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# The role of psychodynamic psychotherapy in a modern general psychiatry service

John Hook

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The relationship between psychiatrists and psychotherapists is a complicated one. It has become no easier as mental health services have come under increasing strain over recent years, with pervasive bureaucratisation and the introduction of market forces. I aim in this article to elucidate the roles that a psychodynamic psychotherapy service can play as an integral part of a general psychiatric service in addition to its specialist treatment functions. I also explore some of the reasons why psychotherapy and general psychiatric services are still not fully integrated, thus failing to provide the most effective range of treatments and enhance the effectiveness of mental health staff in all settings in the delivery of those treatments.

It is clear from the literature that psychotherapists interact with general psychiatric and, indeed, medical services in a number of often innovative ways (see e.g. Lucas, 1986; Sklar, 1986; O'Connor 1998, 1999). What is equally clear is that the vast majority of papers describing this work appear only in psychotherapy journals. It follows that much of what psychotherapists do is not seen by general psychiatrists and other mental health staff. Perhaps psychotherapists are reticent to present their work to general scrutiny because they fear that it will not be regarded as scientifically credible and will therefore be rejected. Yet what psychotherapists have to offer (mind science) is complementary to what is currently regarded as scientific psychiatry (brain science). Hinshelwood (1999) goes further in implying that psychodynamic understanding acts

as an antidote to the failure of scientific psychiatry to understand how it can paradoxically reinforce the very problems it seeks to treat.

The result of this vacuum of information is that psychotherapists and psychotherapy services have become prey to a good deal of criticism, warranted and unwarranted. This can take many forms, for example, a common view persists among psychiatrists that psychotherapists have easy working lives, operating within ivory towers, protected from the hurly-burly of acute psychiatry; or among community mental health teams that they are forced to spend their time looking after patients languishing on long psychotherapy waiting lists. No matter that senior psychotherapists mostly work with the most damaged and often chronically suicidal patients for prolonged periods (a model itself disparaged as having no evidence base). For their part, psychotherapists feel hurt that their work is not afforded proper appreciation. They offer counter criticisms that the general services overvalue drug treatments to the exclusion of treating patients as people.

Whatever the degree of truth and validity of these mutual complaints, we have come to a position in which general psychiatry and psychodynamic psychotherapy are all too often failing to work cooperatively and interdependently. This is compounded by the failure of psychodynamic psychotherapy services, led by consultant psychotherapists, and psychology services, led by psychologists, to collaborate and coordinate psychological treatment

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services into an integrated structure. Such integration is described in a joint statement produced by the British Psychological Society & the Royal College of Psychiatrists (1995). Instead, these failures lead to a competitive and ultimately fragmented approach.

## The mental health task

As new treatment methods and refinements of traditional treatments have arisen from our greater understanding of psychiatric problems, so too have significantly different methods of providing mental health services. The treatments the service offers and the style in which it presents them traditionally depended to a large degree upon the passivity and compliance of patients and society. Increasingly, society is demanding not only higher standards of care but that patients should be treated with the respect due to each as an individual. I would argue that the fundamental psychodynamic task has not changed to meet this demand.

It is not possible to treat any given individual without reference to their personality, their history and their current family and social situation. Yet, all too frequently we appear to be doing just that. Why? The problem lies in the fact that we are confronted daily with human misery and suffering. This affects us emotionally and psychologically no matter how effective we consciously think we are in separating our work from the rest of our lives. The results of our work in terms of whether or not a patient gets better are far too variable to offer us anything but the most fleeting of rewards. Instead, we must look to the quality of our work on a day-to-day basis for satisfaction. As with most endeavours, this revolves around relationships and, in this context, the relationships are with our patients and colleagues.

