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Psychotherapy case discussion groups: supporting psychiatric trainees

Psychotherapy case discussion groups for trainee psychiatrists not only teach psychotherapeutic skills but also afford empathic peer support. We outline how case discussion groups were set up in such a way as to maximise their supportive functions, and describe the emergence of psychological competencies in response to this supportive framework. Four case discussion vignettes illustrate this process.

The Royal College of Psychiatrists' Guidelines for mandatory psychotherapy training for psychiatric trainees (Royal College of Psychiatrists, 2004) stipulate psychotherapy 'case discussion groups' as an essential component of training.

Case discussion groups in psychiatry are based on Balint Groups introduced for general practitioners by Michael and Enid Balint in the 1950s, (Balint, 1984). In Balint groups, psychodynamic ideas inform discussion about emotional and psychological issues raised within the doctor–patient relationship.

One of the values of case discussion groups for trainee psychiatrists based on these lines is that they can play an important role in the development of reflective practice and the art of empathic colleague support. Sympathetically conducted, the groups provide opportunity for trainees to enhance their capacity to engage effectively with their patients' concerns and predicaments, become more aware of how their practice may be constrained by their personal beliefs and experiences, and learn about the value of sharing the process of psychological problem solving with colleagues. In this way they foster the development of 'good doctors' as defined by the General Medical Council (2000). In addition, they allow regular protected space for exploration of the particular emotional challenges and risks associated with contemporary psychiatric practice.

Psychotherapy case discussion groups

Case discussion groups run by the authors, all medical psychotherapists, each consist of 8–10 trainee psychiatrists meeting weekly during working hours. The groups are held both in a psychiatric unit and in a psychotherapy service. The trainees and their consultants are asked to respect the protected time. Bleeps are left with the administrator outside the group, and their vital role in supporting the importance of this format is explained to the clinical tutors on the training scheme. At times protecting time may become a central topic in the group itself.

Trainees take turns to present a clinical case or work situation that interested, puzzled, or left them feeling out of their depth. The background surrounding the patient's clinical situation is explored, together with the doctor's subjective responses or the responses of other staff and carers. A focus on psychodynamic understanding takes place, including relational patterns, motivation, conflict and anxiety avoidance. Respect for the confidentiality of both trainees and of their patients is an essential aspect of the good functioning of the groups.

Role of groups in developing psychological competencies

The wish to understand human behaviour is usually an important motive for people seeking to train in psychiatry. Stack-Sullivan (1953) observed, 'Everyone is much more simply human than otherwise.' The aim of remaining 'simply human' alongside professionalism is supported by the groups and thus helps doctors offer their patients realistic, human ways of approaching their symptoms.

One way this sort of empathy can develop is through reflection of personal experiences of managing conflict and stress. In the case discussion group, thinking about the similarities and differences between ordinary experiences and experience complicated by mental ill health supports a robust psychological framework for psychiatric practice.

Trainees are encouraged to use their personal resonance to reflect on patients' experiences of loss, disappointment, feeling overwhelmed or in the midst of an illness or breakdown. The likely impact of patients' interpersonal experiences, including their experience of being a patient, is emphasised in the groups in a way that is intended to minimise exposing personal revelation for the trainees.


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The use of everyday language in the discussion, alongside the more technical languages of psychiatry and psychotherapy, helps trainees to develop their capacity for self-reflective practice and ordinary communication with patients. Learning to talk to patients in an understandable way is an essential skill for any medical practitioner, but particularly so for those working with individuals with mental illness.

These skills can also be extended to improve communication with colleagues by encouraging a culture of open discussion, which includes sharing emotional responses in a respectful, circumspect way. This reduces isolation and promotes honest, considered peer support, which is in the best interests of both patient and doctor. Better communication helps reduce the dangers of burnout that can ensue from the emphasis on personal responsibility and self-reliance, which is fundamental in medical training. Learning about limitations, setting personal boundaries and having realistic expectations of oneself and others, can also increase satisfaction and effectiveness at work.

Thinking about disturbing or frightening situations with colleagues away from the pressurised work environment, sharing emotional responses to accounts of clinical work and addressing the range of anxieties that psychiatric work evokes, enables greater acceptance of personal upset and reduces its stigmatisation.

Role of the facilitator

Maintaining a safe environment for learning is the facilitators' main role. For this it is essential for them to protect a consistent, boundaried and cohesive group, despite the demands of shift working, study leave, sickness and on-call duties, which may lead to a changing membership or depleted numbers.

