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Trainees' forum

First steps in psychotherapy

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The Royal College of Psychiatrists (1986) recommends that psychotherapy be part of training in general psychiatry. The College suggests weekly specialist supervision with two individual patients for at least one year.

As a Senior House Officer, training in general psychiatry, I saw six patients for weekly individual psychotherapeutic work, some with and some without supervision. I describe not so much the cases (altered anyway for the sake of confidentiality) but more my experience in three settings: a day unit in a general hospital department of psychiatry, a long-stay ward in an old-fashioned mental hospital and a modern, self-contained psychiatric day hospital.

The day unit

Simon, a stocky Glaswegian, had been on the unit for several months following a schizophrenic breakdown. He complained of depression and asked for psychotherapy. Simon told me his grandmother was his "Mum" since his real mother had abandoned him. He explained that his father was a gangster in Glasgow's underworld. Simon's arrival in this world was initiated when his father "failed to take precautions". At school Simon had been "best fighter". Now he was 20 years old and told me that inside he felt like a little boy who would not survive in the outside world.

By the third session I realised that Simon's current grasp of reality was precarious. I felt quite scared as he graphically described the day he had carried an axe through the streets when he had thought there was a gangland conspiracy against him. He had planned to kill his girlfriend and grandmother in order to save them from torture.

After a few months Simon started drinking; he went out for one pint and could not stop. It made him feel good, relaxed and confident. Not long afterwards, he started to hear neighbours shouting through the wall. He told me he felt as if the block of flats where he lived was haunted.

When the non-medical analyst strongly agreed with a suggested increase in psychotropic medication, I knew I would not be doing conventional psychotherapy with this patient. I found it helpful to consider with my supervisor how best to talk with Simon about issues such as illness, drinking, medication and his experience of hospitalisation.

As the sessions went on, Simon inevitably brought up matters which he wanted to discuss. He presented me with intimate details of his relationship with his girlfriend, revealing he was super-sensitive to any kind of rebuff which might hint at rejection. I became acutely aware that whatever happened in the sessions would also be carefully reflected upon. As our six months came to an end we talked about saying "Good-bye". Simon missed a session. At the last meeting he complained of premature ejaculation.

Since finishing I have heard that Simon has suffered psychotic breakdowns. I certainly learnt a lot from him and became horrifyingly aware of the devastating impact of psychotic illness on someone's whole life. However, I guiltily speculate on whether Simon benefited in any way.

The long-stay ward

For the next six months I worked in three wards inside a large psychiatric hospital. Some wards, scheduled for closure, were both short of staff and in a very poor state of repair. It was in such a setting I met Doreen. On the first day my predecessor took me aside and told me an unfortunate part of the job was seeing a big fat lump of a lady every week. As he introduced me to her she offered him a present and said she would miss him.

Not yet 40, Doreen was indeed very overweight. I felt despondent at our first encounter. She was lying, pale and wan, on the hospital bed, puffing like an old person with chronic respiratory disease. She explained, with a touch of pride, that she was so ill she had to have two drug charts, full of all the medicines she needed. Our sessions, for want of any more suitable place, took place in her bedroom.

Doreen told me her problem was overdosing. She would get herself admitted to hospital and when they discharged her, she hitch-hiked to the next town where she found another hospital and took another overdose. After a time, she began to cut her wrists,

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often when she felt someone had let her down. Such incidents still occurred, usually at night or during the weekend. Once it happened when I was on the ward.

Intense rage was the expression on Doreen's face as she punched her arm through the glass window-pane. I couldn't stop her. In a frenzy she tore with her fingers at the severed flesh. Inside myself I felt turmoil. As ward doctor, I presented a calm and clinical 'front' when I treated the injury. Doreen had said she could usually see the face of somebody in her arm, sometimes her father, often someone else who had upset her. I wondered who it was this time.

Seeking help from my consultant, I found out that the arrangement with Doreen was a surprise to him. Unfortunately psychotherapy teaching seminars coincided with his ward round and he had no spare time for regular supervision. He suggested that I stop seeing her. I felt unable to suddenly do that, but Doreen made a decision to stop the weekly meetings when I left.

I do not know what effect the sessions had on Doreen. She always said she looked forward to Monday afternoons. Some time ago she wrote to me, saying she was now living outside hospital and had a voluntary job at a school for blind children. For my part, I remember feeling apprehensive each time we met, wondering whether she had injured herself again since my last visit. Nursing staff sometimes told me they considered individual sessions encouraged attention-seeking behaviour. They pointed out other more deserving patients who might benefit from extra help. Certainly, other patients often came up and asked why they could not be seen individually too; they viewed my seeing Doreen as favouritism.

The day hospital

In this job I was part of a multidisciplinary team using the key-worker system. For six months I worked for two consultants. One referred all patients for psychotherapy outside the hospital; the other asked staff to see patients individually. There was no staff supervision available.

