Foundation Year 1 and 2 trainees are assessed with direct observation of procedural skills, clinical evaluation exercise (mini-CEX), case-based discussion and multi-source feedback (mini-PAT). I had no problems completing mini-CEX and case-based discussion because of the weekly educational supervision sessions. I was encouraged to experience other services within a multi-disciplinary team, hence the multisource feedback was truly multidisciplinary. I was able to appreciate what each discipline brings to care and when, why and how they are accessed. Regarding direct observation of procedural skills, only simple procedures could be undertaken, although the same standards were achieved in general regardless of complexity.

Achieving the overall 'generic' competency standards did not pose any problems, although 'acute care' competencies were challenging. For mental health problems, the senior house officer would take responsibility. For physical problems, I found there was the limitation in treating physical problems in the psychiatric setting. I felt that not having on-call commitments and the Trust guidelines not allowing independent prescribing was restricting; however, subsequent feedback from senior colleagues has shown that overall development has not suffered.

On reflection, I have enhanced my patient-centred approach by appreciating the circumstances of those with mental health problems. I have been able to discuss psychiatric referrals of variable quality and have been able to educate others where a mental health multidisciplinary team opinion might be of value, who in the multidisciplinary team can best provide this and what information adds to the quality of their response. I also appreciate why physical problems receive limited treatment in psychiatric settings. A growing number of doctors working in diverse specialties will increase understanding of how others work, leading to better working relationships and ultimately improving care.

The new training structure in the UK has received criticism, but my experiences have converted me to be its cautious welcomer. I await my application to psychiatry specialty training with interest.

Declaration of interest

None.

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What is it about dynamic psychotherapy?

The new Modernising Medical Careers agenda in the UK raises concerns about maintaining the standard of psychotherapy training (Mizen, 2007). In 1993 the Royal College of Psychiatrists made psychotherapy a mandatory rather than recommended work experience and there is now a competency portfolio outlining requirements for trainees. However, startling data have been revealed recently, showing that 91% of senior house officers did not meet the requirements of the Member of the Royal College of Psychiatrists (MRCPsych) exam regarding psychotherapy training and 23% were not even aware of them (Agarwal *et al*, 2007). The quality and variability of psychotherapy experience in training have been surveyed in several papers (Podlesjka & Stern 2003; Carley & Mitchison 2006; Pretorius & Goldbeck 2006), and some solutions to practical problems with its provision have been proposed, for example, consultation from a consultant psychotherapist, utilising feedback from trainees, and focusing on practicalities and logistics at a local level (Wildgoose *et al*, 2002; Mitchison 2007). However, little has been said about trainees' own experiences of undertaking supervised practice in psychodynamic psychotherapy. This paper discusses trainees' outlook on psychotherapy training schemes.

Case study 1

> 'After sitting in a supervision group over the recommended 6 months, listening and trying to sound like I understood, asking questions, and more listening, I eventually plucked up the courage to find the waiting list, read a few assessments and pick a name. We discussed it in supervision. I started. The first session was easy; meeting, greeting, talking about the boundaries, the rules and expectations. I talked, [the patient] talked, it was great, and we both left feeling positive and empowered. The next session it was [the patient] and me in the room. I imagine we were both thinking, 'What am I doing here?' I wrote everything down afterwards. I wanted to get it right. The session after that [the patient] did not attend. What followed over an 18-month period was a growth, an intense emotionally charged experience of being in that room, sitting on my hands, biting my lips, controlling my face, wondering if I was being too 'cognitive'? Sometimes feeling completely rubbish and sometimes feeling like the best therapist that ever lived. I had not previously been so entangled in a patient's internal world.'

Unlearning and relearning

The wealth of literature is testament to the general feeling that psychotherapy is different from the rest of

education & training

psychiatry training (Wilson, 2001; Das *et al*, 2003) and trainees may be apprehensive about approaching it (Mitchison, 2007). The mystery surrounding psychotherapy, particularly psychodynamic psychotherapy, is perhaps caused by the fantasies it evokes in any film-loving, book-reading individual: smoky rooms, couches, beard stroking, and being asked penetrating questions such as, 'Tell me about your childhood'. Everyone is a little scared of being analysed. Therefore, to break through the boundary between psychiatry and psychotherapy is to take a leap of faith.

Participating in Balint or supervision groups can be bewildering. The language, the linking of hypotheses with feelings, is far removed from discussing a practical management problem in an out-patient setting. Trainees also have practical concerns, such as where to write the plan, what happens if we can't always get the same room, how strict to be about timing, what if we meet our patient in the supermarket, etc. Our actions towards a patient are not ordinary human exchanges; common courtesies in a psychodynamic setting come under scrutiny for transference implications.It provokes anxiety and lowers one's spirits to have to admit to oneself that previously valued skills are not required and new skills need to be learnt so that the theory and language make sense. To the patient, the therapist is the expert, and yet they are not, making some trainees sensitive to feelings of inadequacy or incompetence.