There is now good evidence that, whatever the form of treatment, it is the quality of the therapeutic alliance that plays a large part in its success or failure. This necessarily requires self-reflection. We are subject not only to the effects of our patients' direct behaviour and projective mechanisms but also to our own anxieties. We fear being contaminated with our patients' suffering. To protect ourselves from the pain inherent in this work, we use individual defence mechanisms allied to those of the institution. Also, we are not immune from projecting unwanted aspects of ourselves and of our working environments onto our patients and reprojecting their own projections back onto them, each other or the managers. If we are to serve our patients to the best of our ability then we have to

address these defensive processes that otherwise interfere with our work.

A primary function of psychotherapy is to encourage containment of these anxieties and to minimise inappropriate defensive formations. The essential prerequisites for containment are to understand the nature of these anxieties, both generally and specifically in relation to any given individual or group of patients, and the psychological processes by which these anxieties are transmitted between individuals, within and between groups, in the wider organisation and in society.

This function can be achieved through a number of different processes, which are summarised in Box 1. The specialist skills of the psychotherapist are used to enable the staff team to organise their experience of the patients into a usable tool.

## Psychodynamic functions

### *Individual patient assessment*

There are many patients who may not, at a given stage in their presentation, be able to use formal psychotherapy. However, there are probably very few whose management would not benefit from a psychological formulation that focuses upon an assessment of their defence mechanisms and how these could be predicted to affect response to treatment and produce countertransference responses in the staff team. Such a formulation would identify potential problems in the patient-staff relationship and allow the staff team to consider possible strategies for management of those problems. A

#### **Box 1 Aspects of the mental health task**

**Understanding the individual patient in terms of personality, history, current family and social circumstances**

**Enhancement of all treatments through understanding and development of the therapeutic alliance**

**Self-reflection in order to understand anxieties generated by the nature of the work**

**Reflection upon team dynamics in order to understand group defences**

**Reflection upon institutional dynamics in order to understand institutional defences**

**Use of psychosocial treatments within a therapeutic milieu**

### Box 2 Specific functions of the psychodynamic psychotherapist

#### *Patient-directed: faceto face*

Assessment for the purposes of diagnosis, consultation and management

Co-leading ward or community groups

#### *Patient-directed: indirect*

Attendance at case reviews

Supervision groups

Balint groups

#### *Staff-directed*

Staff support/sensitivity groups

T-groups

Theoretical teaching

Training courses: internal and external

#### *Community-directed*

The therapeutic milieu

All of these activities can be adapted to a variety of settings:

- in-patient wards
- out-patient settings
- community mental health teams
- other mental health services
- primary care

and to different groups of staff, be they uni- or multi-professional

specific outcome would be to mitigate against the staff team being split by the patient. This would, of course, require a considerable psychotherapeutic presence on each ward and it is at present unrealistic given the current inadequate workforce in psychotherapy. It should, however, be possible to identify particular patients for whom an assessment would be of greatest benefit, for example, where there is suicide risk, acting out, threat of physical violence or repeated admissions. Wherever possible, there should be joint assessments between a team member and the psychotherapist. The team member benefits from direct observation of the way the psychotherapist works, discovering new ways of talking with patients, particularly when addressing sensitive topics.

## Group work

The majority of psychotherapeutic work in most contexts is individual face-to-face work between patient and therapist. However, many patients have chronic illnesses that destroy their capacity for

making relationships, producing a social isolation and fear of stigmatisation which are best addressed in supportive psychotherapy groups. These need to be medium- to long-term, in the community, in order to provide the necessary stability and security for patients to develop the confidence to express themselves in ways that allow them to derive support from the group and begin to learn to relate more adaptively in their daily lives.

Such groups, as well as groups run for specific types of patient, for example, victims of childhood sexual abuse or the bereaved, should be co-conducted. One conductor should have specialist training and the other should be a member of the mental health team who in time will develop sufficient group skills to take over the lead role, with supervision. This model gradually disseminates thinking about group processes throughout the team.

On the in-patient unit, a variety of groups can be run along similar lines, for example, regular community meetings, leavers' groups and psycho-educational groups such as medication groups.

