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Development of psychotherapeutic training in learning disability

There has been an increasing awareness of the usefulness of psychotherapy as a treatment modality for people with learning disabilities and mental health problems over recent years. However, the difficulties involved in providing appropriate training and supervision in this field has resulted in a patchy and erratic development of service provision nationally (Royal College of Psychiatrists, 2004). A review by Hollins and Sinason (2000) of all the available published evidence found that nationally there was inadequate availability of psychological treatments for people with learning disabilities, that there had been few outcome studies published and most of the literature consisted of single case studies. They recommended that ongoing clinical audit, using standard outcome measures, should be part of learning disability psychotherapy service protocols, and that psychotherapy training and supervision should be made available to health and social care practitioners in the learning disability field.

Examination of publications to date reveals that there is evidence of a wide variety of psychotherapeutic techniques being used in this area. The use of psychoanalytic psychotherapy (Beail, 1998), cognitive therapy (Lindsay, 1999), art therapy (Rees, 1998) and other creative therapies, group therapy (Barber *et al*, 2000), family therapy (Vetere, 1993) and solution-focused therapy (Cooke, 2003) have all been described.

The Royal College of Psychiatrists produced training guidelines in 2001 on psychotherapy training for senior house officers (SHOs) (www.rcpsych.ac.uk/traindev/postgrad/ptBasic.pdf), and this included mandatory fulfilment of psychotherapy training objectives in order for them to enter for MRCPsych Part II. It also stated that other experience should be available in specialist posts. It is now mandatory for all SHOs in psychiatry to do 6 months in either child and adolescent psychiatry or learning disability psychiatry, and this has created some difficulties in our experience. Some SHOs entering via the learning disability posts may now only be there because it is compulsory, rather than because they have chosen to practise learning disability. Some of the particular difficulties identified by SHOs in Bristol (Quinn, 2002) have included:

- The underlying condition (the 'handicap') is usually not open to amelioration.
- They may not see sufficient improvement over a 6-month period to feel they have made a difference.
- Many of them stated that they felt more vulnerable working in learning disability psychiatry, because they found it more difficult to predict aggression in the patients.

It may be that SHOs feel less effective in learning disability because of the feelings of helplessness and powerlessness engendered by working with someone with a learning disability. The family dynamics of some of the situations they become involved in may be difficult and complicated to deal with. In addition they feel more vulnerable themselves than in some other psychiatric specialties. For all these reasons it was decided that SHOs needed a forum to which to take their difficulties and problems with working in learning disability psychiatry, and a Balint group was set up in Bristol 3 years ago.

Specialist registrars (SpRs) in learning disability may continue to require this kind of support, and in addition require specialist training in the use of psychotherapy with people with learning disabilities. The Faculty of the Psychiatry of Learning Disability of the Royal College of Psychiatrists has produced a document entitled *Psychotherapy and Learning Disability* (Royal College of Psychiatrists, 2004). This outlines the current national situation and makes recommendations for training, including clear and comprehensive draft guidelines for psychotherapy training for SpRs in learning disability psychiatry. However, it states that there may be difficulties in implementing these without a sufficient number of trained and experienced supervisors.

We therefore decided to develop a model of psychotherapy training that would attempt to meet the needs of both SHOs and SpRs working in learning disability psychiatry.

Method

Following discussions with the consultant psychotherapists in Bristol, it was decided that one way of providing training might be through a supervision group for both SpRs and SHOs, and an SpR in her last year of training for psychotherapy in Bristol was identified as a supervisor for

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the group. The group commenced in August 2001 and was attended by both SpRs and SHOs. It met weekly for 1 h at a time. An art therapist joined the group as co-supervisor in June 2002, and the group was discontinued in February 2003. The function of the supervision group was twofold. First, to provide a forum for the discussion of individual clients taken on by the trainees for psychotherapy. These clients were assessed initially by the SpR in psychotherapy as to their suitability for psychotherapy. Second, the group provided a forum for the discussion of case vignettes and psychotherapeutic issues arising out of trainees' clinical experiences, and thus performed the function of a Balint group.

As this was a new venture, we felt it was important to evaluate this properly from two perspectives: first, from the clinical outcomes for the patients; and second, from the training outcomes for the trainees involved. The evaluation of the clinical outcomes for the patients is not yet complete. This paper describes the evaluation of the training outcomes as experienced by the SpRs and SHOs.

