columns

e-interview

Sean Spence

Sean Spence is Reader in Adult Psychiatry in the Division of Genomic Medicine, University of Sheffield. He studied at Guy's, Charing Cross and Hammersmith Hospitals and in New York (Cornell Hospital). His special interest is in the functional neuroimaging of executive function in health and disease.

If you were not a psychiatrist, what would you do?
Improvise poorly and write a genre novel.

What has been the greatest impact of your profession on you personally?
It has exposed me to some of the most extreme states that human beings can inhabit, while (often, simultaneously) requiring me to assimilate varying modes of reductionism. The latter rarely do justice to the former. Yet this discrepancy has often served as a goad, making me think more deeply about things, especially our dual nature as organisms and agents. My working framework is that there are limits to our freedom but that it is in coping with these constraints that we define who we are.

Do you feel stigmatised by your profession?
No. It's been a privilege to practise and it would be disrespectful of the sacrifices made by others if I ever lost track of that.

What are your interests outside of work?
Thelonious Monk, Francis Bacon, Anselm Kiefer, Jean Nouvel, Evan Parker. . . . I like music and art at the edge and I enjoy people who are good at what they do. Increasingly, I am preoccupied by the limits of human behaviour (whether good or bad), so that although this (reading) is 'outside work' it informs some of the questions I might ask at work (e.g. what is going on in the brain/mind when humans deceive each other?).

Which book has influenced you most?
For its clarity of focus and elucidation of ideas it's hard to beat Richard Passingham's *The Frontal Lobes and Voluntary Action* (Oxford University Press, 1993).

What part of your work gives you the most satisfaction?
I have two contrasting roles, each of which I find rewarding: as psychiatrist to the homeless service in Sheffield I get to see a lot of people who have 'fallen through the net' and for whom one can do something simple and tangible; on the other hand,

academically, I pursue the cognitive architecture of human volition in health and disease, where the enjoyment is in asking novel questions and chasing their answers, utilising neuroimaging.

What do you least enjoy?
Dealing with trainees and members of other disciplines who are 'going through the motions'.

What is the most promising opportunity facing the profession?
In each clinical encounter we revisit the possibility that our intervention might help to restore someone else's autonomy. Whether by talking therapies or physical treatments, the very possibility of this is compelling.

What is the greatest threat?
Although we have many effective treatments, so often the clinical reality is that services fail to deliver, and if we cannot manage them ourselves then others will do so for us. The care programme approach was necessary because services did not follow their patients; it seems to me that the proposed Mental Health Bill exploits the failure of services to conceptualise and adequately address the disordered personality.

What are the main ethical problems that psychiatrists will face in the future?
The treatment of the asymptomatic is an area that has yet to be fully 'unpacked'. However, right now, I am most often disturbed at the extent to which the symptomatic are left untreated.

How would you improve clinical psychiatric training?
I would ask trainees to spend a year as casualty officers before they enter psychiatry (an anachronism, I know). Then I would ask them to write their own advance directives and to reflect on them, from time to time, when they treat others.

What single change to mental health legislation would you like to see?
I would like the pink form to include a box where one might list those treatment options unavailable locally.

How should the role of the Royal College of Psychiatrists change?
I think the clue is in the name: it should exist to foster excellence among psychiatrists and it should represent the profession to the wider world. Those with broader political ambitions should pursue them in the appropriate contexts.

What is the future for psychotherapy in psychiatry training and practice?
The last time I visited Tate Britain I was struck again by a painting of a family doctor sitting up through the night with a sick child; an image recalling the knowledge of disease states that physicians gleaned through prolonged contact with their patients. It seems to me that the demise of psychotherapeutic time, spent in the company of clients, rehearses the problem of medics, in general, spending less time with patients. The pattern is exemplified by wards where in-patients are merely warehoused and there is little meaningful, purposeful activity. It would be a great shame if the human dyad at the root of psychiatry collapsed into a brief discussion over a prescription or a manual. Psychotherapy experience exposes trainees to the detailed analysis of another's mental life. Also, I'm not sure that concepts such as 'splitting' or 'projection' could have arisen through any other branch of psychiatry (than the psychodynamic), nor that one can adequately manage acute disturbance without an understanding of these ideas.

What single area of psychiatric research should be given priority?
The physiology of empathy and understanding.

What single area of psychiatric practice is most in need of development?
General adult psychiatry.

Dominic Fannon

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