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Trainees' forum

The psychotherapy clinical seminar at the Maudsley Hospital

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The open psychotherapy clinical seminar at the Maudsley Hospital is a weekly teaching event in which psychiatric trainees can present a case from their general psychiatric work to a forum chaired by a consultant psychotherapist. The seminar has a history stretching back to the 1960s when Heinz Wolff, Henri Rey and Murray Jackson taught in the Maudsley Psychotherapy Unit. The seminar is currently chaired by Nicholas Temple. It draws on a tradition of teaching psychotherapy which owes much to the pioneering work of Michael Balint. The psychotherapy training seminar which he developed is well described in the appendix to *The Doctor, his Patient and the Illness* (Balint, 1957). A trainee presents a case with particular emphasis on his or her feelings about the patient. The trainee's counter-transference is used as the raw material for the seminar's discussion of the patient. Balint adopted this method for teaching psychotherapy to a variety of professionals including social workers, general practitioners, and medical students. As Pedder (1986) pointed out, it is a model which has been very influential in British psychotherapy training.

During my nine month registrar attachment to the Psychotherapy Unit at the Maudsley Hospital, a colleague and I recorded details of the cases brought to the seminar and the ensuing discussion. Of the 16 cases presented over this period, ten were out-patients and six were in-patients. The presenter was usually a senior house officer or registrar in psychiatry, although other members of the multi-disciplinary team involved in the patient's care were encouraged to attend. In reviewing these presentations I want to concentrate on some of the repeated issues that emerged in the interaction between patient and staff.

Findings

The most consistent finding was that the particular patient had somehow got "under the skin" of members of the clinical team. The patient had usually secured more investment of time and energy from staff members than other patients. He or she had become a "special patient", to borrow a term from Main's (1957) seminal paper on patient-staff interactions 'The Ailment'. For in-patients, this special status was evident in the way the patient was the subject of a disproportionately large amount of staff discussion time, for example in nursing handovers or weekly management rounds. The patient occupied a prominent place in the minds of the ward staff. In the case of out-patients, the patient had usually aroused particular concern in the doctor and was seen more frequently than other patients.

How does a patient evoke such an investment of time and energy from his or her carer? The evidence from the seminar presentations was that this investment was closely related to the powerful feelings which the patient evoked in the carer. I want to consider these responses further.

It was not uncommon for the presenting clinical team to express uncertainty regarding the patient's diagnosis. This was particularly noted when patients with disordered personalities were presented. There was often a palpable uneasiness among the presenting team that the patient was not genuinely mentally ill and therefore did not warrant psychiatric care. It was often these patients who elicited the strongest feelings of resentment among staff. The question of whether the patient's behaviour represented "madness" or "badness" repeatedly raised its head in staff discussion. Put crudely, behaviour due to madness was treated sympathetically whereas behaviour due to badness evoked anger and sometimes a wish to punish the patient, for example by curtailing liberties. The goal-directed and often attention-seeking behaviour of some of these patients attracted the label "manipulative" – an overused word which, in my view, is fast becoming synonymous with "I do not like this patient".

An example of such a patient was a 34-year-old woman who had over the previous four years engineered repeated admissions to general medical hospitals in London by simulating renal colic and other medical emergencies. In the two months prior to her presentation to the seminar, she had had three separate admissions to a general psychiatric ward. The first of these followed a life-threatening overdose of warfarin. She did not appear to be clinically

depressed while on the ward. She angered staff by various attention-seeking manoeuvres such as deliberately setting off the fire-alarm. Within a few days she said that she felt fine and requested discharge. Careful assessment of her mental state did not reveal any wish to harm herself and she was allowed to leave hospital. One week later, she was back, having taken another life-threatening overdose. Again within three days she claimed that all was well and that she no longer needed help. It is not difficult to imagine how this patient generated much frustration and anger among staff members, who felt that they were being used in some dangerous game played by the patient. It was important for the staff to recognise these feelings, so that their understandable frustration would not prejudice discussion of how to contain the patient's self-destructive behaviour effectively. In several other cases, the recognition of the negative feelings which a particular patient evoked in staff seemed to free the staff to make more informed and sensitive decisions about the patient's care.

A repeated pattern observed in the seminar was the way a patient would choose one member of staff to be idealised as a perfect carer. This member of staff, who was often the key nurse or registrar, would be made to feel special by, for example, being told information which the patient claimed no-one else knew. The patient would denigrate other members of staff so that the idealised figure was tempted to believe that he or she was the only person who really understood the patient. One of several examples of this pattern of interaction was the case of a female patient who "fell in love" with the male registrar so that it was felt prudent for the registrar to see the patient in the presence of a female chaperone. The patient's affection for the registrar contrasted sharply with her dislike of the male charge nurse. Such splitting of the staff into idealised and denigrated objects can easily provoke staff conflicts, as was well described by Main (1957). Healing such rifts can be helped by sensitive understanding of the role of the patient's psychopathology in provoking them.

Just as an individual member of staff can be idealised by a patient, so a whole ward or unit can be held in a similar light. For example, one patient with a long history of contact with the hospital felt that he was only properly cared for by the locked intensive care ward. He despised the open general ward where he was usually transferred once his acute level of disturbance had subsided. He rewarded the intensive care ward with favoured status. This status was often reciprocated, and there were numerous instances in which this patient was given more lee-way and more time than other ward patients. Thus the favoured carer or ward can find it difficult not to collude with or reciprocate the patient's idealisation. In addition, the carer may feel under pressure always to live up to the patient's expectations of ideal care. The carer may feel indispensable and then the prospect of "letting the patient down", for example by going on holiday or changing jobs, arouses considerable concern and guilt. This was often a focus of discussion in the seminar and some staff members found it helpful to recognise that the patient was expecting them to be more than they were able to be.

Comment

All the patients presented to the seminar were difficult patients in whom the clinical teams had already invested much therapeutic work. It was noteworthy that in many instances the help of the seminar was sought when the clinical team had reached some form of impasse or critical period in the patient's management. These were times when a psychodynamic perspective appeared to be particularly appreciated. This has implications both for the teaching of psychotherapy to trainees and for the wider provision of such seminars within NHS hospitals. Sklar (1985) discussed some of the issues faced by consultant psychotherapists in meeting such needs. The teaching of psychotherapy to trainees cannot be divorced from the larger question of the place of psychotherapy within general psychiatry, which was well addressed by Freeman (1989). In my view, an awareness of psychodynamic issues in general psychiatric practice can foster sensitive and constructive management of patients. The psychotherapy clinical seminar provides an opportunity for psychiatric trainees to develop such an awareness.

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