the columns

correspondence

Communication skills of overseas doctors and training implications for psychiatry

The ability to communicate effectively is fundamental for a doctor practising in any medical specialty, and it assumes crucial importance in psychiatry. Good communication between doctor and patient is necessary for history-taking, eliciting symptoms of mental illness, exploring sensitive issues and establishing rapport with patients. Proficiency in the English language may not be sufficient in understanding its subtleties and nuances.

The General Medical Council (GMC) guidelines state that doctors should have adequate language and communication skills to practise in the UK, involving submission of an original International English Language Testing System (IELTS) certificate, showing attainment of minimum scores in speaking, listening, reading and writing English (www.gmc-uk.org/doctors/registration_applications/join_the_register/language_proficiency.asp). In 2008, just 6% of candidates sitting Paper 1 of the Membership of the Royal College of Psychiatrists examination were UK graduates (www.rcpsych.ac.uk/member/rcpsychnews/august2008.aspx). A majority of psychiatry trainees for whom English is not their first language have received training overseas.

A qualitative survey was conducted to gauge the opinions of trainers, trainees and service users regarding communication skills of overseas doctors. Self-report questionnaires addressing communication and language were completed by a sample of consultant trainers, psychiatry trainees and service users of Greater Manchester West Mental Health NHS Foundation Trust. Questions addressed issues regarding effective communication, language ability, impact on patient care and training implications for psychiatrists.

There were 99 respondents (11 trainers, 15 trainees and 73 service users). Trainers perceived the need for additional training for trainees if their language skills were deficient. They suggested that a system for assessing language competency should be provided by the Royal College of Psychiatrists. Trainees reported a high level of English language competency, but regarded IELTS as not meeting the requirements for training in psychiatry. They also suggested additional training components and language testing to be introduced by the College and the GMC. Service users who had been seen by overseas doctors perceived them to be good communicators with minimal language difficulties. They also felt that doctors who had problems speaking English should receive additional training.

Although overseas doctors' language competencies are regarded as being adequate by trainers, service users and trainees, additional formalised language training is felt to be necessary. This should be recognised by the GMC and the Royal College of Psychiatrists. Localised language training should be facilitated and encouraged as part of skills development and should be assessed through regular workplace-based assessments.

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Dealing with transphobic harassment: the experience of a transsexual in-patient

Up to 33% of female in-patients on psychiatric wards experience unwanted sexual comments and pestering of women patients is also common (56%).[1] Harassment has been a particular problem for one our patients, a male-to-female transsexual who required admission for depression and suicidal thoughts. She has found hospital admission particularly difficult both due to prejudice from fellow patients and because of what she describes as 'transphobic' abuse from staff. Even during the first hours of her admission it became clear that our in-patient service was not going to find it easy to meet her needs and she was moved between wards, allocated a bed in a female area, then in a male area, and then finally moved to a single bedroom in a mixed ward.

Although these were real practical issues (i.e. trust wards operate either as same-gender wards or as wards with specific male/female areas with gender-specific bathrooms), it also seemed that staff's attitude was a major factor in the patient's feeling harassed and discriminated against. Following a complaint to management she has agreed to meet with ward managers to discuss the issues.

Helpfully for the medical staff, the patient also agreed for her case to be presented at the academic programme to which all grades of doctors attend. She preferred to be present throughout the presentation of her history, talked of her own experiences and participated in the subsequent discussion.

A questionnaire survey of the attendees at the presentation revealed that most understood the difficulty experienced by the patient and appreciated the issues of harassment and discriminatory practice as she described them. The majority (76%) had no training in transgender issues and would welcome some.

The Department of Health guidelines on transgender issues[2] do not specifically refer to in-patient accommodation but are more focused on staff attitudes.

It would be interesting to see whether in-patient accommodation would prevent the harassment described by our patient or whether staff awareness is the more vital component.

1 LawnT, McDonald E. Developing a policy to deal with sexual assault on psychiatric in-patient wards. *Psychiatr Bull* 2009; **33**: 108–11.

2 Department of Health. *Trans: A Practical Guide for the NHS*. Department of Health, 2008.

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Xenophonia: a new term in psychiatry?

Studying the international literature in psychiatry and the publications in psychiatric journals, we could not identify

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any simple term that could describe 'strange' speech.

Currently there are terms that only partly describe what we wanted to be included in a single general term. For example, schizophrenic speech is composed of unusual oral creations which cannot be considered as a language as the latter is nothing if it is not creative.[1] The term 'schizophasia' designates, specifically, at least two forms of unconventional surface speech behaviours – 'glossomanic behaviour' and 'glossolalic behaviour' – that can be observed in certain patients who experience a psychotic episode.[2] Both can be spectacular. The essential characteristics of 'glossomanic schizophasia' is the production of utterances the linguistic components of which – be they phonemes, words or more complex units – are selected and combined on the basis of superficial or semantic kinships rather than an immediately shareable topic. The main characteristic of 'glossolalic schizophasia' is an entirely or nearly entirely neologistic discourse.[1]

However, the Greek term *xenophonia* describes what we are looking for. The exact definition for *xenophonia* is any strange/odd/paradoxical voice or speech[3,4] and *xenophonic* is one who speaks or sounds strange. Following a thorough research of all available databases, including EMBASE, MEDLINE and PsycINFO, without any language restriction, the term *xenophonia* has been referred to in only one paper, a non-psychiatric study. It is being used there to describe a vocal abnormality during and after the sound variation stage; the main symptoms are high tone, low voice, short breath and unstable sound control, which are usually a functional variation, a habitual vocal defect.[5]

As the term *xenophonia* has never been mentioned in our fields of interest we would like to propose it as a new psychiatric term which describes the phenomena of generally 'strange speech'.

