education & training

Psychiatric Bulletin (2002), **26**, 354–355

KATE F. LOVETT

Time for cognitive reframing – becoming a specialist in adult psychiatry

Psychiatry has always relegated itself to being the Cinderella speciality of medicine. Nowadays it appears that general adult psychiatry is competing for the Cinderella subspeciality of the speciality. The profession may or may not be in crisis but it probably is depressed. Would we accept, unchallenged, such low self-regard and hopelessness from patients? Not if we are trying to be in the least bit therapeutic.

I have always wondered about the story of Cinderella. There are several different versions but most say that Cinderella was invited to the ball. Generally, she perceived that she could not go because of the bullying she received from the ugly sisters. You know the rest. Her fairy godmother intervened, Cinders got to the ball and lived happily ever after. If adult psychiatry is now the 'Cinderella' speciality, have we become paralysed into waiting to be rescued by a fairy godmother?

My problem with Cinderella is that the magic is too passive. I prefer to think of the fairy godmother as being a wise old woman who understood human psychology, challenged Cinderella's perceptions of her situation and helped her come to the realisation that the obstacles preventing her from getting where she wanted to go were not insurmountable. The cognitive reframing worked. To Cinderella, it was magic. To our patients, such psychotherapeutic intervention can be dramatic and magical too.

Psychiatry captured my imagination when I was a medical student. To me, it was the most fascinating blend of science, psychology, sociology, philosophy and law. It was also a youthful discipline and its academic underpinnings were striving to establish an evidence-based practice long before the term had been coined. The rest of medicine seemed banal in comparison. I was lucky to have met diligent teachers. The last question at my final examination was 'Have you considered a career in psychiatry'. I did, and 12 years later I became a consultant psychiatrist specialising in adult psychiatry.

I do not want to minimise the problems faced by colleagues elsewhere and I am not trying to be complacent. The job is challenging and, at times, stressful. Some tasks are simply impossible to perform. Some cultures are so dysfunctional that they have become toxic working environments. The resources we are given cannot ever provide everything for everyone.

However, at some stage all of us will have loved the subject. What was it that made us go into psychiatry in the first place? What aspects of the job have we enjoyed in the past? We need, as with all long-term relationships, to recapture the initial sparks of attraction in order to maintain a lively and fulfilling marriage. We also need to value ourselves and the unique blend of skills we have developed. We are specialists in our own right and need to defend our specialist status.

Adult psychiatry is a psychiatric subspeciality

I often perceive that adult psychiatrists resent being expected to deal with psychiatric emergencies. Lack of protection by a waiting-list, compared to other subspecialities, makes them see themselves as a general 'mopping up' service, unable to set boundaries with referrers; making them feel overwhelmed and undervalued.

We must abandon the idea that one needs a waiting-list to be a subspeciality. Would we deny that our colleagues in accident and emergency medicine and intensive care anaesthesia are specialists? The nature of adult psychiatric epidemiology means that, *de facto*, we have to develop expertise in emergency and intensive care psychiatry. If you enjoy the 'turn and burn' of emergency work, then adult psychiatry has to be a career option. The tension comes when you are not free from other commitments to respond. Casualty consultants who were trying to perform elective operations at the same time as responding to emergencies would also feel intolerably stressed. We need to modify working patterns to give dedicated sessions to particular aspects of our work.

Adults of working age present unique psychotherapeutic opportunities; old enough to take responsibility, mature enough to gain insight into their difficulties and sometimes young enough to make significant changes. A basic grounding in psychotherapy assessment, eclectic understanding of the modalities of psychotherapy and some basic psychotherapeutic skills are important tools for the adult psychiatrist.

https://doi.org/10.1192/pb.26.9.354 Published online by Cambridge University Press

Knowing when to refer patients to other subspecialities is a skill we have developed. Like our colleagues specialising in general practice, we look after the vast majority of patients coming through our doors without referring on. We could probably learn a thing or two from the general practitioners (GPs) whose self-perception and standing has changed over the past 20 years. Like GPs, we too deal with conditions unique to our speciality. One would not refer to a forensic psychiatrist or an alcohol specialist for help with agoraphobia. Likewise, one would not send every patient with a criminal record to see a forensic psychiatrist or every patient with alcohol problems to see an addiction specialist.

