columns

e-interview

David Kingdon

David Kingdon is Professor of Mental Health Care Delivery at the University of Southampton and Honorary Consultant to Hampshire Partnership Trust. He trained in Bristol, Jersey and Nottingham. He worked first as a consultant adult psychiatrist in Nottinghamshire, then Senior Medical Officer at the Department of Health and Medical Director in Nottingham. His clinical and research interests are developing and researching therapeutic options, especially based on cognitive therapy, and services for people with severe mental illness.

If you were not a psychiatrist, what would you do?
Anything involving sitting and listening to a range of different people which didn't involve selling to them.

What has been the greatest impact of your profession on you personally?
Providing me with the sheer enjoyment of working in a fascinating area and in meeting some extraordinary people, in and outside of the profession.

Do you feel stigmatised by your profession?
Yes, within medicine. But much of it is our fault – failing to demonstrate just how much is known about mental health problems and how successful we can be at managing them.

What are your interests outside of work?
Southampton Football Club (Saints), Indian curries, walking in the New Forest, folk and roots music festivals and a drink down the pub with my wife.

Who was your most influential trainer, and why?
Graham Rooth at Barrow Hospital, Bristol. He introduced me to a wealth of psychotherapies and demonstrated that they could be used as part of a psychiatrist's day-to-day practice.

What job gave you the most useful training experience?
My first consultant post in Worksop. It was a completely new service in a new district general hospital. I had to learn rapidly about management and how to develop community services when there were not a lot of examples around.

Which books have influenced you most?
I read a lot of psychology and sociology just before medical school and books such as Michael Argyle's *Psychology of Interpersonal Behaviour*, Laing & Esterson's *Sanity, Madness and the Family* and Jan

Foudraine's *Not Made of Wood*; all had a considerable influence on me.

What research publication has had the greatest influence on your work?
Peter Tyrer introduced me to clinical trial methodology in the early 80s leading to a group publication in *The Lancet* – learning about that process has been invaluable.

What part of your work gives you the most satisfaction?
Direct patient contact and thinking of new ways to approach old problems.

What do you least enjoy?
Attending coroners' courts.

What is the most promising opportunity facing the profession?
Internationally, DSM–V and ICD–11. Reconceptualising classification in terms of the vulnerability–stress models that clinicians use and patients can understand would revolutionise research, clinical practice and the public perception of mental health problems. In the UK, the Layard developments could be pivotal – extending the availability of cognitive therapy, but much more important is influencing politicians to promote mental health ('happiness') above wealth creation as a core objective of government.

What is the greatest threat?
That psychiatrists fail to establish their individual positions as experts to primary care and mental health teams in both psychosocial and biological assessment and treatment.

What single change would substantially improve quality of care?
Making psychosocial interventions as available as medication.

What conflict of interest do you encounter most often?
Drug lunches – convenience *v.* subversion.

Do you think psychiatry is brainless or mindless?
Although there has been movement towards accepting the importance of the mind, there remains a continued disproportionate focus on the brain – that if we search hard enough we will find a 'magic bullet' to cure mental disorder. This has a negative effect on the direction of research, and often clinical practice, because of the continued diminution of the importance of psychological and social factors.

How would you entice more medical students into the profession?
Ensure that university departments of psychiatry systematically nurture any who show interest in the area during their clinical or elective attachments.

What are the main ethical problems that psychiatrists will face in the future?
From 1998 to 2004, I chaired a Council of Europe working party which eventually resulted in a recommendation on human rights and psychiatry. Throughout that period, balancing the individual's right to autonomy against their – and other people's – experience of potentially avoidable distress and disability was the central concern and remains so.

How would you improve clinical psychiatric training?
Get trainees to spend more time with patients and their carers in day centres, with voluntary groups, in their homes and other settings, as well as in hospitals and out-patient departments.

What single area of psychiatric research should be given priority?
Treatment resistance (what should be available when medication and 'standard' cognitive–behavioural therapy (CBT) fails); developing and evaluating combined social, psychological and pharmacological algorithms. These would need to be based on effective individual and family reappraisal using appropriate assessment tools with allowance for problems in the therapeutic alliance and differences in therapist expertise. Systematic evaluation of social interventions is needed, e.g. social support and problem-solving, and potential therapy options, e.g. cognitive–analytic therapy, social skills and assertiveness training, anxiety management, transactional analysis, mindfulness, logotherapy or other variants of CBT, for specific indications.

What single area of psychiatric practice is most in need of development?
Systematic management of treatment 'resistance'.

Dominic Fannon

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