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Kent Journal of Psychiatry

Dedicated to Psychiatry trainees and trainers

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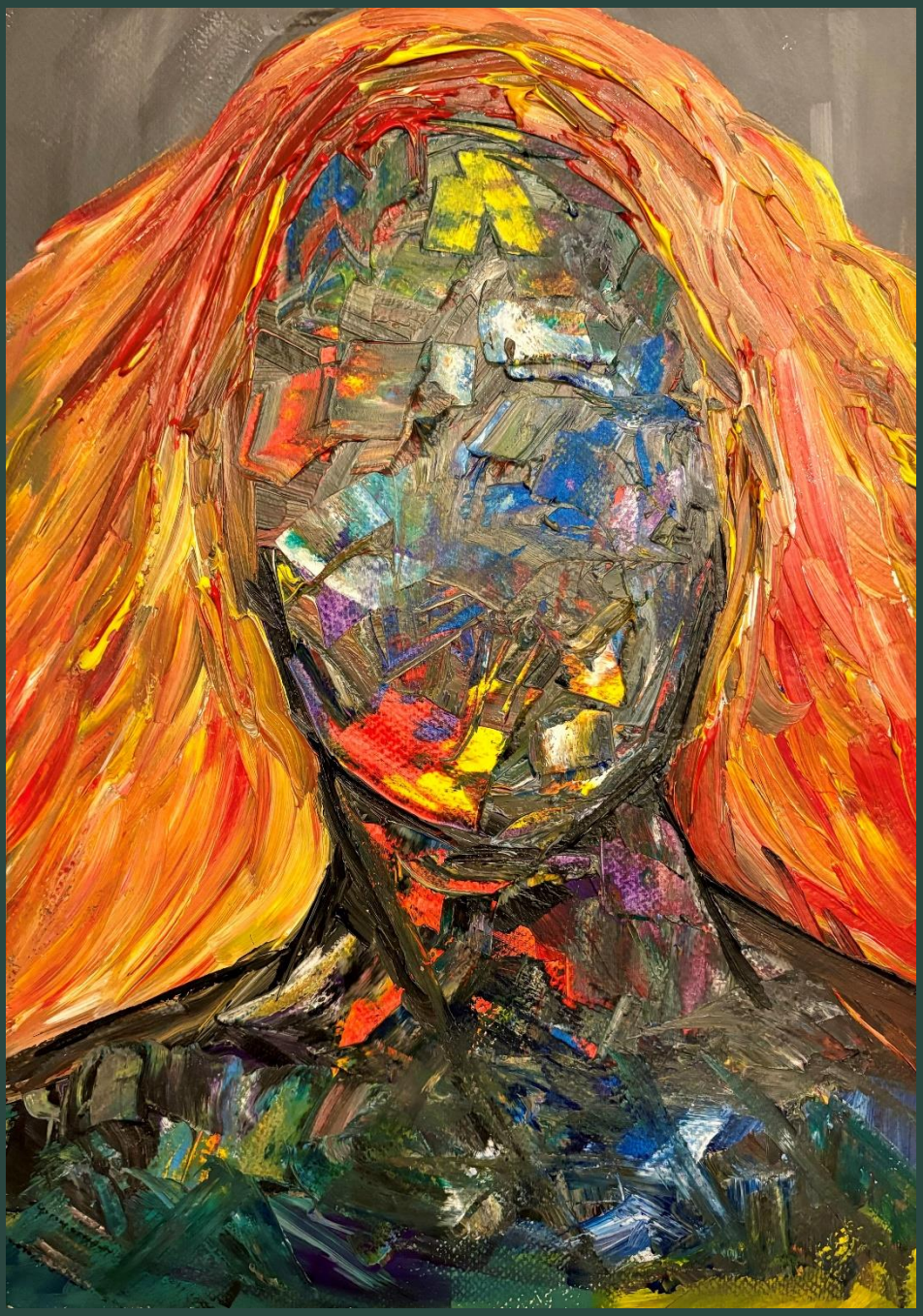

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Contents

2 **Editorial Board**

4 **Editorial Introduction**

5 **Model of care in Early Intervention in Psychosis: how do we make the square peg rounder?**
Michael Jewell, Ryan Lord & M. Aamer Sarfraz

13 **Can you really teach clinical communication virtually? Evaluating new methods in the time of Covid-19**
Adam Montgomery, Faeez Ramjan, Alistair Cannon, Sae Kohara, Chloe Saunders, Deekshitha Umasankar, Lois Zac-Williams & Sophie Butler

24 **Inpatient stroke caregivers support group: a pilot study**
Juvairia Qasmi & Carlotta Urso

29 **How Trainee Factors May Affect Treatment Efficacy in Psychodynamic Psychotherapy**
Rebecca Bennett

36 **Meditation and Psychosis**
Bruce Tamlinson & Diksha Malhotra

Editorial Introduction

Welcome to the first edition of KJPsych in 2024. This edition covers a variety of pertinent topics in mental health as perceived by psychiatry trainees and their colleagues working up and down the country.

We have articles in this issue that evaluate the stagnant domain of Early Intervention Psychosis services, highlight the challenges in teaching clinical communication virtually, explore ways to lessen the care burden experienced by care-givers of stroke patients, navigate the minefield of psychodynamic psychotherapy offered by psychiatry trainees, and whether meditation has a place in supporting psychotic patients.

Our regular readership would notice that Dr Rhian Bradley and Dr Benedict Harmon-Jones have stepped away from the editorial board after providing years of most valuable service. We welcome Dr Rebecca Howard to the board; she has made a sterling contribution by reviewing most the articles in this issue.

Model of care in Early Intervention in Psychosis: how do we make the square peg rounder?

Michael Jewell, Ryan Lord & M. Aamer Sarfraz

Introduction

Early Intervention in Psychosis Service (EIS) is a multidisciplinary community mental health service that provides treatment and support, typically for 3-5 years, to people experiencing or at high risk of developing psychosis [1]. This approach is based on the early detection and treatment of emerging symptoms of psychosis as it is thought to prevent relapses and reduce the long-term impact of the condition. Built on influential research on first episode psychosis from the 1980s, frontline early psychosis clinical services were established, first in Melbourne and soon afterwards in many major locations in the UK, Europe, North America and Asia [2]. They were developed as a stand-alone model of care, but with ample multiprofessional resources, and a specific focus on treating people with a first-episode of psychosis. Since this initiative was a part of the National Service Framework (1999), most mental health trusts in the UK adopted it from 2001 onwards, following the publication of the Mental Health Policy Implementation Guide (MHPIG) by the Department of Health (2001) [3].

EIS started with much fanfare but came under criticism soon after its establishment because it had the same in-built challenges, which hampered progress in mental health services more widely, including stigma, cynicism, the silence that surrounds the mentally ill, and doubts about future investment [4]. It also struggled to address conceptual and operational challenges regarding its evidence base, expansion at the cost of other services, rationale for the treatments offered, choice of cases, and inherent chronicity of psychotic illnesses [4,5]. Despite robust defence of this remarkable innovation on behalf of the early adopters [2,6], most of the early criticism has not gone away since, including the long-term outcome of treatments offered, and the increasing burden of questions regarding its cost effectiveness [7, 8].

The perceived effectiveness of EIS has encouraged a view that it favours a shift away from generic towards specialist community care, and a suggestion that the creation of separate specialist teams, has led to the fragmentation and discontinuity of care [9]. The NHS Long Term Plan (2019) has pledged a new framework of "transformation and modernisation" of existing community care that requires a certain threshold of severity of mental health to qualify for support. The proposed new "core" community mental health service will incorporate existing CMHTs with primary care mental health services (for people who need more than Improving Access to Psychological Therapies, IAPT, services can offer but currently fall below CMHT thresholds) and "residential care" services such as supported housing and care homes. This "whole person, whole population" service will offer a wide range of interventions, including care coordination, advocacy, psychological therapies, employment, housing and benefits support, and physical health care.

This article aims to orientate a traditional EIS to the NHS Long Term Plan's vision for joined-up community mental health care. Our approach is threefold: to better understand the warrants of EIS' siloed model of care; to describe a case study of a London EIS; and to synthesise and draw conclusions from the first two with the aim of presenting a view on how to situate the future EIS within the NHS Long Term Plan.

Evidence base for EIS model of care

EIS is a multi-component specialist community mental health service which aims to prevent, detect early and treat first-episode psychosis. The central assumption is that earlier intervention results in better outcomes. In the case of psychosis, it is hypothesised that a critical period, when the psychosis first develops, is implicated as a major risk factor for a poorer prognosis [10]. Thus, therapeutically intervening in this early critical period is believed to improve prognosis - this motivated the clinical concept of minimising the duration of untreated psychosis (DUP). The DUP is the time between onset of psychosis and the initiation of treatment. Since the implementation of the UK's first EIS at the turn of the century, a maturing international evidence base has sought to test these claims. Various quantitative systematic reviews offer insights into the following four major warrants of EIS' model of care: the link between the DUP and prognosis (2.1); EIS effects on the DUP (2.2); the clinical effectiveness of EIS (2.3); and the cost-effectiveness of EIS (2.4). In addition, qualitative studies have identified that stakeholder perspectives, particularly those of service-users, highly value EIS [11,12,13].

2.1 The link between the DUP and prognosis

The theoretical basis of EIS relates to the conception of chronic psychotic conditions, such as paranoid schizophrenia, as varieties of neurodevelopmental disorders. The concept of the DUP aims to clinically represent a particular neurodevelopmental period when an early adult's biology and social functioning is most vulnerable to the deleterious effects of psychosis - the 'critical period' hypothesis [13]. The prognostic significance of this early untreated period is supported by observational studies that prospectively tracked the natural history of psychotic conditions following first onset [10]. Although it has been contended that the DUP is definitionally imprecise (for example, does initial treatment with psychosocial or pharmacological intervention mark the endpoint of the DUP?), two meta-analyses in 2005 showed that the DUP is related to poorer 6-12 months' multi-dimensional outcomes [15,16]. In particular, the DUP was an independent predictor of, with small to moderate effects on, symptomatic and functional recovery. Moreover, a meta-analysis (2014) found that long DUP significantly correlated with poorer long-term outcomes, such as severer symptoms and poorer social functioning but was not associated with quality of life or hospital treatment [17]. Thus, it seems that there is a plausible link between the DUP and prognosis.

