

Psychotherapy on a shoestring: improving training using existing resources

Stephen Paul Davies

Aims and method This article aims to describe qualitatively attempts in one NHS trust to improve psychotherapy training for psychiatry trainees, according to the Royal College of Psychiatrists' Guidelines, using existing multi-disciplinary resources.

Results Training opportunities in a wide range of interventions were identified. A psychotherapy supervision group was established, and a psychotherapy training post was introduced for a trial period. The costs and benefits are discussed.

Clinical implications Substantial improvements in psychotherapy training can be made using existing resources, even in the absence of a consultant psychotherapist. Flexibility and coordination are required.

In 1993 the Royal College of Psychiatrists published its guidelines for psychotherapy training as part of general professional training (Grant *et al.*, 1993). Since then several articles have appeared in the *Psychiatric Bulletin* pointing out that training schemes frequently fall short of these standards (Arnott *et al.*, 1993; Hawlton & Tracy, 1996), and that the lack of experience in particular areas, such as psychodynamic and cognitive behavioural interventions, is no less than "alarming" (Hwang & Drummond, 1996). Few articles have addressed ways in which the situation might be improved. This paper describes recent attempts to improve psychotherapy training in one regional training scheme, using existing resources.

The setting

The training scheme encompasses a large county in south Wales, employing 22 trainees over dispersed sites as part of a single National Health Service (NHS) trust. Historically, south Wales has had a paucity of psychotherapy services, and trainees, like some patients, have had to look elsewhere. The Trust had no designated consultant with responsibility for psychotherapy, and although many had experience as trainees, none of the nine general adult psychiatrists formally practised psychotherapy

as part of their usual NHS work. However, one consultant has begun a masters course in systemic family therapy, and a psychodynamically-orientated nurse therapist had been appointed, having obtained United Kingdom Council for Psychotherapy approved training and registration.

Addressing the problem

The lack of psychotherapy training facilities in the Trust had been pointed out by both trainees and consultants, noted on a College visit, and emphasised by unpublished local research projects.

The Training Committee, which included a trainee representative, considered the problem, and the following measures unfolded from the discussion:

- (a) a supervision group in psychodynamic psychotherapy would be set up and facilitated by the nurse therapist;
- (b) other individuals or groups, within the service, willing to give supervision in various forms of psychotherapy would be identified;
- (c) as a trial, one trainee on the rota would be allowed to spend four sessions per week for six months arranging for and pursuing exposure to various forms of psychotherapy within the trust (i.e. a 'psychotherapy job').

Identifying supervisors

Initially the clinical tutor approached all consultants to ask if they would be willing to give supervision in therapy to a trainee, not necessarily the one working on their team. There was a good response, with extremely diverse forms of treatment being represented. However, most consultants lacked recent practice in the treatments mentioned.

Subsequently, the psychotherapy junior, having established a network of contacts, was able to identify individuals, scattered across various

sites within the Trust and from across the disciplines (nurses, clinical psychologists, occupational therapists) with appropriate training and qualifications. A list of those willing to supervise trainees in a broad range of interventions or include them in sessions was compiled. It includes family interventions in schizophrenia, systemic family therapy, cognitive-behavioural therapy plus group-based anger and anxiety management.

Supervision group

Working on psychodynamic lines, this group was set up to run over a trial six-month period, to coincide with rotation dates. There were several practical difficulties (or forms of resistance, according to your point of view) including setting day, date and location to suit everyone. A time was therefore set when most could attend, with the aim of running a closed group for these individuals. However, it proved difficult to maintain such boundaries. Several trainees who wanted to attend were unable to because of examinations, unforeseen clinical emergencies, cover for colleagues, or inability to reschedule other work. Some of those who were able to attend regularly were unable to find suitable patients. The group ran for six months with attendance towards the end falling to four to five trainees weekly. Each session consisted of two 30 minute trainee-initiated discussion of therapy sessions, followed by 30 minutes open group time. The latter initially consisted of issues around setting and assessment, progressing naturally through issues of transference and countertransference, to a consideration of dynamics within the group itself. The facilitator provided literature references on the topics discussed.

It is planned to restart the group after the next rotation of posts.

Psychotherapy job

Following exposure to the above group, one trainee (S.P.D.) expressed an interest in spending more time in psychotherapy training. As a full-time psychotherapy post was not available locally, the options of an exchange placement with another scheme, or simply applying for work elsewhere, were explored, but seemed not to be feasible. A service need for an additional part-time junior in old age psychiatry had been identified, though none had been found. It was therefore agreed that this junior should spend four sessions per week working in old age psychiatry and four gaining experience in various forms of psychotherapy.