1 Sims A. *Speech and Language Disorders in Psychiatry.* Gaskell, 1995.

2 Lecours AR, Navet M, Ross A. Langage et pensée du schizophase. *Confrontations Psychiatriques* 1981; **19**: 109–44.

3 Liddell HG, Scott R, Jones HS, McKenzie R. *A Greek–English Lexicon.* Clarendon Press, 1940.

4 Dimitrakou D. *Grand Dictionary of the Greek Language*, Vol. 10, 1964.

5 Zhiqing W, Wenjun Y, Yiting C. Tratment of xenophonia in male youths by extralaryngeal massage and language training. *J Tradit Chin Med* 1993; **13**: 221–2.

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ECT: there is more than just unilateral or bilateral selection!

The assumption that all doctors are well informed about the latest arguments regarding the pros and cons of unilateral or bilateral electroconvulsive therapy (ECT) may not be right. We would like to take this opportunity to update readers of current developments that may potentially revolutionise or even significantly modify our thinking about this controversial treatment.

As the author says, the UK ECT review group in 2003 had an important shortcoming of inclusion of all stimulus intensities, leading to a dubious conclusion in favour of the advantages of bilateral ECT.[1] Although we do believe that the uncertainty in evidence exists, the emerging evidence base, particularly in the USA and Australia, may tilt the balance of opinion and attitudes, more in favour of right unilateral (RUL) ECT with the ultra-brief type of pulse width.

Sackeim *et al*[2] and Loo *et al*[3] have in 2008 published research indicating that ultra-brief pulse width right unilateral ECT is likely as effective as the conventional one (brief pulse RUL), in addition to being significantly better in terms of cognitive disability. This is an exciting new development as we believe cognitive disability has consistently been underplayed in studies on ECT over the years. Robertson & Pryor[4] as well as Mangaoang & Lucey[5] cite extensive relevant body of research suggesting a lot more cognitive damage and disability, undetected by conventional testing. Additionally, if the patients were to be made aware of a potential modality of treatment with significantly less cognitive disability, they may actually make a more completely informed decision.

Although it is not difficult to adapt current practice to using ultra-brief pulse width RUL ECT by slight modification of the 'programmes' settings available on current machines in the UK, this detail is clearly beyond the scope of this letter.

In conclusion, we posit that the need for faster recovery by using bilateral ECT may be more than balanced by the need to deliver the treatment that is less disabling (in terms of cognitive disability) and possibly equally effective.

1 The UK ECT Review Group. Electroconvulsive therapy: systematic review and meta-analysis of efficacy and safetly in depressive disorders. *Lancet* 2003; **361**: 799–808.

2 Sackeim HA, Prudic P, Nobler MS, Fitzsimmons L, Lisanby SH, Payne N, et al. Effects of pulse width and electrode placement on the efficacy and cognitive effects of electroconvulsive therapy. *Brain Stimulat* 2008; **1**: 71–83.

3 Loo CK, Sainsbury K, Sheehan P, Lyndon B. A comparison of RUL ultrabrief pulse (0.3 ms) ECT and standard RUL ECT. *Int J Neuropsychopharmacol* 2008; **11**: 883–90.

4 Robertson H, Pryor R. Memory and cognitive effects of ECT: informing and assessing patients. *Advan Psychiatr Treat* 2006; **12**: 228–37.

5 Mangaoang MA, Lucey JV. Cognitive rehabilitation: assessment and treatment of persistent memory impairments following ECT. *Advan Psychiatr Treat* 2007; **13**: 90–100.

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A survey on takeaways in a secure unit

Physical health monitoring of long-term detained psychiatric patients in secure care has attracted much attention in the past few years.[1] The rate of coronary heart disease in patients with schizophrenia is almost three times higher than in the general population and is thought to be a greater contributor to mortality in this group of patients than suicide.[2] Patients on antipsychotic medication seem to have a worse metabolic profile.[3] Metabolic syndrome has been described as a risk factor associated with the development of coronary heart disease and includes central obesity, impaired glucose tolerance, hypertriglyceridaemia, hypercholesterolaemia and hypertension.

For long-stay patients in secure hospitals a combination of antipsychotic medication, poor diet, sedentary lifestyle, lack of exercise and leave, smoking and illness effects are all likely to contribute to weight gain and metabolic syndrome.

As part of a wider consultation exercise promoting healthy lifestyles, concern has been raised about the number of takeaways ordered by detained patients within a National Health Service (NHS) medium secure unit and how this may contribute to metabolic syndrome. A survey monitored the number of takeaways delivered to the unit over a 21-day period.

In total, 326 individual takeaways at the overall cost of £2736 were consumed at an average of £8.40 per order (range £3–23). The figures included 'group bookings' from two wards within the learning disability directorate that have two designated takeaway nights per week.

It was estimated that around three-quarters of patients ordered a takeaway during the study period: 29 patients consumed at least one takeaway a week and 16 patients consumed at least