2.2 How does EIS affect the DUP?

The DUP is a relatively independent measure of prognosis in psychotic conditions. Therefore, it's important to show that EIS can actually intervene on the DUP. A Norwegian study (TIPS), in 2005, compared the effects of two regions, with and without EIS, on the DUP [18]. The regions with EIS had reductions in the DUP with averages between five and sixteen weeks [19]. This study was not randomised but showed that EIS can reduce the DUP. However, a 2016 US study (RAISE) used a cluster randomisation design to examine the interaction between EIS and the DUP. At baseline, there was no significant difference in the DUP between EIS and the control group. Following two years of EIS intervention, they found that having a shorter DUP (less than the study median of 74 weeks) resulted in better quality of life and symptom outcomes [20]. The authors concluded that a timely EIS intervention in reducing the DUP can optimise outcomes [20]. These studies suggest a complicated interaction between the DUP and EIS; EIS can reduce the DUP, but the DUP can also moderate the effectiveness of EIS. Despite the RAISE study's findings of EIS and the DUP interacting, a meta-analysis (2017) found that the DUP did not significantly moderate the clinical effectiveness of EIS [21]. One answer is that the meta-analysed median DUPs from the individual studies varied significantly (from 8 - 74 weeks) creating too much noise [21]. Secondly, although EIS has at least two distinct aims of early detection and treatment of First Episode Psychosis, the trials included in the meta-analysis vitiated the first aim by controlling for the DUP at baseline between EIS and standard care arms. Thus, the true efficacy of EIS, in both intervening on the DUP and improving clinical outcomes, was masked. This is in part due

to the confusion over what the term 'early intervention' denotes: treatment of pre- or post-onset psychosis, or both [22]. Thus, if implemented correctly, the suggestion is that EIS can effectively reduce the DUP.

2.3 The clinical effectiveness of EIS

Studies have tested two independent objectives of EIS: pre- and post-onset psychosis intervention. The quality of pre-onset intervention depends on correctly identifying a clinically high-risk group of developing psychosis. A meta-analysis (2013) found that early detection and intervention on a high-risk group can prevent or delay psychosis, particularly in the first year of treatment [23]. However, prevention interventions are contested in light of the high false positive rate indicated by the small proportion (34.9%) of individuals in the high-risk group progressing to psychosis [24]. Thus, the benefits of pre-onset interventions ought to be weighed against the iatrogenic harms, such as diagnostic mislabelling and unnecessary treatment, of misidentifying false for true cases of psychosis [25]. In response to minimizing iatrogenic harm, and to improve identification of future morbidity, clinical staging models are evolving towards trans-diagnostic models [26]. There is less emphasis on sub-threshold categories like clinically high-risk groups and a greater focus on the dimensions of morbidity. An advantage of this broader approach may provide better predictive tools compared to those based on conventional categorical diagnoses. This is an important area for future research.

In terms of post-onset psychosis intervention, a meta-analysis (2018) of EIS versus standard care for FEP found that EIS was superior in all thirteen outcomes, relating to symptoms, relapses, hospitalisations, functional status and quality of life [21]. Thus, establishing Cochrane level 1 evidence for the effectiveness of EIS. Despite the quality of evidence, there are some lingering concerns. First, the meta-analysed studies only reported short-term outcomes (6 - 24 months) [21]. Long-term follow-up has shown that the beneficial gains of EIS are actually lost [27,28]. Second, although EIS was superior in all thirteen outcomes, only relapse prevention, remission and psychiatric hospitalisation were clinically significant (defined by the authors as a number needed to treat of less than or equal to 10). Third, EIS is a better-funded service with more highly motivated staff compared to standard care. The clinical efficacy of EIS has not been established to be independent from this funding disparity [29]. This issue is made more pressing by the lack of evidence supporting individual elements of EIS, such as psychosocial or pharmacological intervention, that account for its superiority to standard care [30]. It seems that system-level factors such as smaller caseloads, more funding and staff with specialist training could be more important than distinctly specialist modes of intervention.

In summary, evidence supports the case that pre- and post-onset psychosis intervention by EIS is clinically effective. However, interpretations of the effectiveness of EIS are complicated by the risk of iatrogenic harm for the former and, for the latter, the loss of clinical benefit over the long-term and the blunt effectiveness of EIS which could be more closely tied to systemic-level factors.

2.4 The cost effectiveness of EIS

Most studies which support the cost-effectiveness of EIS are service-evaluation studies [31]. In the literature, reduction in hospitalisations is a common index of cost saving in favour of EIS [32]. When a clustered randomisation trial (2016) measured cost-effectiveness, they found that EIS had a high probability (0.94) of being more cost-effective than standard care [33]. EIS benefits also exceeded costs in terms of monetised Quality Adjusted Life Years. A 2019 meta-analysis had also found that the total evidence was consistent with the cost-effectiveness of EIS compared to standard care across various countries [8].

The cost-effectiveness of EIS is connected to the argument that EIS model of care is discriminatory because there are not any relevantly specialist services that are funded for other mental disorders, such as affective or personality disorders [28]. A response could be that the costs saved from EIS could be re-invested into standard care. Furthermore, there is not a relevantly similar

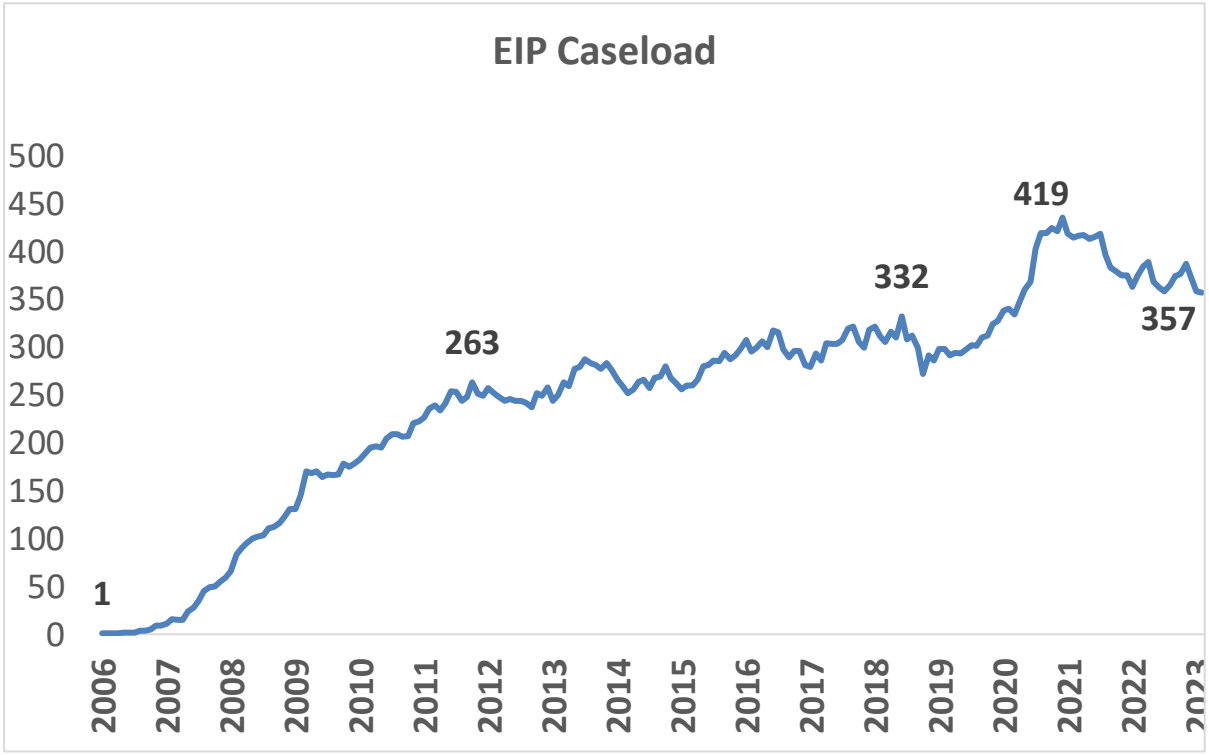
critical period hypothesis that justifies early intervention in affective or personality disorders. However, the specialism of EIS has been viewed as a token of a broader approach to adult community mental health service that emphasises specialist teams that aim to address the needs of specifically diagnosed populations. This is a shift away from generic to specialist community teams, which bypasses the aforementioned discrimination. This is the model of care adopted in some London NHS Trusts and elsewhere, but may not be the typical model of care in the rest of the UK.

In summary, the strengths of the EIS model of care can be seen to be represented by the clinical relevance of the DUP, the ability of EIS to reduce the DUP and the superior clinical and cost-related outcomes of EIS over standard care. It is also a service which is highly valued by the staff, carers and, most importantly, patients. The weaknesses include complications in interpreting the clinical effectiveness of EIS, such as iatrogenic harm, diminished benefits over the long-term and the salience of system-level factors, such as better funding.

Case study: a description of a regional EIS

3.1 Clinical descriptors

Figure 1. Total EIS caseload in a London NHS Trust



We examined three EIS teams who each cover a London Borough. All three services were commissioned in 2006. Regarding referrals, males were more commonly referred than females. In terms of ethnicity, most patients were white (approx. 70%), followed by black (approx. 10%); the latter were overrepresented relative to the UK general population but not the local population as described by the 2021 UK Census [35]. Since being commissioned, the total caseload had risen to around 360 (See Figure 1). It rose sharply to 260 patients to begin with, but in late 2011 plateaued and has risen slowly since then apart from an interesting spike in the first year of the COVID pandemic. The average length of an EIS episode of care ranged from 407 to 531 days across the three teams.

In terms of Emergency Department (ED) attendances, the majority of the referrals to EIS (62%) did not present to ED. The average number of ED attendances for mental health reasons per discharged EIS service-user, during their EIS care episode, was between 0.08 and 0.18. In other words, between 1 in 10 and 1 in 20 EIS service-users presented to ED with mental health needs during their EIS care episode. The average rate of psychiatric hospitalisations per EIS referral was similar ranging from 0.12 to 0.16. Following EIS treatment, most service-users (18%) were discharged to the care of their GP.

