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Starting out in psychodynamic psychotherapy

Many trainees, like myself, are so daunted by the prospect of working with patients within a psychodynamic framework that their anxieties can overcome them, and their experience of psychotherapy suffers. As a result they can end up deeply sceptical of this style of treatment. Later in their career, when they are more confident of their general skills, they may wish to return to psychotherapy to try to understand at a deeper level the interaction between individuals, in particular between doctors and patients. Often though, there is too little time to develop these skills at this stage.

In this paper I hope to outline some of the very basic assumptions that I believe underpin psychodynamic psychotherapy, based on my early experiences of psychotherapy and of supervising trainee psychiatrists. With luck this will demystify the process enough to instil sufficient confidence in trainees and give an understanding of what they may reasonably achieve. This should enable them to embark less fearfully or sceptically upon the process.

Obviously one needs to be prepared to incorporate as much theoretical knowledge as possible. However, this can often be overwhelming for beginners and may well prevent an attempt at psychotherapy. Trainees are more used to learning facts and figures and are expected to be both 'useful' and competent. Entering the world of psychotherapy, a new and potentially hostile place, often results in trainees reverting to doing what they know best. For doctors this can be to base one's understanding of the patient's problem on diagnostic issues, defence mechanisms or terms such as personality disorder, and then to prescribe solutions. However, without a more thorough understanding of the underlying processes this can often result in disappointment and frustration for all.

What psychotherapy is not

When embarking upon seeing a patient, one needs to be clear about what one is hoping to achieve. There are many misconceptions about what psychodynamic psychotherapy is and is not. Possibly the most common is that one should aim to allow patients to expel their feelings; that they should become upset, angry, etc. This catharsis would then in some way produce a resolution of some underlying psychic or emotional pain. Indeed, for some this may lead to temporary relief, but generally, with the type of difficulties currently being referred to psychotherapy departments, this is not enough. Psychotherapy is an active process and involves more than simply ridding oneself of something.

Another common belief is that psychotherapy aims to provide a corrective experience, which will in some way impact on an earlier experience. This 're-parenting' would then allow old wounds to be healed and encourage the learning of new behaviours. Again, elements of this may happen, but within each of these models there is an element of passivity on both sides.

Many trainees seem to believe that telling people where they are going wrong in their lives is an active and useful interaction. However, it is unrealistic to expect someone to change long-standing patterns of relating to the world so easily. Too often doctors assume that their pearls of wisdom have made a real difference to a patient, yet we know that patients will frequently not take medication as prescribed, let alone change their inner world as a result of being 'told it like it is'.

What psychotherapy is

Psychodynamic psychotherapy, as with many other forms of psychotherapy, sets out to offer patients a forum in which to begin to 'understand' their difficulties. Through the medium of a relationship with a therapist, the patients have the opportunity of seeing how they view and react to people, the nature of their relationships with others and how they cope with this interaction. Psychotherapy assists patients in becoming aware of their internal world and thinking with some objectivity about their difficulties. It is an active process where the patient and therapist together consider the patient's assumptions and how these manifest themselves both within the patient's life and within the sessions. Ultimately patients' concept of themselves becomes more available to them.

To attend a psychotherapy department each week and have the experience of being listened to by another who is interested is very powerful. It may be a new experience for many. If the therapist tries to understand the patient humanely and objectively, the issues that arise within this setting will quickly mirror how the patient perceives the world outside, as well as the relationships

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that the patient has with others. However, it may be a terrifying experience for the patient at times. This is because therapists maintain (or try to maintain) an attitude that is neither judgmental nor lacking in objectivity. They neither reassure nor antagonise, and withhold from giving advice. They also observe the patient–therapist relationship and, at times, comment upon what seems to be happening between the two. As a result, this will become a unique relationship for the patients with new 'rules' to be learnt and through which self-reflection is encouraged.

This is clearly at odds with how trainees practise in busy wards or clinics, where they are often expected to fulfil the roles just mentioned. This is precisely why psychodynamic psychotherapy experience can be so useful for trainees. One can take the time to try to understand a patient at another level and in doing so shift from labelling patients, to entering their world with all of its fears and desires. Just why is this 'personality disorder' behaving like 'it' is? Why do they appear to need to provoke those around them? What are they afraid of? The patients are almost certainly not deliberately trying to be malicious or difficult, but rather they are probably trying to protect themselves from some real or imagined terror.

The importance of setting

In order for such patients to be able to understand what terrifies and drives them, they need to feel secure within the setting. Hence it is crucial to attempt to keep to the basic principles of the session. This involves, for example, strict time-keeping, not cancelling sessions unless absolutely necessary and keeping the same seating within sessions. This is not the usual doctor–patient contract, where doctors feel that they can be late, cancel appointments and so on. A psychotherapy session needs to be set up to be a reliable and protected time for patients, in which they can begin to understand themselves. If meetings occur on an ad hoc basis then all opportunity for security, and therefore for patients to have some chance of holding onto their inner pain within the sessions, goes out of the window. A consistent environment affords the opportunity to allow more objectivity and to observe variables (for example, lateness, cancellations, over-running) when looking at what is being played out in the sessions – either by the patient or the therapist! It also allows inner states or changes to be considered with the minimum influence from external factors.