Groups run by generic mental health staff alone are usually psychoeducational, for example, for anxiety management. Few, if any, staff have any qualification or experience in other types of group work. Groups are often perceived as time-consuming to set up and difficult to run. The focus on case management to produce specific changes militates against more open-ended therapeutic groups.

## Attendance at case reviews

This can be mutually educational. The psychotherapist learns at firsthand about the types of patient that teams work with, as well as the working dynamics associated with that specific team. The team can benefit from a psychodynamic way of thinking about the patient, which can lead to alternative management plans that may or may not include referral for assessment for psychotherapeutic treatment. The team comes to learn which patients may benefit from the different forms of psychotherapy and which are likely not to do so. A working relationship can be developed that mitigates against prejudicial views on both sides.

## Supervision groups

A supervision group allows staff to bring a problem or set of problems, which at any particular time may focus on one or two patients but which will inevitably represent commonly experienced problems. Thus, learning derived from a specific patient comes to be generalised. Over time, the staff group will incorporate psychological

understanding into their management plans and day-to-day interactions.

Groups will vary in their focus from being more patient-centred, that is, considerate of patient dynamics, to being more staff-centred, that is, considerate of countertransference responses, depending upon the level of psychological sophistication and maturity of the staff group.

### Balint groups

This is a specific type of supervision. The group leader uses the group process to highlight the experience and skills of the whole group. This gives the group a positive sense of its own expertise, encouraging its capacity for the understanding and management of problems.

### Staff sensitivity or support groups

There is often considerable anxiety associated with these groups. Psychotherapists will attest to how difficult they can be to conduct and staff members how frustrating they can be to attend. None the less, they can be a valuable tool in providing staff with a safe environment within which to vent their feelings about the patients, each other and, on occasion, themselves. The aim of sensitivity groups is for the staff team to be aware of the conscious and unconscious pressures that affect their capacity to work effectively with the patients, and to develop individually and as a team. They enhance a sense of personal responsibility, which is crucial for staff development.

The anxiety is related to the question of whether or not such groups constitute therapy. Although the aim is explicitly not therapy, in any regular forum that has relationships between patients and staff as its central work, self-learning is inevitable (for a fuller discussion see Haigh, 2000).

### T-groups

It used to be *de rigueur* for psychiatric trainees in many centres to attend T-groups. Although regarded ambivalently, these were often positive experiences, promoting understanding of group dynamics and their impact upon individuals through direct experience. They foster development of the capacity to identify empathically with patients in group situations and a greater sensitivity to the impact that staff interventions have on individual patients and on the group. It is necessary to link this experiential learning to the work with patients and colleagues in order to maximise the learning potential.

### Theoretical teaching

This can be a planned series of seminars on specific topics, for example, the dynamics of working with patients with borderline personality disorders or substance misuse, or ad hoc to address an immediate need. What is essential is to have dedicated time as part of a staff development programme.

### Training courses

There are a wide variety of relevant courses designed for mental health staff to develop knowledge and skills in all aspects of the psychodynamic approach, for example, introductory group work courses under the auspices of the Institute of Group Analysis.

### The therapeutic milieu

In addition to considering each of these activities in isolation, it is essential to understand how the whole environment, in-patient or community, promotes or hinders the therapeutic work. Major advances in psychodynamic psychiatry grew out of the experiences of Army psychiatrists treating traumatised soldiers in the Second World War. The breakthrough they made was to move from viewing the individual as a discrete entity to be treated in isolation to understanding the psychosocial dimensions of his or her suffering and developing group and psychosocial modes of treatment. The total environment was used therapeutically.

The therapeutic milieu movement had its greatest influence in the 30 or so years after the war. In addition to the founding of therapeutic community hospitals such as the Cassel and the Henderson (both in London), a number of acute in-patient wards used similar principles, with a range of group and community meetings for patients and staff. They attempted to integrate physical with psychological and psychosocial treatments. The aim was to understand the inner world of the patient through his or her interactions with fellow patients and staff and to modify it using the influence of the whole community. Other experimental units have used a range of psychosocial and/or psychoanalytic principles. An account of such a unit is given by Jackson & Cawley (1992). Although the Henderson model has recently been endorsed with the opening of new units, in-patient wards using therapeutic community principles have gradually died out. There are, however, signs of renewed interest.