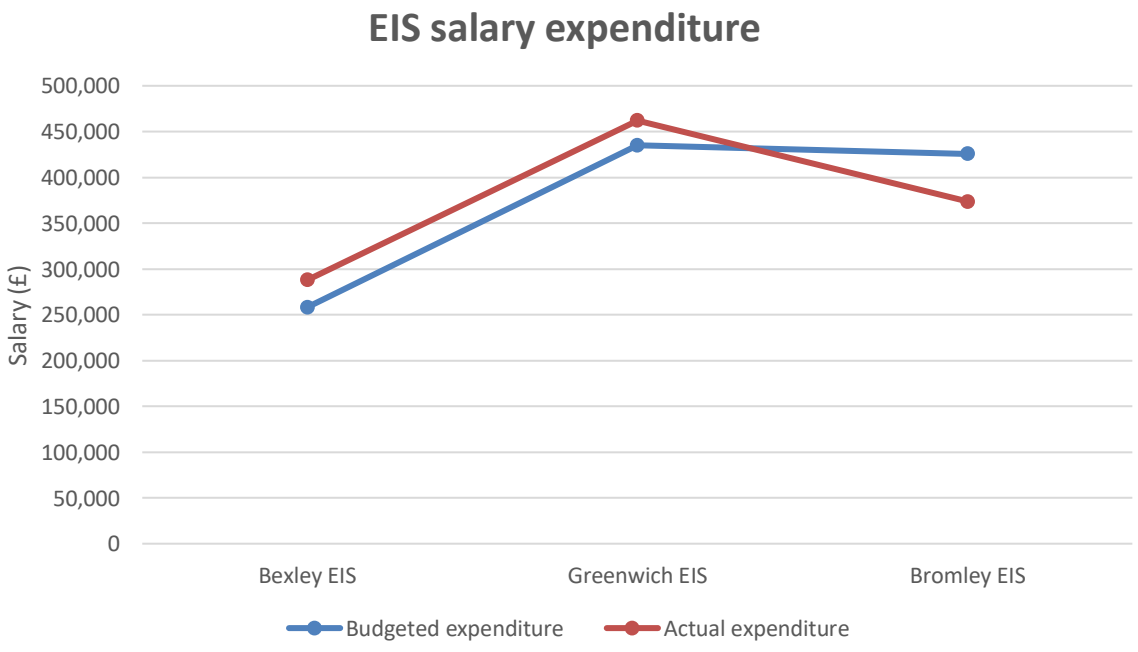
Regarding serious untoward incidents (SUIs), 47 were reported in total since 2012 excluding self-harm. Most (n=21) were related to abuse and aggression. There was a total of 32 incidents of self-harm over the same period; most were related to actual harm rather than threats.

3.2 Budget descriptors

An examination of the financial statement of EIS in this London NHS Trust indicated that staff salaries contributed most to budget expenditure. For the financial year, up to and including October 2022 (YTD), total salary expenditure was £1,123,621 (See Figure 2). More money was spent than what was budgeted for. The largest contributors to overspend included agency staff (£70,686) and unanticipated hiring of Trust staff (average of £85,003). However, these costs, which were not accounted for in the original budget, were offset by the absence of other staff roles in the multi-disciplinary team (MDT). Therefore, the total overspend on staff salaries up until and including October for the 2022 financial year was only £4,532.

In terms of MDT sizes between the three EISs in the trust, whole-time equivalent (WTE) personnel ranged from 9.36 to 14.73. The gross WTE was less than what was budgeted for averaged across the three EIS by 0.25 for the YTD (October 2022). It is interesting to note that the salary budget was exceeded despite employing a gross WTE that was less than what was budgeted. This perhaps highlights the significant cost of agency work.

Figure 2. EIS total salary expenditure (October 2022 - financial year to date (YTD))



The future of EIS implementation in the NHS

The NHS Long Term Plan outlines a vision for the future of healthcare in the UK, including a commitment to improving community mental health services. The Community Mental Health Framework for Adults and Older Adults within the plan aims to enhance community-based care for individuals with mental health conditions [9]. Integrating EIS and other siloed models of care, according to this framework, can help achieve these objectives. This entails seamless collaboration between EIS, primary care, and other community mental health services to maximise a continuum of care. Integration offers several advantages, such as the potential for improved care coordination, reduced service fragmentation, and enhanced support for individuals with psychosis beyond the critical period.

A theme that emerged from our critical summary of the EIS literature was that EIS is clinically effective, but there are some caveats. First, there is some uncertainty about long-term prognoses following transition from EIS to other community MHS. Second, the kind of clinical effectiveness evidenced in the literature demonstrates its bluntness rather than the incisive quality of its particular therapeutic components. We also identified some local EIS budgetary issues which amounted to excessive agency fees and insufficient recruitment. Joined-up care in community MHS has the advantage of potentially finding solutions to the matters that we have highlighted in the EIS literature and the case study.

4.1 Collaborative care models

A shift from siloed, such as EIS, to joined-up models of care is the topical goal for community mental health service in the NHS Long-term Plan. While EIS excel in the early stages, there is a need to provide continued care and support for individuals with psychosis as they transition into the community; this will help to mitigate the clinical losses stemming from moving between separate models of care that we identified in the EIS literature.

A collaborative approach embodies this shift towards joined-up care and aims to maximise continuity of care. In the case of EIS, this could be achieved by embedding EIS within community MHS which could both extend duration of EIS involvement and promote a gradual and seamless transition between services [13]. An embedded approach fosters integration between siloed care models. The integration can involve shared caseloads, joint decision-making, and regular communication between EIS and other community MHS practitioners.

As well as having the possible advantage of maximising the long-term prognoses of EIS patients, a joined-up care approach could also improve efficiency of resources. Our EIS case-study signalled an over-reliance on agency staff that was costly. Blurring the boundaries between separate community mental health teams promotes shared care and responsibility. A positive upshot is that there is potential for greater flexibility with regard to staff allocation across community services. If applied judiciously, staff shortages could be accommodated internally without relying on expensive agency staff, thus maximising efficiency of resources.

Conclusion

EIS have demonstrated their effectiveness in reducing DUP and improving FEP outcomes. To successfully integrate EIS into the NHS Long Term Plan, a shift from a siloed model of care to a collaborative, community-based approach is essential. This transition should involve expanding the scope of EIS, promoting collaborative care models, enhancing training and education, engaging with communities, and implementing robust monitoring and evaluation processes. As EIS evolve to integrate within the NHS Long Term Plan's Community Mental Health Framework, it is essential to address the challenges and harness the benefits of a more integrated and whole-person approach to mental healthcare. By doing so, the UK can improve community mental health services and provide comprehensive support for individuals with psychosis throughout their recovery journey.

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Can you really teach clinical communication virtually? Evaluating new methods in the time of Covid-19

Adam Montgomery, Faeez Ramjan, Alistair Cannon, Sae Kohara, Chloe Saunders, Deekshitha Umasankar, Lois Zac-Williams & Sophie Butler

Abstract

Introduction

"PsychED Up" is an extracurricular clinical communication course, with a focus on Psychiatry, for third year undergraduate medical students at King's College London. Students have large group teaching on a weekly topic, then perform three clinical scenarios with simulated patients based on the topic, with peer feedback administered throughout. Due to the Covid-19 pandemic, one session of PsychED Up was organised virtually, via Zoom™, in June 2020. This provided an opportunity to evaluate novel approaches to teaching, and to evaluate a live clinical communication course being delivered virtually.

Methods

Twelve students and ten faculty members participated in the online session, performing live clinical scenarios with simulated patients, over a two-hour period. Pre-and post-course questionnaires were designed with quantitative measures of confidence and qualitative questions about participants' experience. Eight students completed both questionnaires. Questionnaire answers were analysed using a mixed-methods approach, with themes identified from the qualitative long answers, and statistical analysis of quantitative answers was also performed.

Results

Students found the session beneficial, with all indicating that they would sign up for a full online course. Based on answers to the quantitative questions, 50% of students felt more prepared for their clinical examinations. (p=0.046). However, all participants noted a reduction in their ability to read non-verbal cues and body language. Returning students found they were less attentive during the session compared with the original face-to-face teaching (p=0.05). Actors and faculty members found that the online course was feasible, acceptable and effective, but most preferred face to face teaching.

Discussion

The majority of students and faculty found the session both beneficial and enjoyable but felt face-to-face sessions would be more helpful in teaching clinical communication. Student attentiveness and awareness of non-verbal cues were highlighted as concerns. However, students generally responded positively to the online course, particularly the quality and diversity of peer feedback. Teaching clinical communication virtually has the potential to be successful, and has implications for future undergraduate medical teaching.

Introduction

The ongoing Covid-19 pandemic has caused major disruption to education provision worldwide [1, 2] with many educational institutions seeking to continue teaching via online methods [3, 4]. Social restrictions have necessitated changes to teaching the undergraduate medical curriculum, for example through delivering more lectures and workshops virtually. Whilst teaching the purely biomedical aspects of medicine have been shown to be effective when conducted online [5], it is less obvious whether clinical communication, which is a core skill [6], can be

taught effectively in this manner. Previous evaluations of multimedia-based learning resources show that they may promote deeper learning as well as assist students in becoming self-sufficient learners [7, 8]. Video-based online tutorials may provide flexibility that promotes access [9]. The online nature of learning resources allows asynchronous learning, where the student can engage, in their own time at their own pace with the ability to manipulate the resources (e.g., rewind or speed up) [10].

However, such sessions do not give students the ability to ask questions or access real-time feedback from teachers, and as such offer limited information on the benchmark of performance that may assist students in overcoming barriers of self-assessment of clinical skills [11]. There is a perception that multimedia and web-based education resources are a less appropriate medium for teaching clinical skills such as communication [12-15]. In this way, these techniques are often used as a supplement rather than an alternative to traditional teaching methods. These perceptions however, are based on pre-recorded online modules with an absence of a live tutor.

Literary studies of online communication skills with a focus on Psychiatry are scarce, and to our knowledge there has yet to be a clear evaluation of the efficacy of live, web-based teaching of clinical communication skills, particularly with a Psychiatry-specific focus.

"PsychED Up" is an innovative, Psychiatry focused, voluntary, extra-curricular medical education programme for Year Three King's College London (KCL) medical students. It aims to deliver high-quality and authentic teaching about clinical communication via Objective Structured Clinical Examination (OSCE) style simulation. Experiential learning opportunities are provided through role plays with simulated patients. Each session features large-group teaching focused on a clinically relevant topic followed by three simulations in smaller groups. Each group has a Small Group Teacher (SGT; a Psychiatry trainee) and a Peer Facilitator (PF; a senior medical student) to guide the scenarios and facilitate feedback. A student volunteers to act in a clinical scenario with a simulated patient, while others provide feedback using an adapted "feedback sandwich" model [16] which is then discussed after the scenario. Individuals with lived experience are invited to join the session in an observational capacity, reflecting research on the importance of their unique contribution to mental health education [17] with their feedback supporting the improvement of roleplay and session content.

The final session of Term 2 of PsychED Up was cancelled due to advice issued in March 2020 by the UK Health Secretary against all unnecessary contact and social travel [18]. A decision was made to run the final session of PsychED Up via Zoom™ on 2nd June 2020, with Term 2 students invited to participate, as well as new students, recruited from King's College London (KCL) third-year medical students.

Methods

Setting up the session

Faculty members were surveyed and expressed sufficient interest to run an online session. Email invitations were sent to the 32 students who were enrolled in PsychED Up's Term 2, and 12 students responded. An email invitation was also sent out to all KCL third year medical students (a total of 334) who had not participated in PsychED Up via the KCL Undergraduate medical education department. A total of five students responded. Students were allocated teaching groups. Returning students were matched to their original group where possible and students unfamiliar with the PsychED Up model were grouped together.