Martin, a 30 year old unemployed clerk, described the infantile trauma which he was convinced had caused his psychological problems. As a young child a neighbour had startled him by appearing from behind dressed in a frightening Halloween mask. From that moment his personality had changed. He had major difficulties forming relationships. Later he suffered night terrors which he explained were related to LSD flashback phenomena.

Martin had already been assessed in the Psychotherapy Department as being unsuitable for individual work. However, Martin himself thought differently and my consultant asked me to see him for a few sessions to discuss the "here and now". During interviews my patient took up a cross-questioning stance and presented me with his own interpretations, demanding my own opinion on their validity. I felt quite threatened; aware of my own psychoanalytic ignorance, I was also finding it difficult to stick to my brief to discuss Martin's current relationship problems with day hospital patients and staff. My reflections about his present difficulties were perceived as attacks and Martin got very angry. Trying to conceal my own hesitancy, I adopted a calm and neutral approach, attempting to discuss what was happening just in the room, rather than outside.

After six sessions I expressed my discomfort at a formal ward round review. Martin's key-worker felt I was "duplicating" her work; however after consideration, the consultant decided I should continue the weekly meetings. Following this decision, I tried to meet regularly with Martin's key-worker, listening carefully to what plans she was making. I did not wish inadvertently to cause conflict. During sessions Martin continued to prefer discussing the past while I tried to focus on what was happening day by day. After a few months I felt more at ease in the meetings and less nervous beforehand. Martin left the unit just before I did and went on to join a supportive psychotherapy group for people with problems similar to his own.

The clinical psychologist had spent six months using a cognitive and behavioural approach to try to relieve Mrs Jones, an elderly divorcée, of symptoms of chronic anxiety neurosis. Her multiple affective and somatic complaints had defied all medical and social intervention for the last 15 years. My male predecessor had offered weekly discussion of physical symptoms so the cognitive and behavioural approach could concentrate on other aspects. I was asked to continue this.

Mrs Jones told me that she didn't like women doctors and did not think she could "go on" unless her symptoms were relieved. I suggested we discuss the change of physician enforced by my colleague's departure. She told me she had met most of the trainees within the area during the last ten years and some of them were now consultants. I realised I was in the presence of a very experienced patient. Mrs Jones poured out a multitude of bodily experiences and in between tried to engage me in conversation about her work with the psychologist. Some of her symptoms could be due to a medical condition or drug side effects, it was difficult to know. I felt like a "listening sponge" and sometimes wondered about the benefit of continuing this weekly role.

One month after I left, a new consultant and the psychologist decided it was unlikely that Mrs Jones would benefit from continued treatment; she was discharged.

When Thomas, a 19 year old ex-school refuser, was 15 his parents split up and he refused to go to school. Weekly psychotherapy in the children's department of a local hospital commenced. No

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longer of school age, at 16 he was referred to a clinic specialising in the treatment of sexual perversion. Twice weekly psychoanalytic psychotherapy was arranged at an adolescent centre. A succession of therapists described him as sullen, withdrawn and difficult to work with. Reaching 19, he was "sent" back to the referring clinic. Now officially an adult, Thomas came for assessment at psychiatric day hospital.

An avid search began for evidence of organic or schizophrenic illness, which was not forthcoming. WAIS testing revealed a superior level of intelligence. The consultant said Thomas would not engage easily into day hospital work; daily discussion between Thomas and his key-worker was prescribed. Two weeks later Thomas' key-worker arrived at a staff meeting. In a state of distress, he explained that Thomas had said the sessions were no good and had sent him a hurtful letter. Thomas wrote that all he needed was one person who really cared and would sit and talk to him all day.

At the next ward round the consultant decided that the daily meetings should be split between two workers. The key-worker would do Monday, Tuesday and Wednesday; who would take on Thursday and Friday? Others seemed reluctant, so I "volunteered". Since no supervision was available the key-worker and I met weekly to reflect upon what was happening both in the sessions and in Thomas' activities in the rest of the day hospital.

In sessions Thomas was sometimes silent and unresponsive, only to sit stubbornly on his chair at the end, refusing to leave the room, saying he needed more time. Outside, he could express his anger; not infrequently, he screamed and hurled objects through the corridor. Alarm was felt by both patients and staff. As unit doctor, I had to deal with staff response to such outbursts. Thomas told his key-worker I was uncaring and the key-worker was the one who could really understand him. Feeling a bit like a parental couple, the key-worker and myself met together to discuss limit-setting and other strategies.

In spite of all this there was another side to Thomas; occasional glimpses of a sensitive, thoughtful and caring person kept us going. An image of potential change lured us on even when Thomas shouted out that all psychiatric services were useless and he was not going to join in any of the organised day hospital activities. However, when towards the end of my placement Thomas started weekly counselling with an outside agency, I have to admit I breathed a sigh of relief.