Child and adolescent psychiatrists appreciate the importance of understanding child development and maturational processes of adolescence. Adult psychiatrists, too, have to develop special understanding of the life-stage changes related to adulthood. This provides exciting opportunities to develop expertise in perinatal and reproductive psychiatry, adult relationships and the occupational aspects of mental health. Adult psychiatrists deal with these issues every day but seldom stop to realise they might have become rather good at it!

What can be changed to make posts more enjoyable?

I have argued that adult psychiatry is interesting. Often, however, posts have become difficult to enjoy. What aspects can be changed to allow psychiatrists to enjoy their jobs and develop fulfilling careers?

Developing a portfolio of skills for the job throughout training is important. Do not expect trainees to learn them all in adult psychiatry attachments; consider special interest sessions in drugs, alcohol, forensic, rehabilitation psychiatry and psychotherapy. Support belief in oneself as an emerging specialist. We are specialists! If the title of Consultant in General Adult Psychiatry does not impress, encourage your trainees to become consultants in primary care liaison psychiatry for adults of working age!

Preparation for consultant posts starts as a senior house officer. Trainees can be encouraged to think about the qualities of the consultants they admire and how they handle the pressures of the job. They should think about which skills they will need to manage stress. It is never too early to go on a stress management course. Local consultants and psychologists may be willing to initiate one if there is not an established course locally.

Investigate potential consultant jobs carefully. Having one or two like-minded colleagues is essential. If you feel chilly to begin with it is only likely to get colder. Think about the culture and ethos of the organisation. Do things happen here? What service developments have there been over the past 5 years? What is the strategic vision? Speak to senior managers. Can you see yourself being a valued member of staff? If you feel like potential cannon-fodder, you probably will be.

Have firm boundaries to create a job that is manageable. Negotiate catchment size and remit carefully. Accepting a post that does not comply with College guidelines will lead to frustration and will be difficult to sustain in the long term. Be honest with prospective employers about what conditions you expect. If suitable substantive posts are not immediately obvious, consider locum positions in the short term to give yourself longer to look. Approach trusts directly. Some have given up advertising because of previous lack of response. If catchment sizes are large, you could propose creating a new post to reduce these.

Consider flexible ways of working. Team up with colleagues to provide daytime emergency and Section 12 work. This can free up protected time for meetings and clinics and make the emergency work more enjoyable.

Use and develop skills of multi-disciplinary team members. Spend time finding out what these are and in which directions team members want to develop. Encourage them and fight for resources for training. Delegate appropriately. Consider spending time with other services learning how they deal with the workload.

Make sure you have time to develop aspects of the job which you enjoy, such as teaching and special interest sessions. Use the appraisal process to your advantage. Be constructive. What tools do you need to fulfil your job plan? How can your employers help you? Are there any courses or special training you would like to undertake? Go one step further than considering the concept of 360° appraisal, that is consider the views of other team members, carers, users and GPs of your work. I like to think of appraisal as 'spherical'. Consider yourself in the context of family, friends and community. Are the other aspects of your life helping you to be a rounded human being? Spheres also have the advantage of bouncing when they are dropped from a great height!

If your initial choice proves unsustainable and moves to improve the situation have failed, consider alternatives. Be positive, reflective and honest to potential employers. Think of solutions rather than blame. How could things be different next time round? There are plenty of vacancies around. Although potentially disruptive, a move can be a refreshing change and an exciting challenge.

Conclusion

Looking after adults with mental health problems is a privilege. The remuneration is good (think about how much the other team members are paid and their levels of training and responsibility), the rewards of seeing patients improve are huge and the intellectual stimulation is considerable. Changes can be made to improve working practices and job satisfaction.

Adult psychiatry is in the fortunate position of having a place at the heart of current government policy. Returning to the analogy with Cinderella, we have already received the invitation to go to the ball. What we need to do is to develop a strategic vision for getting there.

Kate F. Lovett Consultant Psychiatrist, Plymouth Primary Care Trust, Westbourne, Scott Hospital, Beacon Park Road, Plymouth PL2 2PQ

https://doi.org/10.1192/pb.26.9.354 Published online by Cambridge University Press