Zoom™, an online videoconferencing software, was used to host these sessions. Students and faculty members were given instructions on how to join the virtual-classroom and how the session was planned to run. This included instructions on how and when to give feedback using a specifically designed PsychED Up feedback sheet and included a request to turn microphones and cameras off when they were not actively participating. Role plays were adapted to be relevant to a virtual setting.

Statistical Analyses

A mixed-methods approach was used with an ethical framework based on it being an evaluation.

Questionnaires were designed for three groups: returning students, new students and faculty members. All students and faculty were asked via email to complete online pre-session and post-session questionnaires which included both open and closed ended questions.

Closed ended questions asked all students to rate their confidence in communication skills, preparedness for exams, and ability to give feedback to peers using a five-point Likert scale (1 = strongly disagree to 5 = strongly agree). Returning students were asked to rate their level of attentiveness, interpretation of non-verbal communication, ability to offer empathy, and willingness to speak up during sessions delivered face-to-face and online. All students were also asked to write free-form answers to questions further exploring their attitudes and experiences. A full list of these questions can be found in Table 1.

Table 1: Free-form questions for students

Pre-course free-form questions (returning students)
• What do you think was the critical component of PsychED Up that helped you to improve your communication skills (if it did)? • If you agreed to the above question (I feel that PsychED Up supported me to give constructive feedback to my peers), how do you feel that PsychED Up supported you in this way? • What did you like most about the delivery of the face-to-face sessions? • What did you like least about the delivery of the face-to-face sessions? • What are your thoughts regarding the upcoming online delivery of PsychED Up? (E.g. potential benefits and limitations, your feelings, group dynamics etc.) • How do you feel about practising scenarios and learning communication skills, through an online format? • Based on your expectations for the online version of PsychED Up, would you sign up to a full 7-week course of sessions if they were to be delivered online? Please share your reasons.
Pre-course free-form questions (new students)
• What were your reasons for signing up to a place for the upcoming online session of PsychED Up? • What are your thoughts regarding the upcoming online delivery of PsychED Up? (E.g. potential benefits and limitations, your feelings, group dynamics etc.) • How do you feel about practising scenarios and learning communication skills, through an online format? • Based on your expectations for the online version of PsychED Up, would you sign up to a full 7-week course of sessions if they were to be delivered online? Please share your reasons.
Post-course free-form questions (returning and new students)
• What skills do you think you have gained from participating in PsychED Up delivered online? • If the online delivery of PsychED Up has helped you to feel prepared for the OSCE, how has it done so? • How does feedback compare in this online session to when you have face-to-face feedback? • What did you like most about the delivery of the online session? • What did you like least about the delivery of the online session?

- How was your experience of the online delivery of PsychED Up? (E.g. benefits and limitations, your feelings, group dynamics etc.)
- How do you think the online session could have been improved?
- Having experienced PsychED Up online, how do you now feel about practising scenarios and learning communication skills, through an online format?
- Based on your experience of the online version of PsychED Up, would you now sign up to a full 7-week course of sessions if they were to be delivered online? Please share your reasons.

Faculty rated various items related to their confidence in the delivery of teaching and answered free-form questions (Table 1b) designed to elicit attitudes about the online teaching experience. All subjects (new students, returning students and faculty members) were asked pre-session and post-session whether they would participate in a full 7-week online course.

Table 1b: Free-form questions for contributors

Pre-course free-form questions (contributors)
• Is there anything that you paid particular attention to when giving feedback face-to-face? • If you agreed to the above question (I predict that my teaching of communication skills will change between face-to-face teaching and online teaching), how do you think your teaching will change? • What were your initial thoughts regarding the delivery of PsychED Up online? • In your role, what do you anticipate will be the challenges of delivering the sessions online? • In your role, what are the benefits of delivering the sessions online? • Based on your expectations for the online version of PsychED Up, would you deliver a full 7-week course of sessions online? Please share your reasons.
Post-course free-form questions (contributors)
• Is there anything that you paid particular attention to when giving feedback online? • If you agreed to the above question (My teaching of communication skills changed between face-to-face teaching and online teaching), how do you think your teaching changed? • How do you think the students' familiarity or unfamiliarity with the group impacted the experience? • How do you think the students' familiarity or unfamiliarity with the PsychED Up model impacted the experience? • How do you now feel about teaching communication skills, through an online format and why? • In your role, what were the challenges of delivering the session online? • In your role, what were the benefits of delivering the session online? • How do you think the delivery of the online session could have been improved? • Based on your experience of the online version of PsychED Up, would you now deliver a full 7-week course of sessions online? Please share your reasons.

Pre- and post-session Likert responses were described using medians and ranges and analysed using the Wilcoxon signed-rank test. Statistical software SPSS (IBM Corp. Released 2017. IBM SPSS Statistics for Windows, Version 25.0. Armonk. NY: IBM Corp) was used. Free-text answers were analysed thematically [19]. Inductive, data-driven approach was used to identify and code semantic themes through which patterns in the responses could be organised and described. Throughout the process of analysis, methods and investigator triangulation occurred. Before coding, DU, LZW and AC read and discussed the transcripts. The responses were split between the three researchers. After coding, the themes were discussed and LZW and DU grouped the codes into themes according to content. Definitions, descriptions

and the focus of each theme were developed. Through triangulation, the reliability and validity of the results is increased, by ensuring that the themes are accurate and representative of the data set. Multiple researchers were used for analysis to reduce bias risk.

Results

On the day of the session, a total of 12 students attended: nine returning students and three new students. The demographic details of these students are displayed in Table 2. Some initial responders emailed to cancel with short notice. The three new students formed one group, with the nine returning students split into two separate groups of four and five students respectively. Each group was co-ordinated by a Small Group Teacher and Peer Facilitator, with four actors moving between groups, for a total of ten faculty members actively participating in the session; two other faculty members and one service user virtually observed the groups throughout the session.

Table 2: Demographic details of students

Demographics		Returning students (n=9)	New students (n=3)
Gender	Male	**1**	**2**
	Female	**8**	**1**
Ethnicity	White	**1**	**0**
	Mixed/Multiple ethnic groups	**2**	**1**
	Asian/ Asian British	**4**	**2**
	Black/ African/ Caribbean/ Black British	**2**	**0**
Age	18-20	**0**	**1**
	21-23	**7**	**2**
	24-26	**2**	**0**

Eight students completed both the pre and post-course questionnaires and were, therefore, included in the full analysis. For the qualitative analysis of the long-form answers, 42 responses from: pre and post returning students, new students, and contributors were analysed.

Returning students reported a significant reduction in their attentiveness and focus through the online format, in comparison to the face-to-face format ($p=0.05$) (Table 3c). They also reported feeling less able to offer verbal and non-verbal empathy to the simulated patients through the online format. However, no significant differences were found in their ability to interpret non-verbal communication, and how comfortable they felt speaking up to ask questions or contribute to discussion, outside of the role-plays.

Table 3c: Questionnaire results for specific OSCE skills and engagement in the session.

Question	Course delivery	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	P value
During the role-plays, I was able to pick up on non-verbal communication (e.g. body language, facial expression).	Face-to-face	0% (0)	0% (0)	0% (0)	50.0% (3)	50.0% (3)	0.317
	Online	0% (0)	0% (0)	0% (0)	83.3% (5)	16.7% (1)	
During the role-plays, I was able to offer verbal empathy.	Face-to-face	0% (0)	0% (0)	0% (0)	50.0% (3)	50.0% (3)	0.414
	Online	16.7% (1)	0% (0)	0% (0)	50.0% (3)	33.3% (2)	
During the role-plays, I was able to offer non-verbal empathy.	Face-to-face	0% (0)	0% (0)	0% (0)	66.7% (4)	33.3% (2)	0.257
	Online	0% (0)	0% (0)	33.3% (2)	50.0% (3)	16.7% (1)	
I felt comfortable speaking up during the sessions (e.g. asking questions, contributing to discussions).	Face-to-face	0% (0)	0% (0)	0% (0)	50.0% (3)	50.0% (3)	1.000
	Online	0% (0)	0% (0)	0% (0)	50.0% (3)	50.0% (3)	
I was fully attentive and focused in the sessions.	Face-to-face	0% (0)	0% (0)	0% (0)	50.0% (3)	50.0% (3)	0.046
	Online	0% (0)	0% (0)	33.3% (2)	50.0% (3)	16.7% (1)	

Comparison of pre- and post-course responses suggested a significant increase in students' confidence in their ability to give meaningful feedback on communications skills to their peers (p=0.05) as compared to having no teaching. 50% of students also reported feeling more prepared for OSCE examinations (p=0.05), with no significant changes in the other 50% (Table 3a). There was no significant change in the students' confidence ratings for interacting with people with mental health conditions.

Table 3a: Questionnaire results for communication skills

Question	Questionnaire	Strongly disagree	Disagree	Neutral	Agree	Strongly agree	P value
I feel confident in my communication skills for interacting with people with mental health conditions.	Pre	0% (0)	0% (0)	25% (2)	62.5% (5)	12.5% (1)	0.564
	Post	0% (0)	0% (0)	0% (0)	100% (8)	0% (0)	
I feel prepared for the objective structured clinical examinations (OSCE).	Pre	0% (0)	25.0% (2)	37.5% (3)	37.5% (3)	0% (0)	0.046
	Post	0% (0)	12.5% (1)	12.5% (1)	75.0% (6)	0.% (0)	
I feel confident in being able to give meaningful feedback on communication skills to my peers.	Pre	0% (0)	0% (0)	12.5% (1)	75.0% (6)	12.5% (1)	0.046
	Post	0% (0)	0% (0)	0% (0)	50.0% (4)	50.0% (4)	

Of the 15 contributors who attended the session, 12 responded to the pre-session questionnaire and ten responded to the post-session questionnaire. On average the ratings were comparable between the face-to-face and online sessions regarding contributors' confidence in supporting students to give meaningful feedback. Following delivery of the course, faculty expressed greater willingness to teach a full 7-week online course (p=0.03) (Appendix 3b).

Table 3b: Questionnaire Results for the question "Would you sign up to a 7 week online course?"

