Conference reports

Association of University Teachers of Psychiatry — Fourth Conference on Teaching Dynamic Psychotherapy

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The fourth AUTP conference on Teaching Dynamic Psychotherapy took place in University College, Oxford from 14 to 16 April 1988 on the theme of *Formal Courses in Psychotherapy*. The location gave me a chance to renew my acquaintance with the dank and awful Shelley memorial which I had had to pass on my way to the baths when an undergraduate in the college more than 40 years previously, but the programme did not leave a lot of time for nostalgia, especially as I had been given (in return for what crime I do not know), the task of delivering the final summing up at the end of the meeting.

The tone of this gathering was both friendly and serious; psychotherapists have a history of wrangling and polemics but this gathering, though lively, remained humorous and constructive. Perhaps this was because five out of six of the participants came from outside London, many from relatively isolated situations, and clearly found here a point of reference, sharing a common wish to learn from each other. There was an undertone of envy for the great metropolis with its psychoanalytic palaces but during the meeting some of this shifted to admiration for South Trent, where four consultants over many years have set up together an excellent in-service training programme within the NHS.

The first conference paper was a grand survey of existing training schemes presented by Jonathan Pedder. The criterion for inclusion was participation in the Rugby conference, from which a list of 24 courses based upon psychoanalytic theory was garnered. The style and content of these courses vary enormously. Most of them accept any health professional for training but those with university links and offering MScs have to restrict intake to graduates. Nearly all courses demand individual therapy from their participants, at varying levels of intensity, but a few leave this to the trainee's own choice while providing some group experience. All but the most academic courses, which are courses *about* psychotherapy rather than training for it, rely heavily on supervised work, usually of one or two long cases. Even the most clinically-based courses, which usually award diplomas, involve some theoretical reading around psychoanalytic theory. It seemed that only a few courses incorporate any study of alternative modes of therapy such as family, marital or group work, or of alternative theories such as cognitive, behavioural or humanistic psychology, although many of their participants will have exposure to these in their work situations or may be involved at other times in courses on these subjects. Graduation from these courses may follow formal examination, as is required in the MSc courses, or may be based essentially on supervisors' reports and the writing up of cases. Independent courses outside the NHS are usually three to four years long, involving two or three evenings work per week, whereas the MSc courses tended to be half day release courses over two to three years. Only the Tavistock (not represented at this meeting) offers day-time training.

The first evening of the meeting was devoted to a debate on the motion that 'Formal Courses are Antithetical to the Spirit of Psychotherapy'. Jeremy Holmes, in proposing the motion, demonstrated brilliantly how interpretation (in this case more Hegelian than Freudian), can be used to destroy meaning and create apparent assent, and the motion was passed by a handsome majority. This did not, however, stop the remaining one and a half days being devoted to the subject of formal courses.

The pattern on Friday continued with plenary sessions, followed by general discussion, followed by small groups. Charles Lund, on the basis of his own experience in the Aberdeen, Leeds and now Newcastle courses, gave a thoughtful paper on the many conflicts of interest, infirmities of purpose, cloudily articulated aims and false expectations that are experienced both by those planning and those attending them. The long and deeply felt discussion which followed his paper showed that his experience had many reverberations for those involved in the planning and running of such formal courses. In the afternoon four trainees shared their doubts and pleasures about the diverse courses which they had chosen. These were, respectively, an exhaustive, exhausting and expensive (over £12,000) psychoanalytic training, the wonders of the NHS-funded South

Trent scheme, the first impressions of the new Oxford University Certificate course and (perhaps out of place in a meeting devoted to individual therapy), the experience of the Institute of Family Therapy training. The small groups which followed were meant to discuss the task of giving advice about psychotherapy training. In my own group the consensus was 'don't' but we did realise that we should know more than we have done up to now about what courses are available and what their requirements are.

The Saturday morning session was run by an educationalist, David Jacques of Oxford Polytechnic. In this case, he was being consulted, in front of the plenary session, by a course convener (Frank Margison) about some worries about his course. The quick-fire process whereby the basic questions were identified was impressive and the activation of parallel working groups of three and then of six in the audience was a good demonstration of one of the '53 approaches' to teaching which we were told are available. This experience highlighted one of the undercurrents of the whole meeting, which was the recognition by this gathering of teachers of how little we have been taught or know about teaching. Another recurrent theme was our similar lack of training in political and managerial skills.

Faced with the impossible task of summarising the above and of reflecting also the conversations over breakfast (except perhaps on the Saturday morning following the annual dinner, which was a bit hushed), coffee, lunch, tea and dinner, I opted for a patchy commentary rather than for any attempt at a condensation or synthesis. There were, I felt, some omissions. For example, in discussing courses, we had attended only to those aiming to produce psychotherapists rather than to those courses aiming to teach psychotherapists particular new skills. In discussing training we had been concerned with the development of individual clinical skills but had not considered the kinds of situations and the kinds of case loads that the therapists produced would be faced with. If consultant psychotherapists see their responsibility to be to their catchment areas rather than to those patients who reach them, then, in my view, much more attention needs to be paid to the development of NHS-relevant psychotherapeutic methods which means, in particular, a focus on time-limited work. Another omission reflects the poverty of academic psychotherapy in that no evaluative studies of teaching or treating were on the agenda.