Arising from the pressure exerted by an individualised view of society, group-based treatments in in-patient units and community mental health teams

have by and large been replaced by one-to-one activity. This is a dramatic change from 20 years ago, when as a psychiatric trainee I spent a considerable percentage of my time in a range of groups regardless of the philosophy of the unit. When I recently asked 20 current pre-MRCPSych Part II trainees what their group experience had been, only one had been in a group of any sort. When one considers that many of our patients suffer from the social stigma and isolation secondary to their mental illness as much from the illness itself, then we are clearly limiting the therapeutic effectiveness of our treatments by failing to pay attention to this aspect of their care.

## Problems in implementing psychodynamic processes into mental health teams

### *Fear, ambivalence and dogma*

The ambivalence that surrounds staff sensitivity groups highlights a central dilemma in introducing psychodynamic work into the team. Psychodynamic theory and practice emphasise the universality of mental processes, that is, fantasy, anxieties and defence mechanisms; taking these seriously can minimise the perceived differences between staff and patients and break down the 'us and them' defence, leaving bare our identifications with our patients. The result is that each of us becomes more aware of our own areas of conflict and disturbance and how these affect our behaviour at work.

The individual and institutional defence is to deny these. The aim of psychodynamic work is the exploration of our transference and counter-transference in order to use the understanding gained better to understand the individual patient and team/ward dynamics. It follows that not to do so increases the risk that our work will be interfered with by our own unconscious dynamics.

A thought-provoking unpublished paper for the Institute of Group Analysis (further details available from the author upon request) draws attention to the ambivalence with which psychodynamic group work is met within the mental health service. It asks why people frequently react to groups with, for example, suspicion, idealisation and hostility or an apparently voyeuristic need to know what is going on. It proposes that in some ways these responses are akin to an organisational negative therapeutic reaction. He suggests that the concept of the group as a container for the 'organisational shadow' – by which he means those aspects of the workplace that

### Box 3 Problems in using a psychodynamic model of understanding

- Increased awareness of own internal conflicts and anxieties
- Ambivalence towards groups
- Increased awareness of conflict between needs of individual and of institution
- Unapproachability of some psychoanalytic theory
- Lack of training in psychodynamic psychiatry for general psychiatrists

are not integrated or directly communicable – both attracts and repels. He quotes Hirschhorn (1988), who articulates the idea of an anxiety chain, in which anxieties are transmitted throughout an organisation via mechanisms such as projective identification, so that people pass on to others, largely unconsciously, their private hurts, shames and anxieties. He postulates that the thought of exclusion from the group touches on primitive anxieties about separation and survival linked to Oedipal anxieties.

It is perhaps the psychoanalytic preoccupation with explaining these and similar tensions in Oedipal terms, with their explicit emphasis on sexuality, that has promoted a barrier to understanding by other mental health staff. I sense that the Oedipal concept has become a too familiar and easily denigrated cliché, which prevents constructive dialogue. Greater emphasis needs to be placed on understanding organisational dynamics from a social systems perspective. The problem lies in the fact that, from the point of view of the individual within the organisation, family dynamics are felt to map directly onto the hierarchical organisation and are responded to from that position. This subjective appreciation fails to grasp the supra-ordinate inter- and intragroup tensions that are the driving force of organisational dynamics. My contention is that this is little understood and therefore paid little or no attention. The failure to utilise this combined model of understanding means that we are ill equipped to address the fundamental differences between the needs of the organisation and the needs of the individual within the organisation. This becomes a source of confusion.

None the less, the paper concludes optimistically:

“The process of dialogue in the group eventually leads to the expression of difference. The creative potential that arises out of difference is evocative of the space between self and other, of intercourse in which something new may arise.”