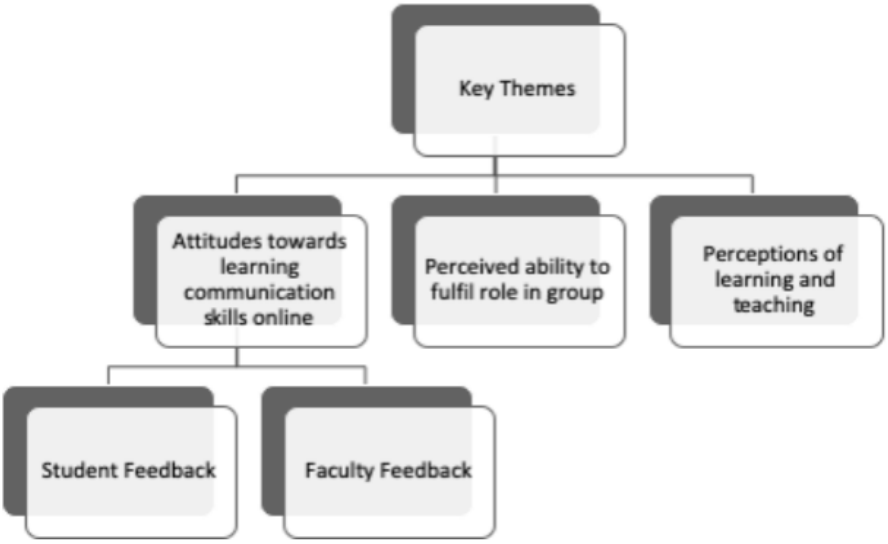
Question	Questionnaire	Yes	No	Maybe	P value
Sign up to 7 week online course?	Pre	75% (6)	12.5% (1)	12.5% (1)	0.655
	Post	87.5% (7)	0% (0)	12.5% (1)	

Qualitative Analysis from online questionnaires - long answer

As illustrated in Figure 1, three key themes, with nested sub-themes were identified:

(1) Attitudes towards learning communication skills online;
(2) Perceived ability to fulfil a role in the group;
(3) Perceptions of learning and teaching.

Figure 1: Key themes extracted from long answer questionnaire data



1. Attitudes towards learning communication skills online

Student feedback

In the pre-course questionnaire, returning students voiced fears about being out of practice with history-taking due to lack of patient contact during lockdown. Other concerns included how the online format would affect group cohesion and the ability to read body language. New students were less apprehensive about the delivery of teaching, welcoming the opportunity to practice clinical communication. Technical issues, such as audio/visual lag, were concerns expressed by both student sets. The majority of students expressed that running the session online would likely be a suitable alternative only during the current pandemic, preferring the idea of face-to-face sessions for the future.

Post-course, many returning students expressed surprise at the similarity between virtual and face-to-face teaching. The general consensus was that it was enjoyable, however there were certain limitations, with some comments that it was harder to conduct the consultation online compared with face-to-face. New students spoke positively of the experience, praising the quality and diversity of feedback. Both student groups felt that running a virtual patient consultation felt "inauthentic." Despite the pre-session concerns, a few technological issues arose. Most issues related to group dynamics, such as when to turn off video or sound functions on Zoom™. All new students, plus some returning students, stated

they would sign up for an online course, although some returning students felt face-to-face teaching would still be preferable.

Post-course, both returning and new students felt that this experience had taught them how to adapt their communication skills, and felt that the online environment was not as detrimental to learning, compared to face-to-face teaching, as was expected.

Faculty Feedback

The faculty expressed excitement at the online format but shared concerns about technological difficulties and authenticity of interaction. Post-course, the contributors were less enthusiastic than the students. Some felt that they did not perform to the best of their ability due to the virtual setting. The contributors generally liked the online session but most agreed face-to-face sessions would be preferable.

2. Perceived ability to fulfil a role in the group

Returning and new students expressed mixed opinions about being able to give feedback to their peers who acted in the scenarios. Some students reported a diminished ability to pick up on non-verbal cues and read body language due to observing a scenario via a small screen. Some students also noted that the webcam only enabled them to see a small part of the participant's body. Additionally, new students were more concerned that camera placement affected their ability to assess the patient while performing in the scenarios.

Many faculty members felt they were able to execute their role well, but expressed concerns that the usual group size of eight students would not work as well.

3. Perceptions of learning and teaching

Views on giving and receiving feedback online vs. face-to-face were mixed, with some returning students feeling it was more focused and others feeling that the online platform made it harder to assess interactions due to the camera not allowing students to see the entire patient. Thus, most of the discourse around non-verbal communication skills was limited to facial expressions. New students valued the experience of the teachers and the different viewpoints they brought to the session as working doctors and senior medical students.

Actors particularly missed the human interaction aspect, with one actor feeling they were unable to fully immerse in their character in this format. PFs and SGTs felt more confident after the session about delivering communication skills teaching online. They also found that students engaged with feedback well, with students making appropriate, constructive points for their peers.

Discussion

In this pilot we have demonstrated that it is feasible to deliver experiential teaching about clinical communication using an online platform. A team of ten faculty delivered this pilot to 12 students with no major issues and good student and faculty satisfaction. A recognised advantage of the online format is that it can offer flexibility in access for both students and faculty, potentially making it easier to deliver and attend [9]. This does assume good access to the technology and needs to be balanced with the barriers that technology can pose that will be further discussed.

The online teaching format was also acceptable for both faculty and students. New students, who had not experienced PsychED Up being delivered face-to-face, were in general more receptive to the course than returning students and faculty members. This could be explained by returning students and faculty having to make many adjustments to online work, compared with the unsullied approach of new students. Overall, new and returning students, plus faculty members, were happy with how the session ran, and would participate in a full online course, but unsurprisingly, a return to face-to-face teaching was a preferred option.

The adaptation of clinical communication teaching to an online setup was also effective. 50% of students felt better prepared for their clinical examinations, and many students felt increasingly

confident in online learning. New students who had not previously participated in PsychED Up found the session to be consistent and straightforward in structure. Returning students generally found that the sessions translated well into the online format, with four out of six returning students who filled in questionnaires remarking that it was “similar” or had “little difference” compared to the structure of face-to-face sessions.

The importance of technological issues in online learning is self-evident [20] and was a source of anxiety among faculty members and students before the session. In reality, technological issues did not heavily impact the session, perhaps reflecting the preparedness of students in the current climate. The study also supports the importance of good “video etiquette,” such as appropriate camera placement to ensure adequate lighting and sound, maintaining eye contact, and keeping hands and arms in the camera frame to ease detection of non-verbal cues [21]. In any future sessions, we plan to embed more thorough preparation of both faculty and students, and the area of ‘onboarding’ before these sessions is surely an area of research with significant future potential [1].

The subtle ways that technology can impact group dynamics (e.g. impairing the ability to pick up on non-verbal cues and to offer verbal empathy) were identified by students and are consistent with previous studies [22]. Specific concerns also detected in the qualitative data include the authenticity of interactions and a reduced ability to focus during the session. This demonstrates that, while adaptation of face-to-face material for an online setting is possible, it is not straightforward and cannot be directly translated without consideration of some intangible factors. Furthermore, longer-term work delivered online risks increasing the isolation of students and educators alike, leading to an increased psychological burden [23].

Some limitations of the study include recruitment, sampling method and size. Sign-up for the online session was lower than would be expected with face-to-face teaching, with only 9/32 returning students participating in the online session. New student numbers were also limited, with 3/334 invited students attending. These numbers limited how representative the results were. Poorer student uptake is a known phenomenon in web-based higher education courses [24]. Reasons suggested for this include psychological factors (financial or family pressures, low motivation to engage at home), course-related factors (lack of structure/feedback as compared to face-to-face sessions) and technological issues [20, 25]. These factors, amplified by the disruption caused by the Covid-19 pandemic (e.g. personal or family illness, prioritising more essential activities), are likely to have contributed to the poorer-than-expected uptake in this pilot. As a result, there was a high faculty-to-student ratio. The issue of uptake is a problem that can be overcome through further research into the effect of the above factors on web-based clinical teaching. In such a ‘proof of concept’ pilot as ours, it was not seen as a disadvantage, but the results cannot be extrapolated to larger groups.

Most returning students felt either as confident or more confident in their clinical Psychiatry skills after the course than they did before. There were also no notable differences in their confidence in contributing to feedback and discussion in the online session vs. face-to-face. This may reflect an element of self-selection bias in those who signed up for the online course.

We have demonstrated that clinical communication can be taught virtually in a way that is effective, acceptable and feasible, but largely not preferable to face-to-face communication. With many educational institutions moving to an online teaching platform, further evaluation of clinical teaching is both desirable and essential for understanding the future of clinical education. Potential areas for future research can include assessing teaching with different camera placements, assessing group dynamics and the ability to offer verbal and non-verbal empathy.

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Inpatient stroke caregivers support group: a pilot study

Juvairia Qasmi & Carlotta Urso

Abstract

Stroke is a common cause of adult disability in the UK. Caregivers often assume the role of primary carers, providing unpaid care and support to stroke patients. The burden of care reported by stroke caregivers is high and there is general dissatisfaction regarding the information offered to them, including lack of support and resources available during and after hospital stays. We started a support group in a stroke ward to examine how the information about stroke patients' support can be delivered effectively. Stroke carers were asked to complete a validated questionnaire before and after the delivery of the support groups. Our results show that most of the critical needs of stroke caregivers were not being met or only partially met on the ward. We also found that the stroke caregivers had found our support group a valuable resource. Our pilot is limited due to its size, duration, and for being conducted at one stroke unit. Nonetheless, we highlight gaps in the current literature and a need to carry out large multi-site studies for drawing firm conclusions regarding such support groups for stroke caregivers.

Keywords: stroke, stroke caregivers, outcome measures, pilot support group, service improvement.

Introduction

A stroke happens when the blood supply to part of the brain is cut off and brain cells are damaged or die. The effects of stroke may vary from person to person, depending on which parts of the brain have been affected, severity of the stroke, and background factors. Stroke is the single most common cause of adult disability in the UK and the third most common cause of death [1].

Stroke can lead to substantial familial challenges [2] with multiple negative outcomes for spouses of stroke survivors, including high levels of strain [3,4,5], perceived care burden [6], dissatisfaction with life as a carer [7] and anxiety [8]. In addition to emotional distress, stroke caregivers are often subjected to disruptions to their social and leisure activities [9], loss of freedom and unmet information needs [10]. Furthermore, stroke can often cause cognitive impairment, and the level of cognitive deficits correlates to stroke caregivers' outcomes, e.g., perceived stress, care burden, and psychological wellbeing [11].

Stroke patients and their carers routinely report dissatisfaction with the volume, content, delivery and timing of needed information. There is consistent evidence to suggest that providing relevant and usable information to stroke survivors and their carers decreases reported levels of stress and frustration [9,12,13]. However, when Cheng and colleagues [14] examined eighteen studies evaluating the effectiveness of psychoeducation and social support groups, there was insufficient evidence about which intervention was optimal and could be provided to stroke caregivers.

We organised a stroke caregiver support group within an inpatient stroke ward, as a pilot, to ascertain psychoeducational needs of the stroke caregivers and to understand whether these needs were being met on the ward.

Methods

2.1 Participants

A total of 12 carers (m=2; f=10) participated in this pilot. Participants were recruited from the Hyper Acute Stroke Unit (HASU) and Stroke Unit (SU) of an acute hospital in Southeast London. They self-enrolled in this pilot

carers' support group after coming across invitation posters on the stroke unit noticeboard.