Another point it seemed worth exploring in summing up the meeting was the way in which serious and complex issues were often enunciated in unhelpfully polarised dichotomies. For example, training courses were seen as either deep and narrow or broad and shallow as if, for example, there were none that were shallow and narrow. Here the best hope seemed to be for trainings that were broad with deep patches, but even this implies that breadth and depth have constant meanings. A course, for example, could be either deeply relevant or deeply arcane. Another such false opposition was in the idea that courses could be either practical or academic, the former being seen as producing incurious plodding practitioners, the latter at producing clinically incapable but informed graduates. Behind this lay some real practical difficulties in organising training and it seems important that courses pay more attention to the need for flexibility in their requirements, depending upon the varying opportunities for clinical work and supervision available to course members.

Another important theme which emerged throughout the meeting was a reference to a kind of implicit hierarchy in psychotherapy and psychotherapy training. This originated in Jonathan Pedder's discussing Professor Cawley's three levels of psychotherapy[1] and suggesting that these three levels were to be equated with three levels of training. This had aroused some discomfort, not entirely dispersed by the use of the word 'category' in place of the word 'level'. It seemed to me that practitioners of dynamic psychotherapy, (which is rooted in psychoanalysis, and in a psychoanalysis which has seen the frequency and duration of training analysis escalate over the past 30 years) have come to regard status very much in terms of criteria appropriate in this more specialist and esoteric world. Using a military analogy, it seemed that only a small number of psychotherapists, graduating from the Sandhursts of psychoanalysis, were recognised as Generals — five, four, three or perhaps two star Generals according to the required frequency of personal analysis in the training. The two to three year training courses were seen to generate more-or-less capable junior officers whereas, at the bottom of the hierarchy, are found the non-commissioned officers and poor bloody infantry of the social workers, community nurses and occupational therapists working under supervision. In place of this hierarchy, I suggested that therapy levels 1–2, in Professor Cawley's terms, would normally be recapitulated in the training, but that beyond this the world of psychotherapy should be represented by a range of mountains rather than by a single peak. The different summits would be occupied by practitioners of different specialist psychotherapeutic skills, including many specialising in skills particularly applicable to NHS settings. Others would be occupied by academic psychotherapists with an interest in the theory and practice and research study of all the psychotherapies and others by psychotherapists skilled in health care delivery, administration and survival politics. There seemed no reason to suppose that personal therapy more than once weekly would develop any of these skills (not that there is any evidence for its effect on clinical skills either, according to Macaskill[2]). The

psychotherapy practitioners of the future deserve to be taught and supervised by people having a full range of relevant skills.

The only sad note in this useful, enjoyable meeting was the saying goodbye to Sidney Bloch. He has played a leading part in the organisation of this AUTP meeting together with Mark Aveline (and on this occasion joined by Stuart Liberman and Bernie Rosen) as well as having been productive in so many other ways. He is due to leave these shores for Melbourne at the end of the year and took with him the warmest good wishes of all those at the meeting.

References

[1]CAWLEY, R. H. (1977) The teaching of psychotherapy. *Association of University Teachers of Psychiatry Newsletter*. January, 19–36.

[2]MACASKILL, N. (1988) Personal therapy in the training of the psychotherapist: Is it effective? *British Journal of Psychotherapy*, **4**, 219–226.

Management and comprehensive psychiatry

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4 November 1987 saw a multi-professional one day symposium in the North West Division *A Comprehensive Psychiatry Service: Norms, Resources, Boundaries and Problems*. Sponsored by Lundbeck Limited, over a hundred managers, psychiatrists, nurses and paramedical professionals attended.

Lack of leadership by psychiatrists reluctant to identify their skills and subject them to indices of efficiency was identified. They should acquire managerial skills, said Dr Digby Tantam.

Making perhaps the most important contribution of the day, Professor Steven Hirsch stated that indices of social deprivation correlate with psychiatric morbidity and should be the basis of service planning, as the College working party he chaired had recently concluded.

Professor Anthony Cox led a group of clinicians who described problems of under-provision, such as the 50% shortfall of College norms which child and adolescent psychiatry suffers. Mental handicap had too few beds but Dr Valerie Anness was content not to lead the team, whose main function was non-medical. Treatment of alcohol, drug, and psychosexual problems were areas limited by resources, as conspicuously, was psychotherapy.

Major requirements for intensive nursing in a structured environment, linking forensic and NHS provision, and absence of resources for the brain damaged and presenile dementia patients were also described.

The general adult psychiatrists' contribution as the major manpower input in clinical work was presented by Dr Sidney Levine. Much of the demand on time was, however, other than clinical.

Following lunch, Dr Douglas Bennett emphasised priority for those chronic patients with low social, medical and political status. Work with these individuals, their families and provision of occupation is neglected, he said. Shelter, support and avoidance of transinstitutionalisation on closure of psychiatric hospitals might be achieved with supervision of continuing care.

Dr Keith Bridges presented an evaluation of Douglas House, a hostel-ward in the community run by the University of Manchester Department of Psychiatry. He concluded that a spectrum of facilities are required in the community. The hostel-ward was cost-effective for those it served; only a few patients returned to hospital.

Managers Drs Baigal and Tunstall for the North West and Mersey Regional Health Authorities acknowledged the need for morbidity linked planning and performance indicator measurements of efficiency. Psychiatry funds were protected, we were assured.

Much interested discussion revealed anxieties on funding, lack of influence of psychiatrists in planning and, as Professor Hugh Freeman pointed out, the wholesale removal of social workers from the Maudsley Hospital showed the failure of collaboration with some social service departments. Voluntary organisations had an important contribution to community care.

The two chairmen of the day, Dr Donald Johnson and Dr David Enoch, concluded that the rush to close psychiatric hospitals without pilot studies and quality control of the emerging services, the failure to emphasise the role of chemotherapy in treatment and