The facilitator encourages the trainees to develop a lively narrative account of their clinical work, including the impact on them of their patients' experiences. This is different from psychiatric case conference presentations in being more explicitly psychologically and emotionally orientated and with a less hierarchical approach to knowledge.

When medical psychotherapists run the groups, the shared professional identity provides an important role model of good psychiatric practice for doctors in training, impressive for also being psychologically well-informed. The facilitators' capacity to use their direct experiences of their medical training and their understanding of the pressures and responsibilities of the doctor's role to help the trainees is then a vital link.

The facilitators' concern about the working environment is also important. The protected time for thinking about this allows the National Health Service culture of unrelenting activity to be questioned and its effects better understood. Recognising the impact of organisational functioning on oneself, as well as on colleagues and patients, contributes to empathic insight at work.

The facilitators use their psychotherapeutic skills, both to prevent the members of the group from becoming bogged down in self-defeating negativity through the contagion of anxieties, and to enable them to provide care and consistency for each other, through reliable attendance and through respectful listening and discussion. This provides a model for care and consistency for clinical work with patients. This reliable frame in patient encounters is a psychotherapeutic tenet also applicable to all healthcare relationships and especially important in the development of helpful working relationships between medical colleagues. Reliability, mutual respect and attentive listening are essential to successful collegiate working.

Themes from the case discussion groups

Through the to-and-fro between case material and personal concerns about the work situation, the case discussion groups address many of the challenges for the trainee psychiatrist in their encounters with patients and colleagues. Likewise, they challenge the trainees in their encounters with their own emotional reactions. There is not room to address this in detail here, but common themes include patient risk, managing personality disorder and suicidal behaviour, team work, relationships with consultant colleagues and with other professionals, handling personal failures, disappointments and vulnerabilities, maintaining clear boundaries and using diagnosis appropriately.

The following vignettes from case discussion groups provide some examples on these themes. Some of the details have been changed in order to protect the identities of the trainees and their patients.

Vignette 1: an alarming joke

Here the emergence of deeper understanding of a dilemma in the work environment is described, showing how the use of spontaneous humour in the safety of the group freed the imagination of the participants to find a different vantage point on an anxiety provoking experience.

The issue of patients who are violent was being discussed in the group. A senior house officer (SHO) described her experience of being hit by a patient, which led to associations from other SHOs about their experiences of being threatened. Concern for the doctors who had been subjected to violence emerged and the conversation turned to how doctors could protect themselves.

The mood of the group became tense. One SHO criticised the lack of protection in the working environment. Another SHO challenged her, asking if she carried a personal attack alarm provided for SHOs by the trust. When she said she did not, he chastised her and took out his alarm to demonstrate its use, held the alarm aloft and pressed the button; there was no alarm signal. There was a stunned silence. Then the SHO's laughter at his deflated safety demonstration triggered the other SHOs' laughter and the group relaxed. Other SHOs' alarms when tested did not work either. The group laughed at the spectacle

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of these useless alarms in which they invested faith. A more serious discussion then ensued about disillusionment with the protection afforded by the organisations in which they worked. The greater risk that nursing staff confronted was also raised. The uncertainties and anxieties surrounding risk were debated.

As a more realistic acknowledgement of objective dangers and personal vulnerability emerged, the group began to question the wisdom of a passive reliance solely on external or mechanical means of protection from harm, and to consider the importance of trying to use their awareness of feelings of vulnerability to inform the stance they might adopt with a hostile patient.

Humour used in this playful way, challenging accepted authority, allowed the doctors to reflect on their fears more seriously, steering between respect and healthy disrespect for the institution's capacities and limitations.

Vignette 2: status and responsibility

In this group discussion, an SHO's efforts to understand his patient's anxieties about growth and responsibility resonated with his own uncertainties about his professional limitations.

An SHO presented a teenager who had an overvalued idea about wanting to be smaller that was affecting his mental health. The patient was over six feet tall. The SHO saw him weekly during his 6-month post. The patient told the SHO that he found change difficult and the SHO brought the case because he felt he 'had not done anything' for the young man. In the exploration, it was revealed that the SHO had spent time discussing his patient's worries about height, and normalising this and its effect on peer relations and interests. Patient and doctor shared a love of golf, and at the end of the contact the patient gave the SHO a picture that he had drawn of a golf match. Although the patient still had ideas about his height presenting a problem, it was no longer an obsessional preoccupation.