2.2 Materials

Two questionnaires were administered by the healthcare team to the participants: the carers' support group questionnaire and a feedback questionnaire.

The carers' support group questionnaire was based on the Family Needs Questionnaire (FNQ - Kreutzer et al, 1994), a 40-item self-report measure that provides a quantitative assessment of perceived needs of family members of brain injury survivors in the acute and post-acute stages of recovery. The FNQ consists of six scales: Health Information, Emotional Support, Instrumental Support, Professional Support, Community Support Network, and Involvement in Care. From the FNQ, the researchers extracted 11 questions which were most relevant for the scope of this study.

The feedback free-text questionnaire was created by the researchers to gather information about how the stroke caregivers perceived the support group itself. It had 6 questions to capture how helpful they felt the group was, and which topics they felt they needed to know more about.

A PowerPoint presentation created by the researchers was used to provide psychoeducation to the stroke caregivers.

Approval for this study was granted by the Hospital Patient and Public Involvement committee.

2.3 Procedure

Following recruitment, the carers attended the support group sessions held in the dayroom of the SU. After the welcome and explanation of the scope of this pilot support group, they were asked to complete the carers' support group questionnaire prior to the start of the first session. The researchers then delivered the PowerPoint presentation, followed by a space dedicated to open questions. The session lasted for approx. one and a half hour. Afterwards, stroke caregivers were asked to complete the feedback questionnaire. The support group had three additional sessions.

For the carers' support group questionnaire, the data collected was entered into Excel data worksheet and the 11 questions were divided into the following three themes:

- Communication skills and inclusion
- Knowledge – Practicalities

Results

To understand whether the need was met, the mean from the responses in data was calculated and then transformed into a percentage value.

Stroke carers were asked to rate the importance of each theme (1-10). This scale was then classified and put in different ranges "low", "medium" and "high" as per following: score 0-4 "low", 5-7 "medium", 8-10 "high". Overall, results can be summarised as it follows.
"Communication skills and inclusion" and "practicalities" themes were rated as "high" importance. Results showed that 70% of participants thought that these needs had been met by healthcare professionals.

The "knowledge" theme was rated as "high" importance. Results showed that 75% of participants thought that their knowledge needs had not been met on the ward/unit. Approximately 70% of stroke caregivers reported that they were not aware of which resources were available post-discharge in the community.

For the feedback questionnaire after the carers' support group, a qualitative approach was used. All stroke carers (100%) identified the support group as being "very helpful" and would recommend it to other carers. Themes were identified on what stroke caregivers found helpful. Suggestions for improvements were proposed, which have been divided into the following three categories:

- to receive stroke education

- to be given information regarding the medications, treatment and investigations related to stroke and its possible aetiology
- to have a better understanding of the impact of stroke on mental health.

Participants also reported on the ways to improve and provided recommendations: to include a group discussion, to be able to share experiences, to be given more information about the support available in the community post discharge, for the support group to be offered earlier in the patient's experience and to have other ward representatives join the support group.

Discussion and Conclusion

Our findings highlight that needs of high importance for stroke caregivers were not met or only partially met on the ward. It appears that stroke caregivers had experienced significant barriers, such as limited availability of information, lack of dedicated time, and lack of participation in healthcare team decisions. This lack of engagement may have created a mismatch between stroke caregivers' and healthcare providers' goals or expectations for recovery [14, 16].

We observed that all stroke caregivers found the support group a valuable and useful space, and would recommend it to other stroke caregivers. It seems that establishing a weekly support group within stroke wards could fill the gap for this unmet need and enhance the support offered to stroke caregivers, providing tailored psychoeducation and resources available post-discharge. Evidence shows that adopting a family-centered care model on stroke wards can lead to better outcomes for survivors post-discharge, and promotes wellbeing amongst caregivers [17].

Growing evidence links psychological and functional outcomes of stroke survivors to family functioning [18]. Providing stroke caregivers with psychoeducation that included stress coping strategies and problem-solving skills has been shown to have a beneficial effect on stroke caregiver's family functioning and a significant reduction of the stroke caregivers' depression level [19]. Our pilot study did not include stress coping strategies or problem-solving skills; a follow-up study could focus on offering these in support groups.

There is a lack of coordination between community resources and inpatient wards as 70% of stroke caregivers reported not being aware of which resources were available post-discharge in the community. Studies report that 44% of stroke caregivers perceive a substantial burden during the post-acute phase [20,21]. Our support group targeted this by including information about post-discharge support resources in our presentation, and stroke caregivers reported this knowledge very helpful. Having healthcare professionals from different backgrounds also allowed for a more comprehensive and holistic approach.

The stroke carers were asked in the feedback forms about what other content they would like to have included in the support group. They expressed that they needed to know about practical issues following discharge, such as how to apply for the lasting power of attorney, quota protection and benefits advice and what to do if their loved one lost capacity. These needs could be addressed in a future support group, with a social worker included in conducting the support group.

In terms of limitations of this pilot, our recruitment process limited participants to stroke support group attendees reducing our sample size. We also offered a few sessions over a short duration due to limited resources. Future studies could include stroke support group non-attendees or controls, for comparison and to gather wider insight into the benefits or otherwise of attending the support groups. Female overrepresentation in our pilot reflects predominance of male patients in the unit at the time and perhaps their own enthusiasm to improve the service.

Despite limitations, this pilot has identified unmet needs of carers of stroke patients in a typical stroke unit in the UK. We recommend large scale multi-site studies for drawing firm conclusions regarding the efficacy of such support groups for stroke caregivers.

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How Trainee Factors May Affect Treatment Efficacy in Psychodynamic Psychotherapy

Rebecca Bennett

Abstract

This opinion piece aims to explore the impact of trainee factors on the treatment efficacy of psychotherapy, specifically focusing on the Psychotherapy Long Case (PLC) requirement in Core Psychiatry Training in the UK. The aim of the PLC is to develop trainees' competence in delivering long-term psychotherapeutic interventions and to provide them with essential skills for a career as a Psychiatrist. However, several trainee factors, detailed within this article, may affect treatment outcomes.

The article explores therapeutic alliance as a fundamental factor for positive treatment outcomes, emphasising trust, empathy, understanding and collaboration. However, negative attitudes and barriers to completing the PLC, such as difficulty finding a supervisor and patient dropout rates, may negatively influence the efficacy of therapy. Trainees' limited preparation and experience in psychodynamic psychotherapy, along with variable supervision, can affect treatment outcomes. Furthermore, the target number of sessions required by the PLC may affect the dynamic within the sessions and the nature of patient selection, to fit with trainee timelines, may mean some unsuitable clients are recruited. The implications of these challenges on treatment efficacy are discussed throughout the paper. The article concludes by highlighting the mutual benefits of trainee-led cases for both trainees and clients, including learning opportunities, quick access to therapy, and personal growth. Overall, this article underscores the importance of considering trainee factors in psychotherapy and highlights potential areas for improvement to enhance treatment outcomes. The author approaches this critique from the position of a trainee who has recently completed the PLC and has experienced some of the challenges first-hand.

Introduction

According to a survey conducted by the Office for National Statistics (ONS) in England, it was found that approximately 1 in 4 adults (24%) were diagnosed with at least one mental illness in 2019 [1]. This equates to around 12.1 million adults in the UK. The actual prevalence of mental illness in the UK may be higher than this, as it is based on self-reported data that may not fully capture all cases, especially those with limited insight into their condition.

Mental health conditions in the NHS are typically treated through a range of different services and approaches, depending on the nature and severity of the condition. Often talking therapies are recommended as a first-line treatment and in 2008 the UK government implemented a program called Improving Access to Psychological Therapies (IAPT) to improve access to evidence-based talking therapies for people with common mental health problems, such as depression and anxiety. According to the most recent data, over 1.6 million people accessed psychological therapies through the IAPT program in 2019/2020 [2]. Those with more complex conditions may require more in-depth therapy, provided by Tier 4 NHS psychotherapy services.

The Royal College of Psychiatrists recommends several forms of psychological therapy for the treatment of mental health conditions including Cognitive Behavioural Therapy (CBT), Interpersonal Therapy (IPT), Psychodynamic /Psychoanalytic Psychotherapy, Family therapy, Eye Movement Desensitisation and Reprocessing (EMDR), and Dialectical Behavioural Therapy (DBT) to name a few. The choice of therapy is generally based on the nature and severity of the condition to be treated, as well as the preference of the

patient and the availability and skills of the therapist.

Psychiatry Training in the United Kingdom

Budding psychiatrists within the UK complete a rigorous training pathway to become a Consultant. To be eligible for Core Psychiatry Training, individuals must have completed two years of Foundation Training following a medical degree and hold full registration with the General Medical Council. During the three-year Core Psychiatry Training program, trainees are required to complete rotations in various psychiatric specialties, such as adult, child, and forensic psychiatry. They must also complete a range of appraisals, including workplace-based assessments, written exams, and a portfolio of evidence of their competence [3]. Trainees must also engage in a psychotherapy long case (PLC) as part of their Core Training Program. The long psychotherapy case is a structured psychotherapeutic intervention that trainees undertake with a patient over an extended period, typically 6-12 months, under the supervision of a qualified psychotherapist. The goal of this training requirement is to develop the trainee's competence in delivering long-term psychotherapeutic interventions as well as gaining the ability to understand the perspective of other people, effective listening, handling challenging interactions in a clinical setting, learning how to set appropriate boundaries and developing problem-solving abilities, some would argue essential skills for a career as a Psychiatrist. As well as completing a long piece of work with a patient, trainees must also complete a short case, typically 12-20 sessions with a patient in a different modality.

Psychodynamic Psychotherapy therefore is a typical therapeutic modality that is appropriate for a trainee's long-case given its suitability for 6-12 months of engagement, availability of supervisors familiar with this approach and known efficacy of the treatment [4]. A survey of 598 psychiatric trainees showed that 80% of trainees were undertaking or had undertaken the PLC in a psychodynamic or psychoanalytic modality.

Although the trainee psychotherapist requires extensive theoretical knowledge, the work of therapy has a practical element, and it is important to be able to merge the two aspects in a balanced manner. A key part of psychotherapy training is therefore putting the theoretical knowledge into practice, and indeed the Royal College of Psychiatrists states that "treating patients is the only reliable way to acquire skills in delivering psychotherapies" [5,6,7]. However, we must be mindful that to become truly proficient in delivering such therapy to clients takes many years of training and trainees are unlikely to be competent in these skills after tackling only a handful of cases.

