Those of us in the field should therefore make a concerted effort to inform each other of developments and projects.

The creation of a profession of adult psychotherapist

It is our habit to hold on to our original profession, while also being psychotherapists; I think the time has come for us to put our weight behind the creation of an adult psychotherapist category of employment in the Health Service. The precedent is there, as is indeed the salary structure, child psychotherapists being employed on the same terms and conditions as clinical psychologists. At the latest count over 20 such posts already exist, all supposedly 'anomalous'. The profession therefore already exists *de facto*.

The confirmation of adult psychotherapy as a profession would provide a firm base for these individuals already employed in the Health Service under a variety of other odd titles and categories, and prevent their eventual loss to the Health Service; it would also provide the coherency for a national network that is at present divided, to the detriment of psychotherapy, between psychiatrists, psychologists, social workers and others who have a dual allegiance to their professions and to psychotherapy.

Public relations

I think as a profession we psychotherapists are not good at public relations. Our anxiety about publicly exhibiting ourselves, which can degrade our professional standards, as well as creating transference problems with our patients, is possibly exaggerated by lack of experience and training in work with the media, and fear of what our colleagues will say if we do appear. Our working traditions are peculiarly private and therefore an obstacle to developing public skills.

In the post-dependency national culture, there is now a greatly increased interest in all matters psychological, and informative radio and television programmes undreamed of ten years ago are now commonplace. There is greatly increased demand by the public and the media for information about psychological aspects of everyday life. We should make ourselves available for this work. Television, radio and the press are important educational tools in the field of personal and community mental health, and should be used wholeheartedly.

Comment

We have a choice – to continue in our "comfortable" settled ways of fighting each other as biological psychiatrists or psychotherapists, or else to cooperate in a new mental health venture. I hope that this contribution will contribute to the latter outcome.

References

MILLER, E. (1986) Making room for individual autonomy. In *Executive Power* (ed. Suresh Srivastva). London: Jossey Bass.

TYRER, P. (1988) Legal repercussions in prescribing benzodiazepines (Comment). *Bulletin of the Royal College of Psychiatrists*, **12**, 190.

Psychiatric Bulletin (1989), **13**, 434–436

The group at work

DAVID FISH, Registrar in Psychiatry; GRAHAM FULLER, Registrar in Psychiatry; SUMI HANDY, Registrar in Psychiatry; RICHARD ING, Registrar in Psychiatry, Walsgrave Hospital (correspondence); MEG KERR, Senior Registrar in Psychiatry, Central Hospital, Hatton, near Warwick; ROBERTO RUSCA, Registrar in Psychiatry, IAN SHAW, Registrar in Psychiatry; and RAZA SILVEIRA, Consultant in Child and Adolescent Psychiatry, Psychiatric Unit, Walsgrave Hospital, Clifford Bridge Road, Walsgrave, Coventry CV2 2DX

Experience in group therapy is recommended by The Royal College of Psychiatrists (1986) as an important aspect of training in psychiatry. However direct experience is unusual. It was reported in the *Bulletin* that a group formed by trainees in psychiatry to study the group process found a demand for personal therapy for its members (Whewell, 1987). In this paper a group is described which attempted to meet both needs.

How it came about

The climate for the group was fostered by the following factors: the presence of a large number of trainees based at Walsgrave Hospital and the daily meetings for training purposes promoted a good group identity.

A senior clinical psychologist organised courses of lectures followed by experiential groups to demonstrate the group process.

Ideas about a group were further aroused by the presentation of a paper at a Journal Club meeting entitled 'Mentally Ill Doctors' (Rucinski & Cybulska, 1985). In the discussion which followed some doctors were impressed by the idea of self help groups.

The group was finally initiated by a registrar with a career interest in psychotherapy. She canvassed colleagues and her consultant and arranged a meeting to discuss formation of a group. At this meeting the group contract was formed. It was agreed that membership would be closed. The group would run for a year. Meetings would last 90 minutes each with no distractions.

What happened

Initially the group had nine members, all being trainee psychiatrists. There were three females and six males. Experience ranged from first to fifth year trainees. There were 27 meetings of the group as on three occasions there was failure to reach quorum. One member left after the fourth session to attend a course, one member left after the 14th session to move to a new appointment and one member seldom attended after the 20th session for reasons which will be mentioned later.

In describing what happened we have decided to concentrate on three main issues which we feel were usually apparent in the group sessions and that they are relevant to a group of trainee psychiatrists.

Group identity

It is interesting to note that the group identity survived despite many pressures. To start with people's expectations of the group were vague. Then, almost immediately, the initiating member was lost to a recognised group therapy course, and bereavement issues, mainly of anger, followed, raising doubts about group survival. These abandonment issues were successfully worked through and by the end of the first term the identity was sufficient to allow self disclosure. Unfortunately near the start of the second term a second member was lost and this resurrected issues of loss but on this occasion the group was better able to deal with them.

