Dynamic psychotherapy supervision for psychiatric trainees

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Following the recommendation by the College that all general psychiatric trainees have the opportunity for psychotherapy training, we describe a pilot scheme for supervised dynamic therapy, commenting on organisational and training issues.

The Royal College of Psychiatrists' article "Guidelines for psychotherapy training as part of general professional psychiatric training" (1993) describes the opportunity for clinical work under supervision as mandatory, but recognises that this requires considerable resources. At the time of the study, the All-Birmingham Rotational Training Scheme in Psychiatry had 35 trainees, of whom approximately half had the opportunity to spend a six-month full-time attachment at Uffculme Clinic, the Regional Psychotherapy Centre. For the others, training in dynamic psychotherapy was limited. Because of the wide geographical dispersion of posts, opportunities for continuing clinical work beyond a six-month attachment were poor. This pilot scheme aimed to fill the gap.

Setting up the pilot scheme

The consultant psychotherapist and registrars' psychotherapy tutor (J.B.) coordinated the pilot scheme. This involved negotiating via the Training Committee for the release of trainees from other commitments, organising the infrastructure for trainees, finding suitable patients and coordinating supervision arrangements.

Training was offered at the Uffculme Clinic. Patients were selected from clinic waiting lists; rooms and secretarial support were provided. Trainees who had passed Part I of the Membership were invited to participate for one year. Four induction meetings covered an introduction to psychodynamic concepts and practical issues. Thereafter the weekly programme comprised a 50-minute session with the patient, appropriate 'writing-up' time, and a 60-minute supervision group. Supervisors were paired, each group containing one experienced psychotherapist (A.B. or M.K.) and one senior registrar in psychiatry (S.E. or S.W.). The consultant psychotherapist met supervisors monthly.

Structural issues

Out of 12 invited trainees, eight participated and showed a high degree of commitment with minimal difficulty in reorganising their usual work. They experienced greater problems in making the 'psychological transition' from the demands of acute psychiatric work to the more reflective nature of psychotherapy. This transition was helped by timetabling clinical work and supervision consecutively, enabling them to move into the psychotherapy culture for a whole session.

The infrastructure required was considerable. Throughout the training period a system had to remain securely in place to relay messages between trainees, patients and supervisors, all of whom were sessional. In psychodynamic terms, the setting has to provide adequate containment to allow the psychological work to be done, and this is as true for organisational settings as for the therapeutic encounter. The consultant psychotherapist provided an essential coordinating role.

The supervision groups started with four trainees each, which was felt to be an ideal size to give both adequate supervisory time for each trainee and exposure to a breadth of clinical material. Crick (1991) describes some of the challenges and rewards of being supervised in a group, in particular the value of hearing and responding to others' clinical work in developing one's 'internal supervisor'.

Co-supervision had several points in its favour. It allowed a high degree of supervisory continuity, which is essential for the beginning therapist. The presence of psychiatrist as well as psychotherapist made the links between the two disciplines more available for consideration, particularly as patients were not taken from a general psychiatric setting. This is in the spirit of the College guidelines, which recommend that trainees "should be

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encouraged to see psychotherapy... as an integral part of clinical work". It also provided the senior registrars with a supervised experience of supervising others, a training opportunity recommended by the Joint Committee on Higher Psychiatric Training (Royal College of Psychiatrists, 1990). Tensions in co-supervision, arising out of differences in seniority, personality, theoretical background and availability for transference from the group, were managed by joint supervision with the consultant psychotherapist and regular discussion between co-supervisors.

We calculated that there was no net loss or gain of therapeutic time to the clinic, and would suggest that this 'balancing of the books' is essential if psychotherapy training schemes are not to be hindered by resource implications.

Training issues

Key training objectives were identified while planning the scheme. These were to provide supervised experience of medium-term individual dynamic psychotherapy, through which trainees would: (a) develop an understanding of psychodynamic concepts and their application in practice; (b) explore the processes of engagement, therapeutic work and disengagement within a therapeutic alliance; (c) gain an understanding of the various manifestations of transference and countertransference and of their use as therapeutic tools; (d) augment theoretical teaching in psychotherapy provided on psychiatry training courses; (e) integrate this learning experience into the practice of general psychiatry.

Oral and written feedback from trainees was mainly positive and highlighted areas of experience they particularly valued, as detailed below.

Understanding the importance of the setting on the therapeutic process

Trainees noted how consistency and continuity of the setting enabled the therapeutic process and how disruptions, for example through periods of leave, lessened the patient's commitment and ability to work therapeutically, unless they had been planned for and worked through. This awareness was felt to be lacking in emergency psychiatric practice where institutional timetables, rather than an understanding of interpersonal functioning, often govern doctor–patient contact. Some trainees drew parallels between the patient's experience of therapy and their own experience of regular supervision; reflecting on their own reactions to disruptions enhanced their ability to empathise with their patient. They felt that the continuity of supervision beyond the usual six-month attachment promoted a sense of personal and professional growth.

Learning about containment of feelings

Trainees learned the value of psychological containment, through acknowledging the patient's distressing feelings and 'staying with' them, rather than acting on the impulse of 'needing to do something'. They recognised that their tendency in general psychiatric practice would often be to react to distress by pharmacological containment (altering medication) or changing the management plan. They also commented favourably on the containment provided by the supervision group, where having their own anxieties about patients acknowledged and thought about enabled them to continue to work therapeutically.

Sharpening an awareness of transference and countertransference manifestations

Different patients reacted to discontinuities in therapy differently, giving an opportunity to view these reactions as transference manifestations shaped by patients' individual loss experiences and attachment styles. Whereas in general psychiatric practice, trainees often have the experience of trying to set aside their feelings towards patients, in the supervision groups they were encouraged to value them as possible countertransference responses and to begin to understand how they might be projections from the patients. This process was amplified by supervisors encouraging other group members to share their responses to the clinical material.

Negative comments pertained to (a) the lack of theoretical input to complement the clinical work, (b) the limited duration of the experience, and (c) frustrations with uncommitted patients. In response to the first point, trainees are now encouraged to attend a theoretical module on psychodynamic concepts in the Part I Membership course prior to joining the supervision scheme. In response to the second, some trainees have found it valuable to move into a six-month full-time psychotherapy placement immediately afterwards. The third point concerns patient selection and is explored further by Ashurst (1993). Patients who have difficulties with engagement can provide as much opportunity for learning about unconscious processes, transference and countertransference as the 'model' patient, but care must be taken not to alienate the trainee from psychotherapy through an experience deemed to be unsatisfactory. A practical step would be to establish a 'pool' of patients suitable for beginners. (A fuller account

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of the experience of two of the trainees can be found in Paul & Black, 1998.)

Comment

In our experience, setting up a dynamic psychotherapy training scheme for general psychiatric trainees requires considerable resources. The consultant psychotherapist is essential in establishing and maintaining a secure infrastructure within which beginning therapists can learn. The supervised experience we provided is shorter than that recommended by the College guidelines and was determined by supervisory resources, the number of trainees to be accommodated, the time available between Part I and Part II of the Membership examination, and other training required at general level. However, we consider that our scheme provided a good introduction to key psychodynamic issues and might even encourage those trainees who are ambivalent about psychotherapy and wary of giving a longer commitment.

Acknowledgement

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