Psychodynamic Psychotherapy

This therapeutic approach is based on the theory that unconscious mental processes, outside of the individual's awareness, play a significant role in psychological disturbance. These unconscious processes are inferred through careful consideration of material such as the person's free and uncensored speech, their actions, and their dreams. It is important, therefore, that the therapist-patient relationship can provide a safe and supportive enough environment for the patient to feel able to discuss and consider their experiences.

There have been extensive studies on common factors which lead to positive treatment outcomes [8,9]. These include therapist factors including experience and competence, treatment adherence, client factors and positive therapeutic alliance to name a few. These issues are not exclusive to trainees, however, they may hold particular relevance, as will be explained below.

1 Therapist Factors

Therapist experience, competence, and therapeutic style have been associated with better psychotherapy outcomes [8]. The concept of the therapist as an expert and a guide is a common one. It is reasonable to assume therefore that the trainee therapist's therapeutic skills and

competence can affect the outcome of psychotherapy. Trainees who have received adequate training and practice in evidence-based psychotherapy techniques are more likely to provide effective treatment [10]. However, often the preparation for completion of a PLC is minimal and often this is the trainee's first experience of Psychodynamic Psychotherapy. Most will not have shadowed any sessions before initiation and only 13% of those surveyed in the Royal College Psychotherapy report had undertaken personal therapy whilst completing their PLC, where they would learn first-hand how psychotherapy should be conducted. Furthermore, the level and quality of supervision that a trainee therapist receives from their supervisor can affect the outcome of psychotherapy. Research has shown that trainees who receive more frequent and high-quality supervision are more likely to provide effective treatment [11]. Trainees have reported difficulties in finding an appropriate supervisor; quality and effectiveness of supervision may also be variable.

2 Treatment Dosage

As discussed, the PLC should be conducted over a period of 6-12 months. The RCPsych specifies that there should be a minimum of 20 sessions and, due to difficulties with regards to accessing patient records, should end when a trainee rotates away from the Trust. Having a fixed number of psychotherapy sessions can influence the patient dynamic in several ways. Firstly, it may create a sense of urgency or time pressure for the patient, leading them to feel the need to address their concerns quickly within the limited sessions. This can impact the depth and pace of exploration in therapy. Additionally, knowing that there is a set number of sessions can trigger anxiety or concerns about the progress made or the ability to resolve complex issues within the allocated time frame. Moreover, the fixed session structure can impact the therapeutic relationship. Patients may feel more inclined to focus on specific symptoms or immediate challenges rather than engaging in deeper self-exploration or addressing underlying issues. This can affect the overall therapeutic process and the potential for long-term growth and change. On the other hand, the fixed number of sessions can also foster a sense of structure and accountability for both the patient and therapist. It can encourage the patient to actively participate and make the most of the available sessions. Additionally, it may help the therapist in structuring the treatment plan and maintaining a focused approach.

The termination of the therapeutic relationship is another crucial aspect of Psychodynamic Psychotherapy. The client and therapist work together to prepare for termination and ensure that the client is prepared to move forward without the support of the therapist. As part of the PLC, the Royal College of Psychiatrists stipulates a minimum of 20 sessions with usually a time limit at the end of Core Training. This may mean the trainee is forced to terminate therapy for the client earlier than would be recommended for the patient. As a result, in some circumstances, the patient and therapist may maintain a sense of stagnation with interactions remaining at the superficial level for protracted periods of time. This may stem from a shared recognition that engaging in a more profound exploration would require a considerably longer duration than 20 sessions. Consequently, there exists a hesitancy to delve too deeply into sensitive matters due to apprehensions about opening substantial avenues of exploration, only to subsequently truncate them.

3 Treatment Adherence

Adherence to treatment, in that a patient regularly attends scheduled sessions, has been linked to achieving positive results from psychotherapeutic interventions [12]. Conversely, missed sessions can create feelings of resentment or mistrust between the therapist and the client, particularly if the therapist is unattuned to the significance of missed sessions. This may lead to the client feeling judged or criticised by the therapist for missing the session. These negative feelings can erode the trust and rapport that has been established in previous sessions. One may argue that this resentment may be more apparent when the therapist is a trainee whose career progression rests on the completion of a certain number of sessions. As completing a PLC is a key tenet to Core

Psychiatry Training Competencies, those who are not able to complete this task by the end of core training are unable to progress in line with their peers. The Royal College of Psychiatry Survey on psychotherapy competencies found that 228 trainees (38%) showed a negative attitude towards needing to complete the PLC with 50.3% experiencing barriers to completing the PLC which included patients dropping out of therapy as being a notable factor [13].

As mentioned previously, while it can be beneficial to explore the significance of a missed session for the client, the trainee's focus on meeting targets may overshadow their understanding of the true implications and thereby hindering the potential progress that could be made during the work.

Literature suggests that alongside exploring the underlying reasons for the missed sessions, such as anxiety or avoidance, and developing strategies to address these issues, the therapist may also need to be flexible with scheduling to a certain extent, to accommodate the client's needs and ensure that therapy remains accessible. However, opportunities for undertaking these psychotherapy experiences and the related supervision are expected to be made available within normal duties at the mental health service where the trainee is employed. This may mean, due to the needs of the service as part of the trainee's role in the National Health Service, flexibility is limited.

4 Client factors

Various client factors, such as motivation, insight, and social support, have been linked to positive psychotherapy outcomes [5]. However, due to the time-restricted nature of completion of a PLC, it may be difficult to find a suitable patient. Almost 10% of those surveyed by the Royal College of Psychiatrists had no support in finding a patient, resulting in severe delays in starting their case and subsequent negative perceptions of the PLC as mentioned previously. On some occasions, it may be that a client who is not entirely suitable for a trainee case is chosen out of desperation by both supervisors and trainees.

5 Therapeutic alliance

Multiple studies have shown that the collaborative relationship between a client and therapist is fundamental to the success of Psychodynamic Psychotherapy [12,14]. The alliance involves several key elements, such as trust, empathy, understanding, collaboration, and awareness of transference and countertransference. Establishing a strong therapeutic alliance is crucial in creating a safe and supportive environment for patients to explore their thoughts, feelings, and behaviours [15]. It is hoped that the therapist, regardless of their trainee status will be able to empathise with and understand the client in order to aid this therapeutic alliance. However, there may be other factors at play which may negatively influence this relationship.

It may be that the compulsory nature of the PLC may have a negative impact on the therapeutic alliance. For one, it may affect the therapist’s emotional reaction to the client. For example, the trainee may be less sympathetic towards the patient’s needs or be inclined to adopt a more lenient approach, prioritising consistent attendance above all else.

Furthermore, it may have an impact on the power balance between therapist and client. Therapy is ideally a collaborative journey undertaken by both the therapist and the client. In other roles, the doctor has traditionally held a good proportion of the power in the consultation, however, the doctor may recognise that the client plays a pivotal role in shaping their future, and therefore this change of dynamic may feel unusual for the budding therapist.

The therapist must strike a balance between being supportive and maintaining appropriate boundaries. When the client feels safe and secure in the therapeutic relationship, they are more likely to open up and make use of the therapy. Often, although the patient will be aware that the

therapist is a trainee, they may not understand what that entails and are unlikely to know the details of the trainee's work life and other responsibilities and work requirements outside of therapy. They may not be aware the trainee works elsewhere, needing to travel to the location to complete the therapy, or that they work nights or weekends in another service as part of their day job. This can mean the trainee holds resentment towards the client if they were to not show up for a session, despite the fact the client would not necessarily be aware of the importance of the session to the trainee.

"...it puts tremendous pressure on trainees who are fearful of their ARCP outcomes. Myself and colleagues frequently came in on nights and annual leave to see our patients who did not always turn up." [13]

However, this may be an element of therapy which is not specific to trainees. In fact, a patient may never know what is going on in a therapist's life. One could argue that there are many reasons for a patient not to attend an appointment, such as to communicate how difficult they are finding the sessions. If a trainee were to get overly fixated on the number of sessions achieved, they may not be able to tune into the true meaning of the lack of attendance and therefore may not be able to fully support and guide their client effectively.

It is of course the aim of such cases to be mutually beneficial for both the trainee and the client, with both parties gaining valuable insights, growth, and progress on their respective paths. For the trainee, it offers a valuable opportunity for learning and skill development as they work with clients, apply therapeutic techniques, and hone their clinical abilities. Supervision and guidance from experienced professionals help trainees receive feedback, learn from their mistakes, and improve their therapeutic aptitude. Moreover, engaging in therapy with clients encourages self-reflection and personal growth, enabling trainees to uncover their own biases, strengths, and areas for improvement. It also contributes to the formation of their professional identity as trainee psychiatrists, helping them understand their theoretical orientation, ethical standards, and therapeutic style. For the client, trainees bring a fresh perspective and innovative ideas to therapy, which can be particularly advantageous for clients who have felt stuck or have not found success with previous therapists. Due to the need to allocate training cases in a timely manner, a patient can often receive psychotherapy quicker and avoid lengthy waiting lists for qualified therapists if they opt to see a trainee. Furthermore, trainees are often empathetic and invested in their clients' well-being, providing a supportive and non-judgmental space for clients to explore their thoughts, feelings, and concerns.

Discussion

This article has hoped to highlight how trainee factors may influence the treatment efficacy of psychotherapy as part of the PLC within Core Psychiatry Training. It is worth noting, however, that there are benefits to the client from taking part in a trainee-led case. As mentioned, the waiting list for tier-4 psychotherapy provision is often very long due to pressures on the service. If the patient is suitable, allowing a trainee to lead their case will often mean that they may be able to bypass long waiting lists. It may also result in patients, who do not fully meet the criteria of referral to secondary psychotherapy services but are too complex for primary care, being able to be seen by a therapist under robust supervision.

With appropriate supervision, the trainee should be able to recognise and understand difficulties the client may have in engaging with therapy and be able to challenge these, to facilitate a strong therapeutic relationship, therefore the fact the therapist is a trainee should not adversely affect this part of therapy.

Despite the negative comments included here, the Royal College of Psychiatry survey showed most trainees (80%) felt the completion of the PLC benefitted their training, and significantly increased trainees' self-rated competence in a range of domains, including empathy, managing boundaries, listening skills, managing difficult clinical

interactions, and formulation skills. In addition, trainees felt that the PLC improves resilience and that working psychotherapeutically adds to their enjoyment of work, thereby increasing retention in psychiatry training.

Perhaps it would be more beneficial to assign a trainee a less complex case. The UK government's IAPT scheme aims to enhance access to psychological therapies, primarily targeting patients with mild to moderate mental health difficulties. Severe mental health conditions or complex psychological disorders fall outside the scope of this scheme. In such cases, patients are typically referred to specialised mental health services, such as Tier 4 services, for appropriate care. For the PLC, it is customary for patients to undergo assessment and be deemed suitable for Tier 4 services, under the care of a psychiatrist. By including IAPT patients as part of the PLC, not only would simpler pathologies be addressed, but it would also expand access to a broader range of patients who might otherwise miss out on such valuable therapeutic experiences.