A total of 18 questionnaires were sent out to learning disability trainees who attended the supervision group between August 2001 and February 2003. Out of these, 6 SpRs (100%) and 10 SHOs (82%) returned their questionnaires.

Results

All SpRs in Bristol were given an opportunity to work psychotherapeutically with people with learning disabilities. Five SpRs took on an individual patient, and one SpR had some experience working as a co-therapist in a group of patients with mild learning disability. SHOs felt that they were unable to take on patients for individual work, as they were limited in their 6-month placement. Also, the number of patients referred to psychotherapy was limited and they felt that SpRs should be given priority. Others felt that they were too busy with their Part II examinations and did not have the time, while some felt that they would not receive adequate supervision, as the supervisor was not from a learning disability background. No SHO actually took on a patient for psychotherapy; however, they were encouraged to bring individual case vignettes for discussion.

The following comments were expressed by trainees when answering the questionnaire:

- 'I didn't feel that I had enough experience and the correct level of understanding'
- 'Communication wasn't always easy which made me uneasy'
- 'I felt uncomfortable talking about my feelings but hoped that this would get better the longer I attended the group'
- 'I realised that unconsciously there was a conflict developing between my theoretical knowledge and my emotional understanding of people with learning difficulties'
- 'I felt more able to support staff by working through difficult times and not being punitive, resentful and frustrated by these clients'

Also, all trainees felt that their experience had contributed to improving their clinical practice, and this was rated as >6 on a scale of 1–10 by all trainees.

General comments were then requested from the trainees regarding the supervision style received. Most trainees felt very comfortable attending the group and felt that the environment was relaxed. This encouraged them to speak out as they felt very supported in the group. Most trainees felt that their contributions to the group were valued; however, some of the SHOs felt that they did not know enough about people with learning disabilities, and as a result felt unable to contribute to the group.

All the trainees rated the supervisor between 7 and 8 on a scale of 1–10, and the comments about the supervisor included one indicating that she was not from a learning disability background and therefore not necessarily the most appropriate person to act as supervisor. However, others felt that there was a limited difference in the psychotherapeutic processes involved in working with people with learning disabilities compared with the general population, and therefore they felt this did not affect supervision style.

Discussion

A recent article by a previous cohort of SHOs in Bristol (Graham *et al*, 2004) discussed themes experienced by SHOs working in learning disabilities. These included:

- helplessness and inadequacy
- powerlessness and futility
- avoidance.

We found that these themes mirrored some of the responses we received in our survey.

The results of this survey have been extremely revealing as to the need for supporting our trainees coming through their learning disability training. Trainees participating in the survey felt that the experience had contributed to improving their clinical practice. A Balint group was recommenced 18 months ago for all learning disability SHOs training in Bristol. This has been run successfully by a senior SpR on a fortnightly basis. The SpR receives monthly supervision from a generic consultant psychotherapist.

The resulting feedback indicates that the SHOs value this forum to bring forward their feelings and attitudes for discussion. There is a feeling of openness, acceptance and warmth generated among participants by the end of their 6-month placement in learning disabilities, which appears to replace their initial feelings of guilt and avoidance. Trainees appear less fearful of their subject matter and more integrated and ready to communicate their emotions.

We have recently commenced a Balint group for SpRs working in learning disabilities which meets monthly. This venture is still in its early stages, but so far the opportunity to meet has been welcomed and attendance has been very good.

SpRs in Bristol continue to take on people with learning disabilities for individual psychodynamic therapy.

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The supervision group described above was discontinued because the psychotherapy SpR reached the end of her training. It was not felt appropriate for an inexperienced SpR to take over this role. Since the cessation of the group in 2003, the SpRs have received supervision by attending the supervision groups set up for the general adult SpRs and run by a consultant psychotherapist. This arrangement is working well.

The recent Royal College of Psychiatrists' guidance (Royal College of Psychiatrists, 2004) for SpRs training in learning disabilities suggests that psychotherapy training should be mandatory. We have described an innovative way of achieving these College objectives. One of the outcomes of our experiment has been a change in assumption by the trainees and trainers, so that psychotherapy with people with learning disabilities is now seen as an essential part of their training.

Our experience in Bristol has not been without its difficulties, but despite these obstacles trainees have been encouraged to incorporate the use of psychotherapy for people with learning disabilities into their clinical practice. Coming up with imaginative solutions to training needs can provide emotional support for trainees in coping with clinical work that can often be distressing, as well as expanding their repertoire of competencies.

Declaration of interest

None.

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