During this time it became apparent that there were divisions within the group. There were pairings which constantly changed and which were to a significant extent brought in from outside. The pairings affected group dynamics; for instance one member of a pair protected the other against scapegoating and in another pair scapegoating was passed to a less established member. There were also polarisations which were relatively fixed and included experienced v. less experienced, male v. female, and talkers v. non-talkers.

Group identity may have been further threatened by one member wishing to invite an outsider to the group although it had been clear that the group was closed. This was not allowed. The member in question was absent for most of the third term.

Approaching the end of the group the quorum had to be reduced to four because of impending absence through holidays. The final sessions looked at what the group had achieved.

Despite these problems for most of the time the group identity held good, allowing discussion with self disclosure.

Self disclosure

Initially there was some discussion as to whether personal issues should be brought to the group. It was felt they could be if they related to inter-personal functioning within the group. Some members wanted a personal therapy group, others did not.

The difficulties of talking about oneself soon became apparent when feelings of anger were aroused over the departure of a member.

Later in the first term one member spent most of the group time on a personal agenda. Some members were worried that the group could spend so much time on one issue but others worried that they might have to follow suit.

In the second term things improved in that trust between members increased. Members were able to talk about personal relationships with parents and partners and this appeared to be beneficial. This confidence continued into the third term.

It was impossible to forget that the group members knew each other outside the group. The ground rule that information from the group should not be discussed outside it did promote trust and hence self disclosure.

Rivalries and friction

Reality based issues such as exam success and failure, career prospects and worries about renewal of contracts were brought to the group. Feelings of envy from some and of guilt from others hampered support for people who had anxieties about these subjects. The principal anxieties were about professional failures which were equated to personal failure, and time was devoted to discussing the point that things were not quite so clear-cut and that single

professional failures should not be such a large blow to self esteem. Members who were happy with their lot in life found themselves to be the subject of scapegoating on the basis that they must be denying their problems.

Many of the group sessions revolved around themes relating to power and powerlessness. This involved the frustration and competition of being junior doctors as well as the responsibilities of the high status involved. Much of the related anxiety was projected onto the consultants including the group leader. Projection was also used as a defence against expressing tensions within the group.

Direct conflict was avoided in the group; however, acting out by non-attendance was used as an indirect form of aggression as it jeopardised the group. Also scapegoating of one person in particular was evident and had to be highlighted and defused by the group leader.

Discussion

What is the justification for a group such as ours? Might the training needs of group psychotherapy be better met by observations of a formal therapeutic group?

It seems to us that participation in a group gives a different perspective than observation alone and that this is useful. Group phenomena can be directly experienced only through the work of the group and we feel our group succeeded because training was not the sole, or even major, aim.

The group was formed by the choice of its members and took as its material a theme of mutual and individual support. The relevance of this to the members contributed to their commitment to the group.

The group was carefully planned. The boundaries were very important. The venue was constant. The room was comfortable and well heated. There were few distractions. The timing suited most members most of the time. Although it was not practical to avoid other group members there was an avoidance of outside discussion of group issues. All these factors added together to make group meetings more relaxed and more trusting. In a smaller rotation than ours it would be even more important to set boundaries.

The group leader was largely chosen by the members and this was a crucial element. Having trust in the leader was a great help. The group, at times, took up a paranoid position which, because of the trust, could be ventilated and resolved. There were quite a few characteristics of the leader which we thought were helpful. He was newly appointed and so was not closely identified with the consultant body. He had an interest in psychotherapy, had previously been giving psychotherapy supervision and, very importantly, he was willing to do it! In the absence of such a person it may be better to enrol someone from outside the training area.

Our measurement of success depended on how the expectations of the group members had been fulfilled. The first level, to experience group work as part of training in psychiatry, was fulfilled in that most members continued in the group to experience it to its end. The second level, to look at work related problems and to explore and improve work relationships, was fulfilled in that there was considerable discussion about these topics. The third level, to get to know and understand others, was partially successful in that group members seemed to have a better understanding of each other by the end of the group. The fourth level, to gain insight and to work through one's own agenda, was more difficult to measure in the group as a whole; however some of the members did say that they thought that they now had new insights into their feelings and behaviour. It seemed therefore that most of our expectations had been fulfilled.

We feel that our experience in holding a group puts us in a position to make recommendations to others who are considering such a venture and we have summarised them here. Firstly, it is essential to create a climate of interest in group work. Secondly, the planning of the group must involve all the group members in establishing clear limits and boundaries. Thirdly, the selection of a neutral group leader is of great importance. Finally, all the above will foster a commitment to the group.

We found that the group provided us with personal satisfaction as well as training. In line with the College recommendations it seems that an experiential group would be useful for training and supplements theoretical input.

References

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

RUCINSKI, J. & CYBULSKA, E. (1985) Mentally ill doctors. *British Journal of Hospital Medicine*, **33**, 90–94.

WHEWELL, P. (1987) Psychotherapy training for general psychiatrists in the periphery of a region. *Bulletin of the Royal College of Psychiatrists*, **11**, 370–372.