## **The leadership role of the general psychiatrist**

In recent years, particularly since the major National Health Service (NHS) reorganisation of the early 1990s with the increasing influence of the management process and the corresponding disempowerment of consultants, I and many of my consultant psychotherapy colleagues have observed a change in the leadership role of general psychiatrists. Although the management process acknowledges the essential position of clinical leadership and accountability there is often an uneasy working alliance between management and clinical accountability structures, thinly papered over by protocols whose main aim is to avoid bad practice and complaints rather than to drive improvements in quality of care.

Generals psychiatrists working under the twin pressures of increasing clinical workload and an exponential increase in management tasks increasingly have little time to devote to the welfare and development of their staff teams, especially as the majority will now relate to more than one staff team in the in-patient and community environments. Hinshelwood (1996) has described these new pressures as 'market anxiety'. He argues that this anxiety has added to the strain of 'clinical anxiety' described in this paper.

Temple (1999) argues that the leadership functions of general psychiatrists are founded in training in psychodynamic psychotherapy. He argues that many of the functions that I have described as the province of psychodynamic psychotherapy are rightly the work of general psychiatrists. I would say that this is where psychodynamic psychotherapy becomes dynamic psychiatry. I fully support the view that training in psychodynamic thinking should be a significant element in continuing professional development. At present, it seems to stop with passing the MRCPsych examination.

Holmes & Mitchison (1995) point out that general psychiatrists have seen their work increasingly hemmed in by statutory responsibilities and are worried that their role will be reduced to assigners of diagnoses and prescribers of medication. Such changes often lead to a defensive rather than effective response.

As ward and community teams also operate increasingly under the pressure of individualised case management protocols, there is often no individual who has both the necessary knowledge and the time to promote the psychotherapeutic aspects of the work.

Some psychologists attached to wards or community mental health teams (CMHTs) do take an interest in this model of working. It does not,

however, appear to be recognised as one of their central functions (Hall, 1996).

## **The role of mental health nurses**

Winship (1997) has raised many of the same issues in respect of the nursing profession. He suggests that the unique strength of mental health nursing lies in the relationship that can develop between nurse and patient as a result of the "sustained intimacy" that obtains. He argues that it is the psychodynamic perspective with its focus on interpersonal relations, which provides the nurse with a framework for understanding the needs of the patient with severe mental illness and for responding meaningfully. He laments, though, that:

"the substructure of psychiatric nursing, from core training through various levels of advanced practice, has not been resoundingly influenced by psychoanalytic ideas."

He cites as an example that the concept of countertransference is mentioned in only two articles in the *Journal of Advanced Nursing* during the 1980s.

Elsewhere, he and Hardy (Winship & Hardy, 1999) argue that the advantages of staff sensitivity groups in conjunction with group supervision include mitigation against staff burn-out, extension of learning about interpersonal relations, achievement of quality standardisation through peer feedback and reflection on practice in truly collaborative ways.

## **Psychotherapy workforce**

There are too few consultant psychotherapy posts. The College's recommended norms (Royal College of Psychiatrists, 1999) appear to be universally ignored in planning services. The overall number of posts is at a standstill despite Government plans to increase consultant numbers across the board. In some parts of the country no posts exist. In others,

### **Box 3 Advantages of using psychodynamic understanding**

**Professional and personal development**  
**Increased work satisfaction**  
**Effective use of team dynamics**  
**Minimisation of defensive processes in individuals, teams and institution**  
**Effective and holistic treatment of patients**

the consultant or a nurse therapist is the only psychotherapist. Clearly, there are too many services that can barely begin to mount the type of service that most of us would advocate.