Time to reflect

In supervision and through the process of reflection, a trainee can construct a detailed and highly individualised formulation for their patient. Seeing a patient for an hour each week for a year is an extraordinary opportunity to tune into their affective and emotional experience, understand how they see the world and how they relate to it. However, in the case study above the therapist cannot escape her own powerful feelings towards the patient, the therapy and the supervision, which may manifest as anxiety, avoidance or loathing towards the patient or supervisor.

Supervision involves honest expressions of emotions, discussions of boundaries, disclosure of thoughts and the unspeakable problem of exposure of weakness in front of colleagues. Trainees have to learn how to reflect on such intense experiences, develop their self-awareness and manage their own feelings, while continuing to work faced with disturbance. Psychodynamic psychotherapy offers some creative freedom, but it cannot be taught in a didactic manner. It is a process one has to live through and then reflect on.

Case study 2

> 'I remember leaving the psychiatric intensive care unit every Friday afternoon to sit in a group talking about other people's patients and feeling guilty as if I was shirking my real work. To make matters worse, my first patient never attended so I spent quite a few months discussing the non-attendance of someone I'd never met, which when compared with the pressing challenges of working on a psychiatric intensive care unit, seemed ludicrous on occasion. It was really hard to slow down, change my mindset and see the experience as just as important for my training. I had this gnawing sense of being idle and not really doing anything.'

Psychotherapy can be seen by trainees as a 'soft option', less worthy of one's time compared with the 'fire-fighting' taking place in acute psychiatry. As trainees, we found it difficult to justify time spent on psychotherapy. Trying to explain to the nursing staff that you are off to do psychotherapy, turning off your bleep for an hour twice a week and sitting in a sometimes empty room thinking seems to run against the culture of acute psychiatry. If the client does not turn up, do you stay, and use the time to think about them? Can you justify thinking for 50 minutes when you know there is pressing ward work? After seeing the client, while processing the session, you find yourself rushing back to your ward or department hoping you have not missed too much. Can you make sense of intense countertransference feelings before you pick up the duty bleep?

Case study 3

> 'I saw my patient over three jobs on different sites. One post was particularly tricky as I had to shift from being on-call at the emergency clinic to being a calm reflective therapist in the space of under an hour. I had the frustrating task of finding someone to take the bleep on a Friday afternoon and a fraught drive through London with lunch in the car on the way. Once, I started a post to discover that I was going straight on nights, I'd said to my patient the week before 'see you next week' and now had to cancel the session with little notice, no explanation and deal with the fall-out because the rota had not been available in advance.'

Practical challenges

It is hard to commit to a weekly slot for a year while changing jobs, moving hospitals, doing nights and cross cover. Sudden changes in rotas and other factors out of the trainee's control can disrupt therapy. Picking a day that offers minimal disruption to your working week, that is convenient for your patient and does not mean you are working over the European Working Time Directive is complicated. Protecting the time for both you and your patient can result in developing an important skill in boundary management but the trainee's lack of control over their timetable may be reflected in therapy as impotence and a lack of professional boundaries.

Conclusions

The differences between dynamic psychotherapy and 'real psychiatry' may cause dissonance and disquiet in a psychiatry trainee. Dynamic psychotherapy involves a new language, bearing uncertainty and valuing this state as a creative process rather than a failure of 'hard science'. Disturbing emotions may emerge at this developmental

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phase, threatening clinical neutrality. Trainees may become anxious when disturbed by their patients, dreaming about them, reflecting on their own feelings about them, or uncertain about the patient's feelings about themselves. They may come to believe that psychotherapy has the capacity to alter one's mind. Yet this experience can be engaging, inspiring and enjoyable. With supervision and time we found our training in psychodynamic psychotherapy gave us a special understanding of the mind, and therapeutic skills that we could use elsewhere in our practice. Psychotherapists and clinicians need new skills and confidence to move away from the urgency to 'do something' to allow space to think with the patient. We were encouraged about our therapeutic skills by the simple construction of therapy described by Peter Lomas: 'Therapy is at best, I believe, the outcome of two people meeting regularly over a long period of time during which one of them, respecting the ordinary conventions of conversation and behaviour, has tried to help the other feel better and lead a better life' (Lomas, 1993). We believe that psychodynamic experience for trainees must be protected as it is as important as practical skills and theoretical knowledge.

Declaration of interest

None.

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