerned about the appropriateness of this as a response to patients with severe insight-disabling illnesses. We can find nothing in the scientific literature to support this development (apart from in psychotherapy services to reduce the non-attendance rate, where the client group has a very different diagnosis and presentation), and are concerned that this represents a dangerous and perverse form of crude demand management. We would be interested to hear of the experience of others, and whether there are colleagues who would defend the practice.

Simon Wilson, Consultant and Honorary Senior Lecturer in Forensic Psychiatry, Department of Forensic and Neurodevelopmental Science, Institute of Psychiatry, London, email: simon.wilson@kcl.ac.uk;
Frank Farnham, Consultant Forensic Psychiatrist, and **Sara Henley**, Clinical Psychologist, both at North London Forensic Service, Barnet, Enfield and Haringey Mental Health NHS Trust, Chase Farm Hospital, Enfield.

doi: 10.1192/pb.37.10.340

Experience of psychiatry in foundation years

There has been considerable discussion in this and other journals about the negative perception of psychiatry among medical students.^{1,2} I am approximately 1 month into my foundation year 1 placement in liaison psychiatry, and would like to share my experiences.

Undergraduate psychiatry placements in the UK usually occur within the last 2 years of medical school. For such a unique medical specialty this can often seem like something of an afterthought. Predictably, at such a late stage students can be very exam focused; undergraduate psychiatric exams, with short, time-restricted stations and simulated patients are drastically different to the realities of clinical psychiatry. As the author and psychiatrist Rivka Galchen recently wrote in *The New Yorker*, ‘the medical field makes the mistake of valuing most what is most easily measured’³ – at exam time this approach is at odds with the subtleties of the skilful psychiatrist.

Without the looming threat of exams, and with a greater involvement in the team, my junior doctor colleagues and I have found psychiatry to be a joy. Although it is a somewhat paperwork-heavy specialty, psychiatry does not suffer from

overuse of protocols and predefined clinical pathways in the same way that core medical specialties tend to, leaving scope for even the juniors to be involved in regular, and real, clinical decision-making.

The rewarding experience of psychiatry as a foundation job highlights the need for more rotations to include psychiatry; doctors who have a psychiatry placement during the foundation years are eight times more likely to enter psychiatry specialist training than those who do not.⁴ This statistic alone supports my theory that a placement during the foundation years is vastly more rewarding than a placement during medical school. It also highlights a need for medical students on placement to be granted as much freedom as possible to spend time alone with patients, an activity that both students and supervisors are often reluctant to facilitate.

- 1 Barry N, Dickenson R, Crow K, Ayers E, Chatzpolous M, Lin T, et al. Medical students and a career in psychiatry: a discussion. *Psychiatrist* 2012; **36**: 79–80.
- 2 O'Brien A, Mudunkotuwe J. Reflective assignments by students completing an undergraduate psychiatry attachment. *Psychiatrist* 2012; **36**: 470–4.
- 3 Galchen R. Every disease on earth. *New Yorker: Ann Medicine* 2013; May: 50.
- 4 Kelley TA, Brown J, Carney S. Foundation Programme psychiatry placement and doctors' decision to pursue a career in psychiatry. *Psychiatrist* 2013; **37**: 30–2.

Oliver D. Gale-Grant, Foundation Year 1 Doctor, St George's Hospital, London, email: og307@doctors.org.uk

doi: 10.1192/pb.37.10.340a

Psychodynamic understanding of serious events

Mark Cohen's editorial on the organisational processes surrounding the investigation of serious events¹ is a valuable contribution to an area of great importance in the work of mental health professionals. However, in my view, he might have commented on other areas, further emphasising the significance of a psychodynamic understanding of the investigation of serious events.

Cohen could also have referred to ‘mentalisation’, which is of central importance in psychodynamic understanding. That is the capacity to understand minds, both one's own and those of others, and therefore to recognise that human behaviour is motivated.² Mentalisation is of central importance in emotional and social intelligence, including healthy interpersonal experience and helpful ways of thinking about the world. It is this emotional intelligence that as leaders in psychiatry we need to bring not only to day-to-day clinical work, but also to the process of enquiry into serious incidents. In my view this is the way to address the emotional distancing where ‘everything . . . feels too much’, which Cohen highlights as typical of root cause analysis investigations.

‘Malignant alienation’ as described by Watts & Morgan³ is also of importance. This is defined as ‘the progressive deterioration in the relationship between a psychiatric patient and staff commonly found leading up to a serious incident such

as a suicide'. This practical concept explains the interpersonal dynamics between professional and suicidal or homicidal patient. In this process 'difficult' patients attempt to have their care needs met in an inappropriate and maladaptive manner. This puts more pressure on professional caregivers who may themselves be unaware of their own vulnerabilities as a result of what is perceived as a professional pressure to 'heal all, know all and love all'. The institutions in which we work also often portray our skills and abilities to know and predict risks as omnipotent thus emphasising these 'narcissistic snares'.

As a result of this dynamic, painful feelings are evoked for the professional who may distance themselves from, and unconsciously reject, the patient. An example of this would be discharging the patient from hospital prematurely and potentially destructively. Cohen describes how hostility and revenge fantasies are central to the suicidal act. In malignant alienation, unconscious countertransference hate is acted out by caregivers in the circumstances described, resulting in an increased suicide risk for the patient.

I suspect this process has not been much discussed in the literature because of our unhelpful disinclination and distaste to talk about such feelings we may have for patients. This difficulty is famously described by Winnicott: 'However much the psychiatrist loves his patients he cannot avoid hating them and fearing them, and the better he knows this the less will hate and fear be the motive determining what he does to his patients'.⁴ It appears that the more we can recognise such

feelings and the safer the containing environment is to share them in, the safer the patient is. This is of particular importance in the present culture of blame.

These important developments in the application of psychoanalytic thinking to the work of the general psychiatrist have great relevance to our working institutions and the response of the healthcare institution to serious untoward incidents. Just as it is important for psychoanalytic psychotherapists to promote the increasing evidence base for their therapeutic approaches, it is also necessary for us to remember the tools we already have for understanding the dynamics of patients who take their lives or the lives of others in spite of, or at times in part because of, our actions and the response of the institutions in which they are cared for.

- 1 Cohen M. Organisational processes around the investigation of serious events. *Psychiatrist* 2013; **37**: 217–20.
- 2 Allen JG, Fonagy P, Bateman AW. *Mentalizing in Clinical Practice*. American Psychiatric Publishing, 2008.
- 3 Watts D, Morgan G. Malignant alienation. Dangers for patients who are hard to like. *Br J Psychiatry* 1994; **164**: 11–5.
- 4 Winnicott DW. Hate in the countertransference. In *Through Paediatrics to Psychoanalysis: Collected Papers*. Chapter XV, pp. 194–203. Basic Books, 1958.

Paul M. Foster, Consultant Psychiatrist, Edgware Community Hospital, London, UK, email: paul.foster@beh-mht.nhs.uk

doi: 10.1192/pb.37.10.340b