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Trainees' forum

Psychotherapy training as part of general psychiatry training

Experience of two registrars at the Cassel Hospital, February to November 1989

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Training in psychotherapy for junior registrars is often piecemeal and relegated to an after hours out-patient and supervision. We are fortunate in having had the opportunity for a whole-time psychotherapy placement at the Cassel Hospital, Ham Common, Richmond, itself an internationally renowned clinical and training centre devoted to psychotherapeutic treatment of in-patients and out-patients.

It may be helpful to describe briefly the hospital and the ingredients of our experience. The Cassel has developed from a hospital devoted to the treatment of shell-shocked soldiers in the First World War (as an alternative to shooting them!). It was endowed by Sir Ernest Cassel, the financier, for this purpose, but following the Second World War it came to prominence as a therapeutic community for the treatment of neurotic disorders, under the directorship of Tom Main – one of many psychotherapists who were involved in the pioneering of group work at Northfields. These days, in-patients include borderline and severe neurotic single adults as well as families – particularly where there has been a breakdown in effective parenting including physical and sexual abuse of their children.

Every nine months, two registrars on our training scheme have placements at the hospital (one on the Families Unit, and the other on one of two Single Adults' Units). Each of us came to the Cassel with adult and sub-speciality experience behind us. On hearing trainees talk of their experiences there we had concerns about the job; would we feel isolated, could we do the job? An atmosphere of excessive interpretation had been described and we feared this might stultify our spontaniety.

We were initiated into the working of the hospital by an induction programme lasting ten days in which we had a chance to sample most of the activities and meetings of the patients and to become acquainted with most members of staff. While in most training jobs a programme of this kind would be considered a luxury that could be ill-afforded, we found it to be central to our later ability to work in the hospital and our only opportunity to obtain an overall picture of the community before getting down to our jobs as therapists. Therapists see patients twice weekly for analytically orientated psychotherapy. There are major differences between in-patient psychotherapy at the Cassel Hospital and ordinary out-patients' psychotherapy. Therapists have to cope with a mass of information about their patients outside therapy sessions, in staff meetings, reviews and from the daily summaries of the hospital log-book. The relationship between therapist and nurse has become a focus of the work at the Cassel and is seen as very much analogous to the relationship between parents. This puts quite a pressure on therapists and nurses to get on with each other or at least to "have it out!" The barrier of confidentiality is often blurred with therapists facing questions about what their patients do or say in the therapy sessions. Patients often give very different impressions of themselves to different staff and so staff can end up enacting a splitting of different parts of a patient's personality. The same is true of the dynamics in families and it is of great importance that the child psychotherapists often put a voice to the dynamics from the child's perspective.

The experience is confusing at first but eventually some sense emerges. Interestingly, the family dynamics or dynamics of the single adults in the community could sometimes be reflected in the hierarchical staff structure with us representing the more junior members of the staff family. Other major differences compared to previous experience is the release from a bleep and the ability to plan over a whole day, week and even a month. Infrastructure, too, is much more reliable; the switchboard is well adapted to daily psychotherapy patients and interruption in session time is very rare.

The sheer quality of experience spent in session with in-patients is immensely valuable. There are no SHOs at the hospital and registrars are very much adopted by the senior registrar group. We joined them for supervision of group and out-patient work (including brief focal psychotherapy and marital therapy) and academic seminars, journal clubs and case presentations. Supervision of the nurse–therapist relationship is also provided. Overall, a rich academic and clinical milieu is created by a relatively large number of psychotherapists often with rather different trainings and perspectives.

In looking at the differences in our experiences of the two jobs, we found that the day-to-day nature of the work of the different units was often so different that we found ourselves unable fully to understand and support one another. This dynamic is important when considering the isolation of trainees that could be experienced in such an attachment, especially when geographically separated from the bulk of peers in other training posts, when trainees are sometimes in an unfamiliar culture and when other peer groups in the hospital are significantly larger than theirs. The effect of constant changes due to registrar turn-over on the smooth running of the institution has also to be considered. Juniors on training rotation schemes are generally used to having to adapt rapidly to different working environments. However, the beginning and end of a short attachment can be associated with much intra-psychic and institutional turmoil which leaves a relatively small amount of 'settled time' in the middle, especially for two inexperienced psychotherapists. Furthermore, nine months is not long enough to see a full in-patient treatment through from beginning to end.

In summary, very positive aspects were the variety, volume and intensity of the clinical experience and the clear demonstration of institutional dynamics. Relatively negative aspects were the potential for isolation and the sorts of conflicting pressures we were subject to, the latter perhaps being inescapable. Since moving on to new jobs in general psychiatry we are both aware of some difficulty in incorporating our experience into our new areas of work where aims of treatment can be considered to be very different.

In conclusion we thoroughly recommend this experience and hope that the future will see similar opportunities for trainees being more readily available.

At the time of writing, we are sad to hear that the Cassel is under threat of closure, and we fully endorse the viewpoint of a recent article on the Henderson Hospital in the *Psychiatric Bulletin* which stresses the importance of specialist treatment centres for training as well as service provision.

(*Editorial note*: The District Health Authority's closure proposal put forward earlier this year has been withdrawn following agreement on plans to raise funds and make arrangements for the hospital to opt out in April 1991.)

Further reading

KENNEDY, R. *et al* (1987) *The Family as In-Patient*. London: Free Association Books.

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ROYAL COLLEGE OF PSYCHIATRISTS (1986) Guidelines for the training of general psychiatrists in psychotherapy. *Bulletin of the Royal College of Psychiatrists*, **10**, 286–289.

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Training matters

A model of training for consultancy in psychiatry

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In the medical profession a consultant is a doctor who has attained the capacity for totally independent practice, otherwise known as clinical freedom. Consultants differ from other doctors in the important respect that they have full clinical responsibility (BMA, 1984). The work of the consultant may be audited by his peers, with his full participation, but may not be supervised by one (DoH, 1989a).