The group took up the notion of the aims and limitations of psychiatric help. They then addressed the meaning of the young man's anxieties wondering if tall stature represented a problem of 'looking bigger than one felt inside' in terms of age and experience. The SHO was moved to discuss the use of medication for this patient and how his consultant had spoken to him in a way which gave the SHO opportunity to take some responsibility for this decision. He reflected that his consultant had given him a degree of autonomy that had brought with it the anxieties that can accompany responsibility, including fear of failure and of the limitations of possible success.

From this presentation the group gained some understanding of developmental processes. From the forging of professional identification through relationships with senior clinicians, to finding their own identity as competent practitioners, trainees must gradually leave behind the security of reliance on a consultant.

Vignette 3: too close for comfort

This vignette illustrates how exploration of anxiety about the interface between a trainee's world and his patient's, which was felt to be 'too close for comfort', reduced tensions in the group.

There was an initial reluctance for anyone to bring a case. When the facilitators asked what the difficulty was, one SHO said provocatively, 'Apathy!' He then volunteered his own case, a patient in a high security prison. He described how he had gone to look at what was involved in providing psychiatric care for prisoners through long sentences. During the clinic he saw a patient he recognised from his home town. The SHO described his internal struggle, since he did not want his recognition noticed by the prisoner patient, who he thought had also recognised him. After the interview, during which the SHO had remained silent, he looked at the prisoner's medical record, which revealed that he was a long-term sex offender. The SHO described his shock and curiosity about the patient as well as his concerns about patient confidentiality.

Another SHO described the experience of practising psychiatry in a part of the country where he had old friends, recounting that he was on call and playing cards with his friends when he was called out to see a parasuicide case, who turned out to be the brother of one of the friends he had just left. When the SHO returned to his friends he made no reference to what had happened but 'carried on playing the cards'.

The personal impact of possessing such knowledge when it relates to individuals we know well was taken up with fervour by the group. This was a moving encounter for the group members as they shifted from apparent apathy to intense involvement. It enabled wider discussion of the many different connections practitioners can feel in relation to their patients and how this can be handled.

Vignette 4: models of mind

In this case discussion the group had begun using models of mind to find a self protective 'island of sanity' to handle the anxiety surrounding direct encounter with a patient's disturbed language and behaviour; but this limited discussion.

The patient, a frightened man in his 30s, had become acutely distressed following an acute genitourinary infection. The man's father was at the same time terminally ill. The presenter described how the patient had said he had felt 'tingling sensations' in his head 'whooshing up' from his groin. The patient was also angry and irritable, in a manner which made his family and the staff feel perturbed. In the group discussion there was a strong sense that the material presented was not understandable in relation to either psychiatric or psychological models and was frankly 'mad'.

However, gradually the presenter and group members began making sense of the patient's symptoms and his circumstances. There had been a recent discussion with his partner about having children (the patient did

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not want children), and this had happened just before his father had been admitted to a hospice. One member of the group offered the Freudian theory of castration anxiety as a way of understanding the symptoms; but this seemed 'too neat'. The facilitator helped the group consider the anxieties that imminent loss of a father might create in a son. This opened up further thoughtful discussion about the generational and personal transitions involved.

The presenting SHO felt helped by this thinking and described how he had initially not known what to make of his patient, feeling in contrast that his colleagues would be 'all knowing' about which diagnostic category to allocate to the patient – psychotic, psychosomatic, neurotic.

The group seemed to have made a similar journey from an attitude of anxious incomprehension, to overly simplistic, knowledgeable categorisation. Subsequently, they created a synthesis of elements from different positions, which was constructive.

Anxiety can lead clinicians to take premature refuge in the certainty of diagnostics, whether psychiatric or psychological, but this can limit a thoughtful approach. The value of having several models of mind or mental distress is that they provoke a dialogue which broadens the clinical approach.

Discussion

These vignettes describe the sharing of frightening experiences and vulnerability in an empathic group setting. Addressing such predicaments in this format helps trainees realise the value of sharing difficulties with colleagues in their daily work. In a case discussion group which is working well, the trainees' experience is of being understood, assisted in their own understanding and actively encouraged to be curious and empathic when faced with either their own or another's difficulty. We see this as an important formative experience for doctors in training.

Conclusions

In mental health services good psychiatric practice has much in common with well-established psychotherapeutic principles. The experience of a thoughtfully conducted case discussion group where the challenges and risks of clinical work can be shared with supportive peers brings the values of the two disciplines together.

The psychotherapy case discussion group makes it explicit that the human encounter at the heart of psychiatry continues to be of central concern.

Declaration of interest

None.

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