I first met Marie-Claire, a young office-cleaner from the Philippines, when I admitted her to the acute ward of the hospital where I did my second job. She complained of suicidal thoughts. When the time came for me to leave, the consultant asked me to continue seeing her because she was eventually going to be discharged to the day hospital anyway. He said that I would have to find my own supervision, since he unfortunately had no spare time.

Marie-Claire had lived with her grandparents until she was old enough to join her parents working abroad. Her first job was that of office-cleaner. By the time Marie-Claire came to psychiatric hospital, she had already been physically investigated for weight loss and abdominal pain. She had refused to return to her parents and was now living in bed and breakfast accommodation. There was a suspicion of sexual abuse within the family.

I found a trainee in psychoanalysis who agreed to supervise me. Initially, Marie-Claire travelled weekly to her sessions from the in-patient unit. When she left hospital and became a day patient, I became both her therapist and general physician. Outside sessions, Marie-Claire arrived complaining of physical symptoms such as blood in her stools, feeling faint and pains in her chest. Carrying out appropriate physical examination and investigations felt very uncomfortable, when with the same person I had discussed intimate personal experiences and feelings.

What I found most difficult however, was what Marie-Claire did when the day hospital shut on Friday afternoons. I often worked late in the office and sometimes the telephone rang. Marie-Claire told me she had just wanted to let me know that if something happened to her, it was not my fault. While I was away from work I found myself thinking about what might be happening. It was here that I found supervision was helpful in trying to understand what was going on both in and outside the sessions.

Comment

Working with the six cases I have described was in many ways a rich learning experience. Three points in particular stand out for me.

(a) *Supervision* When available this was a valuable resource. I knew that support was there if complicated problems arose. It was good to be able to improve one's own judgement and objectivity through discussion with an experienced therapist.

(b) *Context* Bleeps, delays and emergency interruptions were all factors I battled with; sometimes they made individual work almost impossible. In some settings it was difficult to find somewhere quiet and private where one could meet regularly. In the ward setting I noticed that staff and other patients reacted to the singling out of certain individuals for special treatment. At times this caused problems and needed to be discussed. Added complications arose when I had to be both doctor and therapist to the same individual. I would have preferred to separate the two roles.

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(c) *Working alone* No matter how carefully a case was set up, once I was in the room with the patient, I knew I was working on my own.

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Reference

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Comparison of 'on-call' experience in two different training schemes in psychiatry

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The natural grouping of training rotations in psychiatry into those based on a central University Teaching Hospital and those in a peripheral location invites comparison between the two groups. Training perspectives in two neighbouring schemes, one in each category, have been explored recently (McWilliam & Morris, 1988). It was noticed that, although styles differ, resulting clinical competence is comparable. An important part of clinical training is out-of-hours experience. For approval of a rotational scheme, experience of on-call duties and emergencies is necessary (Royal College of Psychiatrists, 1987). We were interested in comparing on-call duties in two different types of scheme, one in Sheffield, the other in Chichester.

The Sheffield rotation is based at a University Teaching Centre with the workload divided between a large mental hospital and a psychiatric unit based in a District General Hospital. The non-resident on-call commitment is one in seven and the duties are divided into three categories, admissions, general medical cover, and casualty. When on call 5 p.m. to 9 a.m. for admissions the junior doctor is generally the first point of contact for all admissions. Referrals cover all of Sheffield (catchment population involved is 450,000). The trainee actually covers the 24 hour period 9 a.m. to 9 a.m., but calls 9 a.m. to 5 p.m. occur only in exceptional circumstances when the usual ward doctor is not available. When on call for medical cover, the trainee is available for all psychiatric, medical and surgical problems for a total of 110 acute admission beds, 25 bedded academic unit, 296 long-stay, 60 rehabilitation, 249 ESMI, 53 acute elderly functional and 51 dementia assessment beds. When on call for casualty, the trainee covers all referrals from two large District General Hospitals, including all medical and surgical wards from these hospitals. The Sheffield scheme involves pre-Registration House Officers doing some first on-call duties for admissions and medical and general psychiatric calls but not for casualty. The trainee has back-up cover from a senior registrar (SR) and a consultant. The SR on call is designated the consultant's nominated deputy for the Mental Health Act.

Graylingwell Hospital, Chichester is a large mental hospital covering a mainly rural catchment area consisting of two Health Authorities, Chichester and Worthing, with total populations of 179,000 and 243,000 respectively. The on-call rota was one in seven for three months and one in five for four months. The trainee is resident and is the first point of contact for admission requests, and medical (including cardiac arrest) surgical and psychiatric in-patients' problems. On-call duties run from 9 a.m. to 9 a.m. For three months of the study both areas were covered involving 82 acute admissions, 184 long-stay, 30 rehabilitation, 144 psychogeriatric, 17 acute elderly functional, and 27 dementia assessment beds. Functionally ill patients over 65 from Worthing were not included nor were acute admissions under 65 from Worthing in the latter four months. Cover for Accident and Emergency or District General

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