The organisation of the post was delegated to the junior concerned, under the supervision of

the clinical tutor. The option of attending a course outside the area in one form of psychotherapy was also considered, but rejected as it would leave too little time for clinical sessions and supervision.

One idea the trainee had was to obtain experience in as many forms of psychotherapy as possible and to fulfil all of the College guidelines. Though desirable, this idea was rejected as being impractical in the time available. Instead it was decided to concentrate on three forms of intervention, determined by availability and the trainee's interest.

First, brief dynamic psychotherapy – individual supervision with the nurse therapist was arranged. In addition, the supervisor agreed to select suitable patients from her own lists. Treatment was begun with two patients, with two others having been assessed by the trainee as being unsuitable for brief work. One patient dropped out prematurely. Unfortunately, the supervisor was taken ill, with no prospect of return for several weeks, prior to the second patient completing. A clinical psychologist with a mixed perspective was approached to step in.

In addition the trainee simultaneously organised a personal/training therapy with a privately practising (retired NHS consultant) psychotherapist. This was paid for by the trainee.

Second, the trainee took part in the systemic family therapy team, consisting of a consultant, two nurses and a clinical psychologist, as part of the child and adolescent service. The trainee acted as a team member in the interventions and discussion, rather than merely observing.

The remaining slot was in a psychosexual clinic, run by one adult sector team, working with an experienced nurse co-therapist, and using existing supervision arrangements (consultant/peer supervision). Five couples with a variety of problems were seen and treated.

Apart from the interruption due to the supervisor's illness, the main difficulty experienced was one of 'changing cognitive set', that is alternating between these quite different approaches (not forgetting old age psychiatry too). This occurred both at the outset, with need for rapid assimilation of concepts and terminology; and again when one form of intervention (brief psychodynamic therapy) emerged as a personally preferred method over the others for the trainee.

Discussion

The fact that several trainees were unable to attend the supervision group after the nurse therapist had allocated time for this was disappointing. If this form of training is seen as important then proper arrangements for cross-cover or rescheduling of the whole team's

activities may need to occur. The College guidelines (Grant *et al.*, 1993) suggest that one half day per week is made available for treatment and supervision. As other work seems to easily encroach on this, perhaps this should be considered as 'protected' time.

The psychotherapy 'job' did have the advantage of protected time. It provided a taster of several forms of therapy, and in this sense was a useful introduction, but achieved breadth rather than depth of coverage. The post covered most aspects of the College's recommendations on clinical experience in brief psychodynamic psychotherapy, family therapy, with some cognitive-behavioural therapy. It did not allow for the one long-term case recommended (because of time constraints) or group therapy, but could have easily been expanded to cover the areas of other experiences recommended. In retrospect, my view is that small amounts of protected psychotherapy time over several years is preferable. The arrangements are under review.

The recent NHS Executive Review of psychotherapy services (Parry & Richardson, 1996) called for a more systematic and coordinated approach to psychotherapy provision. The number and range of psychotherapeutic interventions being practised within the Trust, and which were available for trainees to take part in, was surprisingly large. Bradbury *et al.* (1996) found that psychiatrists tended to have little knowledge of local psychotherapy services, and so a thorough review of what is on offer would seem an important first step in organising training. This seems especially important in trusts where service provision is through several decentralised sites. Coordination by a named individual would seem sensible.

Without access to a consultant psychotherapist in this Trust, use of multi-disciplinary professionals was needed as a mainstay rather than augmentation in training. On a sociological level, this required some adjustment of role and traditional perception of status by both trainees and supervisors, but did not present problems. Such integration in training is entirely compatible with recent moves towards integration (as a step beyond coordination) of psychotherapy services (Holmes, 1995).

Costs and benefits

Issues of cost may have been implicit in the presence of a nurse psychotherapist and the absence of a consultant psychotherapist within the Trust. The fact that consultants are, per hour, the most expensive form of health professional is as relevant to training as it is to patient's treatment. Obviously the supervisor's time is an important factor to consider in assessing the

costs of psychotherapy training. Calculating the direct cost of, for example, the supervision group, would involve summing the wages of the supervisor and, say, 10 trainees for 90 minutes weekly for six months. This would produce a figure which might blithely be equated with the cost of treating two patients with typical doses of clozapine for a year. However, other activities within psychiatry (e.g. journal clubs, multi-disciplinary meetings) might well fare poorly in such a stark cost-benefit comparison.