However, there are centres in the UK where psychological therapy services are becoming more complex structures. In recent years, staff from professions other than medicine and psychology, in particular nursing, have trained through in-house supervised practice and in external psychotherapy training schemes in a variety of psychotherapeutic modalities. Services are therefore increasingly made up from psychotherapists drawn from all the major mental health professions. The implication is that these should be able to provide psychotherapeutic teaching, training and supervision, consultation and liaison to general mental health services by drawing on the whole range of professional perspectives. This is vitally important if we are to be able to utilise and develop the unique strengths of each professional group in the multi-disciplinary team, rather than sink to the worst forms of generic working that deny difference, specialist knowledge and experience. Although psychological therapy services should promote cross-professional and multi-disciplinary working, there is an essential place for nurses with psychotherapy training to work alongside ward and CMHT nurses. Their training and experience as registered mental nurses (RMNs) allow them a more empathic sensitivity to their colleagues and greater confidence in opening themselves up to psychological perspectives.

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## A model for the future

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Holmes (1998) argues that the prime role of the psychological therapy service is to be a repository of psychotherapeutic expertise offering CMHTs training, supervision, assessment and treatment of complex cases.

He and Mitchison (Holmes & Mitchison, 1995) have described a model for service development between psychological therapy services and CMHTs. They argue that supervision and training of community workers by qualified psychotherapy staff is essential to good practice. Indeed they provocatively suggest that without it “their interventions may otherwise be ineffective” and that “it will be impossible to meet quality standards for mental illness”.

They advocate a model of “cross-fertilisation” between different psychotherapeutic modalities and with general psychiatry, which has the potential for “enhancing the relevance and job satisfaction” of all parties. They see the main problem to realising

this as the resistance to change well-established practices, which would threaten professional identity.

This model can be transposed to any mental health setting.

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## Conclusion

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The aim of this article is to continue the argument for the development of a model of psychiatric practice, which is grounded in knowledge derived from experimental and experiential learning based on psychodynamic theory. What I have said is not new (see, e.g., Royal College of Psychiatrists, 1998; Hobbs, 1990). Hopefully, it will serve as a reminder of fundamental principles that have long been proven effective. This is not the place to review the evidence base for a psychodynamic model of work. It is implicit that experiential learning has validity and value as evidence for good practice.

We are fortunate to be living in an age when understanding of brain function is reaching a level of sophistication that is beginning to enable us to link neurochemistry and neuroanatomy with psychological observation. It is imperative that we keep open minds to the insights of both disciplines, rather than see them as competing paradigms, in order to maximise our usefulness to our patients and to society. If Clinical Governance is to generate meaningful change then we must address what Holmes (1998) has described as “an urgent need for improved organisation, audit and enhancement of psychotherapeutic skills within the CMHT” and, I would add, within every mental health setting.

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### Box 5 Model for service structure

**Integration of departments offering psychological therapies in order to provide coherent teaching, training and supervision**  
**Greater integration of psychological therapy services with ward teams and community mental health teams**

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2. Institutional defence mechanisms:
    - a can lead to splitting between staff teams
    - b can encourage differentiation between staff and patients
    - c include projection by staff onto patients
    - d are Oedipal in nature
    - e can decrease anxiety in staff.
  3. The therapeutic milieu:
    - a is relevant only to therapeutic communities
    - b has no relevance to acute in-patient wards
    - c utilises the total environment to promote change
    - d integrates physical and psychosocial treatments
    - e includes staff sensitivity groups.
  4. T-groups:
    - a foster empathy
    - b involve didactic teaching on group dynamics
    - c are compulsory for psychiatric trainees
    - d are experiential
    - e are not suitable for nurses.
  5. Psychodynamic psychotherapy interventions for staff can:
    - a reduce staff burn-out
    - b increase job satisfaction for mental health staff
    - c provide peer feedback
    - d enable collaborative practice
    - e enable staff to understand their relationships with patients.

## Multiple choice questions

1. The role of the psychodynamic psychotherapist includes:
  - a co-leading ward groups
  - b running Balint groups
  - c providing therapy for staff
  - d conducting anxiety management groups
  - e leading ward rounds.

### MCQ answers

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>
a T	a T	a F	a T	a T
b T	b T	b F	b F	b T
c F	c T	c T	c F	c T
d F	d F	d T	d T	d T
e F	e T	e T	e F	e T