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Group psychotherapy: trainees' perspective

The Royal College of Psychiatrists recognises the importance of psychotherapy for general psychiatric trainees. Guidelines on psychotherapy training for trainee psychiatrists were first published in 1971 by the College and subsequently updated in 1986 and then again in 1993. Concern has been raised regarding the implementation of earlier guidelines and about the shortfall in training with regard to the latest guidelines (Hamilton & Tracy, 1996). These guidelines set out objectives for training, teaching methods, clinical experience, theoretical teaching and include comments on occupational stress, team-working, and organisational requirements and difficulties. In the most recent guidelines group psychotherapy is a required area of experience either in an "in-patient and/or out-patient setting(s), with an experienced co-therapist and/or supervision". Arnott *et al* (1993) and Hamilton & Tracy (1996) compared their local psychotherapy training with the 1986 and 1993 guidelines, respectively. Both studies found experience falling below the guidelines, with group psychotherapy prominent among the areas of deficit. Hwang & Drummond (1996) found that 58% of successful MRCPsych candidates had experience of group psychotherapy but, perhaps more typically, Byrne & Meagher (1997) found only 19% of trainees in the west of Ireland had experience of group psychotherapy.

One of the consequences of the Calman reforms was the shortening of the duration of higher professional training, but experience to date has not borne out optimism that there would be increased flexibility of time usage (Cavanagh & Haut, 1999). Although trainees value psychotherapy training, it is often seen as post-membership experience as a result of competing demands (Byrne & Meagher, 1997). In addition, the time commitment and relative inflexibility of group psychotherapy may restrict pre-membership trainees in busy general jobs from acquiring such experience, preferring instead other more flexible and potentially more readily available psychotherapies such as individual psychodynamic or cognitive–behavioural psychotherapy (Rees, 1999).

The setting

The Tayside Area Training Scheme covers Perthshire, Dundee and Angus. There is a tradition of training in psychotherapy although until recently there has been no higher training post. There are full-time and part-time placements offering experience in individual and group psychodynamic psychotherapy and cognitive–behavioural psychotherapy. The University of Dundee runs a Cognitive and Behavioural Psychotherapy Diploma course.

The availability of group experience in Dundee is well established with all trainees encouraged and invited to take part, though ultimately the decision to do so is dependent on the trainees' interest and enthusiasm. This paper will discuss the group psychotherapy experience of four trainees.

Organisation and clinical experience

As a group we reflect the wider spectrum of higher trainees with varying backgrounds, interests and career aims: A.H. is a specialist registrar in general adult psychiatry with a clinical and research interest in post-traumatic reactions; F.H. is a specialist registrar in learning disability and general adult psychiatry; P.C. is a specialist registrar in general adult psychiatry with a special interest in rehabilitation; and C.R. is a specialist registrar in old age psychiatry. A.H., P.C. and F.H. have all completed a Diploma in Cognitive and Behavioural Psychotherapy, and C.R. is completing his Certificate in Psychopharmacology. All of us have had exposure to individual psychodynamic and cognitive–behavioural psychotherapy as well as some exposure to group therapies. C.R. and F.H. had comparatively greater group experience prior to commencing group psychotherapy as post-membership trainees.

Table 1 sets out what we believe to be the potential benefits and potential difficulties in undertaking group psychotherapy.

We spent a mean of more than one year as co-therapists. This contrasts with Hwang & Drummond (1996) who found that while 58% of successful MRCPsych candidates in their study had exposure to group psychotherapy the majority had had fewer than 20 sessions and less than six months' experience.

Our experience differed across the set up of the groups with only one trainee being an original therapist at the outset of the group and two trainees having experience of more than one co-therapist for periods of the group. One trainee's special interest was reflected in the

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Table 1. The dilemma of undertaking group psychotherapy

Benefits	Difficulties
Experience of supervision coupled with the direct observation of one's own clinical practice	Exposure of clinical skills to the scrutiny of a more experienced therapist
Modelling: on skilled and experienced group therapist	Time commitment: balancing competing demands
Gaining an understanding of group dynamics	Fear of exclusion from highly selective 'closed shop' of psychotherapy
Transferable skills	Motivation: greater if there are clearly identified goals — benefits of group participation
Develop understanding of stages of the group	Lack of previous experience and skills
Increase in therapeutic repertoire	

patient group chosen while all the other groups comprised patients with miscellaneous problems.

Supervision was in the main one to one with a supervisor. For doctors this appears to be the most common and, therefore, often the most comfortable (Arnott *et al*, 1996).

Only one of our group had external supervision and that was intermittent as a result of time commitments elsewhere. However, while supervision outwith one's own professional group is unusual (Arnott *et al*, 1996) two trainees (C.R. and F.H.) experienced not only supervision, but co-therapy with a top grade adult psychotherapist, with a background in drama and drama therapy.

Discussion

Upon reviewing our experience of group psychotherapy four areas appeared of greatest importance.

Despite the time commitment it is satisfying that we all found participating in groups enjoyable and rewarding. Special interests, background of co-therapist and source of supervision are all important issues to be considered prior to joining the group. However, the search for the perfect group should not take precedence over the need to accept available training and to experience groups as early as possible.

The time commitment required is considerable. One session per week for approximately a year has to be fitted in with many competing interests and training requirements. As senior house officers often have no formalised time specifically for psychotherapy, group experience becomes a higher training experience, which in our opinion is unfortunate. The awareness of the helpfulness of group psychotherapy is in many ways only apparent during and after the experience.

Training in psychiatry is predominately in individual therapies and it is interesting that we were evenly split as to whether individual or group psychotherapy was most threatening when starting training in this area. This did not appear related to previous exposure to direct observation of clinical skills but did relate to early exposure to groups in psychiatric training. The apprenticeship of individual psychotherapy is lengthy and leaving a familiar system causes uncertainty and anxiety. Therapists need to remain flexible and responsive to new evidence and therapeutic techniques and it may be that the delayed introduction to groups exposes a conflict of previously accepted ideological systems within the new therapeutic approach. Uncertainty is created when the certainty within an ideological system is abolished. In addition, this is coupled with working with deeply troubled people which can cause anxiety in itself.

Groups allow enough space within the therapy for psychiatrists less experienced in psychotherapy to consider more fully transference and countertransference issues. When a therapist moves on from a group this allows the discussion of issues of change, termination and abandonment. The differing roles of the therapists, their gender, perceived experience, actual experience and the perceived role of each co-therapist within the group all have a role in the transference experienced. The application of this awareness of group processes to other multidisciplinary group settings can not be over stressed. A consultant psychiatrist should be familiar with the group approach at the very least. A degree of competence in the application of group principles can best be learnt through exposure to group psychotherapy and has importance within team-working and towards the understanding of organisational dynamics within institutions. At the very least a trainee would gain an understanding of who may benefit from group psychotherapy and therefore who to refer.

The College guidelines (Royal College of Psychiatrists, 1993) advocate one session per week available for psychotherapy treatment and supervision. Even with ready availability of training and a planned programme the time constraints within training post-Calman limits the opportunity to gain experience in all forms of psychotherapy. We would argue the case for group psychotherapy.

Other disciplines, such as occupational therapy, incorporate training in group processes throughout undergraduate training (Cawthra *et al*, 1997). Psychiatry should aim to introduce group processes early to all psychiatric trainees.

Yalom (1985) suggests that there are four essential components in a comprehensive training programme: observing experienced group therapists at work; close supervision of their maiden groups; a personal group experience; and personal psychotherapeutic work. Our group of four managed only the first two of these experiences, but these are perhaps the two areas that

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can realistically be covered by non-psychotherapy higher trainees.

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