Other indirect costs, for trainee and supervisor, include time spent away from other activities, or presumably increased work for colleagues covering, and travelling expenses. There is also a cost to patients in seeing a trainee rather than a more experienced therapist. However, these costs apply to any form of medical training.

Training is not an end in itself, and as the NHS Executive Review (Parry & Richardson, 1996) points out, the relationship between outcomes, therapist skills and level of training is far from clear. In terms of hard economics, benefits of psychotherapy training are hard to specify. Patients may be successfully treated as a result of the training and the trainee may continue to use the acquired skill (though again, less cheaply than others). Few trainees will become full-time therapists, but again this applies to many forms of medical training – dermatologists have been taught to deliver babies at some stage, though are seldom called upon to do this!

An argument could be made for such intangible benefits such as improved communication skills, more appropriate referral patterns, self-development and increased empathy with patients and colleagues following exposure to therapy. Our experience was that working relationships and morale improved as a result of the supervision group, and for some a psychodynamic perspective on strategic and medico-political developments with the Trust was achieved, with greater tolerance of uncertainty and conflict. I have found the exposure to individual psychodynamic and systemic family therapy extremely useful in day-to-day psychiatric work with patients with a variety of problems, and in discussions with patients' relatives. In addition it involved working more closely with individuals from other disciplines, facilitating teamwork in general psychiatry.

However, these benefits are anecdotal and difficult to quantify. It would be difficult to determine whether or not they lead to increased productivity or decreased absenteeism.

Finally, opportunities in psychotherapy were mentioned in juniors' job advertisements. This may have been one factor in improved recruitment, with a direct benefit of reduced costs for locum payments.

Conclusions and recommendations

This exercise demonstrates that it is possible to introduce psychotherapy training even where resources are seemingly sparse, and that doing so can reap benefits extending beyond psychotherapy itself. It is not presented as an ultimate solution to a widespread deficiency in training, but as a start.

In this instance a reconnaissance showed that there were some suitable supervisors and several established forms of psychotherapy that juniors could take part in. Some organisation, flexibility and a commitment to training were all that were required. This could be repeated elsewhere and improved upon, according to what is available locally (e.g. by incorporating more cognitive and group therapy plus experience with long-term cases). This would require planning the training over a longer period than in this instance, and if extending our scheme we would incorporate more goal-setting and feedback as recommended in the NHS review (Parry & Richardson, 1996). Trainees' representative groups have echoed this need in the context of overall training (Davies *et al.*, 1995).

Guidelines are only guidelines, but it seems that in psychotherapy they are widely ignored. Perhaps as a profession we need to decide whether we value training in psychotherapy or if wish to leave this form of treatment to others. If we value it, then it is time to strengthen the implementation of the College guidelines, and perhaps introduce compulsory logbooks with

clearly defined goals and progress reviews in psychotherapy.

Acknowledgement

I am grateful to Dr Pauline Ruth, Assistant Clinical Tutor, for help with the manuscript.

References

- ARNOTT, S., WILKINSON, E. & AYLARD, P. (1993) A survey of psychotherapy experience among psychiatric registrars. *Psychiatric Bulletin*, **17**, 721–723.
- BRADBURY, S., O'BRIEN, I. S. & GOPPERT, M. (1996) Psychotherapy: a survey of psychiatrists' attitudes, beliefs and practice. *Psychiatric Bulletin*, **20**, 15–19.
- DAVIES, S., DAWSON, P. & SHARP, C. (1995) Collegiate trainees committee position on structured training. *Psychiatric Bulletin*, **19**, 455–458.
- GRANT, S., HOLMES, J. & WATSON, J. (1993) Guidelines for psychotherapy training as part of general professional training. *Psychiatric Bulletin*, **17**, 695–698.
- HAWLTON, R. J. & TRACY, D. (1996) Survey of psychotherapy training among psychiatric trainees. *Psychiatric Bulletin*, **20**, 536–537.
- HOLMES, J. (1995) The integration of psychiatry and psychotherapy. *Psychiatric Bulletin*, **19**, 465–466.
- HWANG, K. S. & DRUMMOND, L. M. (1996) Psychotherapy training and experience of successful candidates in MRCPsych examinations. *Psychiatric Bulletin*, **20**, 604–606.
- PARRY, G. & RICHARDSON, A. (NHS Executive) (1996) *NHS Psychotherapy Services in England: Review of Strategy Policy*. London: Department of Health.

Stephen Paul Davies, Registrar in Psychiatry, St Cadoc's Hospital, Lodge Road, Caerleon Gwent