The crucial question at hand is how else can a trainee acquire valuable experience in this significant aspect of Psychiatry? Watching videos or reading literature would be unlikely to provide the trainee with a true understanding of the complex emotional dynamics experienced in therapy. A possible alternative suggestion is that acquiring the essential psychotherapy competencies may be better achieved through the process of shadowing experienced psychotherapists, rather than being the primary therapist themselves. However, having a trainee observe a psychotherapy session may further affect the therapeutic alliance as well as creating a more uneven power dynamic between the multiple therapists and the client. Another option would be for the trainee to undergo therapy themselves. By engaging in therapy, trainees would gain first-hand experience of being in the client's position, fostering empathy and enhancing their ability to connect with and understand their clients on a deeper level. Therapy also offers trainees a safe space to explore their own emotions, beliefs, and experiences, leading to greater self-awareness and self-reflection. This process allows them to identify and address any personal issues or biases that may impact their work in psychiatry. Moreover, undergoing therapy can provide trainees with valuable tools and coping strategies to manage the emotional demands of their profession effectively. By prioritising their own mental health and well-being, trainees would be better equipped to provide competent and compassionate care to their patients.

As discussed, having a fixed amount of psychotherapy sessions can influence the patient dynamic in several ways. While a fixed amount of psychotherapy sessions can provide a clear framework for therapy, it is essential for both the patient and therapist to be mindful of the potential impact on the therapeutic process and adapt accordingly to ensure meaningful progress is made. The question then could be asked, should trainees be focused more on the quality of the work undertaken rather than a fixed number of sessions? Would the supervisor be best placed to determine whether a trainee has achieved a reasonable understanding of the therapeutic modality, sufficient for their level of training? This would remove the fixation with box ticking and switch the focus towards true understanding.

It would be insightful to gather feedback from patients who have received treatment from a trainee to identify any potential negative experiences they may have encountered. However, it may be difficult to determine if their treatment could have been more efficacious had it been completed by a more experienced clinician. Gathering qualitative data enables us to explore and investigate whether the effectiveness of psychotherapy is influenced by the presence of a trainee therapist or if the therapeutic process creates a mutually beneficial symbiotic relationship for both the trainee and the client.

Overall, this article has aimed to underscore the importance of considering trainee factors in psychotherapy. To truly understand the impact of these factors, however, more research should be conducted to enable further improvement and to enhance treatment outcomes

within the context of Psychotherapy competencies within Core Psychiatry Training in the UK.

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Meditation and Psychosis

Bruce Tamlinson & Diksha Malhota

Summary

Background

Traditionally, meditation practice was seen solely as a religious or spiritual practice. However, in recent decades, it has been popular as a healing therapy for many ailments and a way of supporting mental health. Even though it may have many beneficial effects, there is increasing evidence of adverse effects, some of which can be seriously harmful.

Method

This paper presents a case study of a patient with brief psychotic disorder following intense meditation practice. Appropriate consent has been sought from the patient and relevant ethical guidelines were followed.

Results

There were clear chronological and phenomenological links between meditation and the psychotic symptoms. The patient was diagnosed with brief psychotic disorder. He fully recovered days after discontinuing meditation.

Conclusion

Meditation can induce psychotic symptoms in vulnerable patients. The presentation of such condition may vary between individuals. The prognosis is good on discontinuing meditation.

Background

Meditation encompasses various forms of mental exercises that aim to manage an individual's emotions and thoughts [1]. Different forms of meditation have evolved often through different religious practices and cultures; for example, the Buddhist meditation school developed in association with Buddhism, which includes Vipassana, Zen and Theraveda; Yogic meditation associated with Hinduism etc. Other forms also exist – transcendental meditation, pranic healing, and Bikram yoga [2]. According to the meditative techniques, there are three major categories of meditation identified: 'Controlled focus', 'Open monitoring' and 'Transcendental' [3]. For example, Zen, Tibetan Buddhism, Qigong, Yoga and Vedanta, and operate with controlled focus techniques. Vipassana and Zazen are mindfulness–type, open monitoring techniques. Meditation techniques which involve repeating mantras silently are called transcendental meditation [3].

A systematic review and meta-analysis about the efficacy of mindfulness-based interventions found them to be superior to no treatment and equivalent to other evidence-based treatments (such as cognitive behavioural therapy and antidepressants) [4]. This supported a previous meta-analysis which found mindfulness-based interventions to be effective for reducing stress, anxiety and depression [5]. The benefits of meditation are often reported in the media and social media. However, the literature on unintended consequences or adverse effects of meditation is limited [6]. A literature review reported adverse effects of meditation to be hallucinations, delusions, derealisation and a distortion of the senses [7]. Though adverse physical health reactions have also been reported, including ulcers, nausea, headaches, gastro-intestinal problems or muscular pain, such symptoms failed to meet the causality criteria [10].

Case Presentation

Here, we present the case of a patient who presented to mental health services in 'crisis' in inner city London following practice of meditation. BT was involved in their treatment following presentation to the local Home Treatment Team

(HTT), part of a brief and intensive community treatment offer within the crisis pathway as a part of the National Health Service (NHS). DM was part of the multi-disciplinary team offering treatment and RB was involved in the supervision of BT and DM for their clinical work as well as the writing up of this paper.

We encountered 3 patients, in a 12-month period, with psychotic symptoms following meditation. However, we present one of the patients: the clinical presentation, his treatment and outcome as noted whilst he received care with the HTT. The patient consented to the anonymised presentation of his case for the purpose of this article. Trust ethical guidelines were followed. An electronically typed consent was obtained from the patient using BMJ Consent form and a copy was uploaded onto his electronic care records. In addition, audio recording of his verbal consent was obtained since a digital signature was not available.

Case Report

A middle-aged gentleman, with no previous mental health history, presented with anxiety, erratic behaviour and suicidal thoughts to the Emergency Department in psychiatric crisis. This was soon after attending a 10-day Vipassana meditation course. He described the course as "a torture and like a cult". He reported during the meditation course, all forms of communication were restricted, including non-verbal: he began to feel strange and confused. He slept only for two hours at night.

On mental state examination, he reported low mood and poor sleep because of the meditation. He also felt a numbness and tingling in his whole body and a sense of something rising inside him. He denied any auditory hallucinations. He described visual experiences such as seeing ghosts, dead people, and random things like Medusa's head during the meditation. His explanation for what has happened was that he was poisoned by the retreat: he believed they may have put something in his food that was gradually wearing off. He held this belief firmly and it was unshakeable. He believed he was poisoned, as the retreat's goal was to brainwash people in order to control them. He had considered running out in front of traffic or jumping from his fourth-floor balcony: he was able to stop himself from acting on these thoughts. His cognition was grossly intact, and he was alert and oriented to time, person and place. However, he recalled that a few days earlier during the night he had been disoriented. He had no significant health problems. He was not on any regular medications and did not use any illicit substances.

The psychiatrist felt that he was suffering from acute transient psychosis (International Classification of Disease, 10th Edition or ICD 10 code F.23). He was reported to be perfectly well prior to this presentation with no previous psychiatric or medical history. He had not been on previous medication or used substances and other than the meditation course, no other trigger was identified. Following his presentation to the Emergency Department in the first instance he was prescribed sedative medications: Zopiclone, Promethazine and Diazepam and referred to the Home Treatment Team for monitoring in the community as an alternative to hospital admission. He recovered and gained insight after three days without further pharmacotherapy. He had contact with staff including nursing staff from the Home Treatment Team during this brief period.

Outcome and Follow-up

He recovered from the psychotic symptoms within days after taking sedative medication and discontinuation of meditation. He was discharged from mental health services after a week. It was suggested he explores options for psychological therapy subsequently which he could pursue privately. He completely recovered from the episode and could return to his normal function.

We have come across other case reports on the subject but there were no studies considering its prevalence or attempting to quantify risk. Due to the small number of cases and case series reported, we assume the proportion of patients who experience psychotic symptoms as a result of meditation is small. However, it is also

possible there is a degree of under-reporting by those experiencing psychosis, who may not always use a biomedical explanatory model for their experiences and may not consider seeking help through the mental health pathway, unless distressed.

It has been theorised that some patients are more prone to experiencing psychotic symptoms as a result of meditation. For example, it is thought that certain personality types or inherent traits may make individuals more vulnerable to develop psychotic symptoms [8]. Physical health, psychosocial stressors and sleep deprivation may also play a role [11,12]. Conversely, it is not well studied whether the psychosis is a result of malpractice or over-practice of meditation; though, it is difficult to have a consensus on what malpractice and over-practice mean for someone.

It has been proposed that such adverse reactions may occur due to the intrinsic mechanism of such mindfulness-based programmes [10]. It has been hypothesized those practicing meditation achieve a heightened sense of awareness which can be linked to activation of the insular cortex which can potentially cause increased anxiety and flashbacks [9]. Symptoms such as dissociation and blunting have been linked with prefrontal control of the amygdala which is thought to occur in such programmes for those practising 'decentering' [9].

This patient did not have any prior psychiatric or relevant family history and developed symptoms immediately following intense meditation. There is no evidence for these symptoms to have been induced by illicit substances. He was fit and well prior to meditation and developed the symptoms relatively acutely. The experience was acutely distressing for him, and he sought emergency help. Taking those points into account, it is more likely that this was a Brief Psychotic Disorder presentation which was induced by meditation. Some literature discusses similar presentations as a possibility of culture bound syndrome [13,14]. For our case, the presentations were not well-recognised illnesses in his culture. The course of the illness was short and the patient made a good prognosis. He recovered completely without any residual symptoms and reported that he was able to return to his normal life.

Intriguingly, all our cases experienced a sense of ‘something rising from the lower back’. This can be considered a visceral hallucination whereby patients can experience abnormal sensations from internal organs. However, in meditative practice, this is known as ‘kundalini awakening’. This effect can be experienced differently in people. However, it has the dominant feature of ‘pressure waves’ that rise above the waist and are normally located around the spine, neck, throat and head. These have been attributed to energy centres or ‘chakras’. Those practising can be predicted to achieve such a sensation because of meditation [15]. Such a visceral hallucination may also be a result of imagination instigated by intense expectation or a hyper-excited state [17,18]. Extreme sensory awareness and mindfulness can also increase sensitivity around internal organs [16], for instance, the rising feeling might be related to interception of the venous blood flow in large veins such as the vena cava.

In conclusion, the patient presented with symptoms which included losing touch with reality and were thought to be psychotic in nature. In our case, there were chronological and phenomenological links between meditation and the psychotic symptoms. Finally, the patient demonstrated significant recovery within a short period of time on discontinuation of meditation.

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