What to do

But then what? How does one proceed from here? When starting initially in psychotherapy, it is probably worth keeping in mind that what one is trying to achieve is to help patients to understand, tolerate or live with how they are and to consider their lives as objectively as possible. As easily as doctors can attempt to tell patients how to organise their lives, trainees new to psychotherapy can also try too hard not to be prescriptive. Their interventions can become vague and without purpose. The therapy therefore becomes a long, meandering and essentially thoughtless process that both patient and therapist stop looking forward to. However, a trainee will make a reasonable start if he/she sets out to understand, not merely interpret or judge behaviour, as well as ask questions that explore and clarify rather than accepting assumptions. Certainly the patient should take the lead – even if this is by creating silences, although this does not mean that the trainees should always sit mute!

The patients should be encouraged to say whatever is on their mind and the therapist's role is to help them think about this. As the patients' 'story' or thoughts unfold, they should be encouraged to expand on themes as they arise. The therapist is trying to understand as much as possible about the patient, his/her life and his/her relationships. It is a collaborative, not adversarial, process and one in which the therapist is always alert to both the content and the possible underlying meanings of what is being said. Why has he/she brought this up? What does he/she expect? How does it feel to be told this? What is the patient doing about this or what does he/she hope that you will do? Is the patient relating to the therapist in a recognisable pattern or casting him/her into a particular role? If so, what is this role and what does it feel like for the therapist?

All the spoken information that the patient brings to the session is used in trying to understand the patient, as are other pointers; for example, looking at the 'process' occurring or thinking about absences. What is being communicated? If the process seems aimless, or perhaps rushed in some way, then what is this about? Interested enquiry should be used to help the patient to explore issues that arise. This is important, regardless of how strongly the patient or therapist feel that a solution should be found. How can the therapist even begin to suggest what he/she thinks may be going on until he/she has some real understanding?

With experience, a therapist may be able to take some short cuts or look for pointers towards this. The inexperienced can only try to withhold judgement and try to understand. Whether verbal or non-verbal communications are used, it cannot be long before the therapist who is willing to use his/her available capacities to understand will have some inkling of the fears and frustrations that the patient faces. The aim is to listen, to understand and to feedback. Initially, the therapist is not trying to understand complex theories or mechanisms. These will develop with time and aid the therapist in assisting the patient. Generally, relatively simple processes operate to which the therapist needs to be receptive. Therapists need to be able to step out of the relationship with the patient as it happens, to switch between being 'real' and accessible to the patient while at the same time being objective and observing processes as they evolve. To do this successfully, however, will mean taking a step back from the traditional medical model of fixing patients and instead assist them in understanding themselves.

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Use of interpretations

To really understand another person, both intellectually and emotionally, takes a long time. In many relationships, for example marriages, this may take a life time or indeed never happen at all. Statements about what seems to be going on, what the problem is, what is being avoided and what is happening, only really show the limit of how well one understands the relationship. However, these may serve to deepen the relationship if put well. Interpretations, on the other hand, aim to link the conscious and unconscious underpinnings of an event, act or statement and thereby increase patients' understanding of themselves and of their relationships with others. Interpretations are meant to aid the collaborative process, not merely to point out deficits. They differ from clarification, reassurance or confrontation by bringing hypotheses (not dogmatic 'truths') about unconscious motivations that can be considered by the patient. With time patients should be able to interpret and understand their own internal world and how this relates to the external reality.

Interpretation should extend and engage the patient, but not intimidate or persecute. Casement writes of the 'internal supervisor' (Casement, 1988). This is the notion of the therapist considering how an interpretation, or indeed any comment or action, is likely to be taken by the patient, before speaking. Having said this the therapist must not be too terrified to speak – as long as one considers what is being said and looks for the reaction, then this is all part of the process.

Theory and supervision

For these reasons, good supervision is essential. However, it can seem humiliating for trainees to have to admit to feeling lost and out of their depth. It is vital though that this does not prevent them from staying on track, both for the training experience and, of course, for the patient's sake. The more one can conceptualise and consider the interaction with the patient, the better one will be able to understand and, thereby, help. Supervision also enables therapists to consider feelings that are being generated within themselves and be able to use this information appropriately in assisting patients.

The theoretical knowledge, in part, allows the therapist to stand back from the process that is occurring in the room not all of the time, but some of it. It serves to enable the therapist to contain the emotion generated by the patient and to respond to conscious and unconscious demands in a thoughtful manner. The better one can conceptualise the difficulties experienced by the patient, and their manifestation, the more useful one can be. Supervision also allows the opportunity to consider our relationships with others from new angles and it can be fascinating to think about both our patients and ourselves in different ways. However, theory is not a weapon to be used against the patient and regular supervision is essential if one is to be able to consider and understand the patient properly.

Realistic initial aims to trainees

And what is psychotherapy trying to achieve? The truth is that no matter how much one may wish to make another person 'well', it is rarely possible. This is particularly true of the increasingly complex patients who are referred for psychotherapy, often after many years of using the acute general psychiatry services. Usually, patients want something, whether it be to feel better or to avoid being driven to self-destructive behaviour. They may want other people to treat them better and give them what they think they need. These are deeply ingrained ways of relating to the world. By understanding the patient's fears and irritations with the world and tolerating these within the setting, we may be able to assist the patient. But this cannot happen overnight and patients must be able to trust the therapist enough to go through this difficult process. They must be prepared to consider themselves in relation to others and, in particular, how they relate to the therapist. To do this they should be able to tolerate feedback about the process occurring in the consulting room, what is not being thought about and why this might be.

By way of illustration, imagine a patient is annoyed because he/she consistently feels that others do not respect him/her and he/she deserves or needs this respect. Many of us can feel aggrieved like this at times and indeed unwittingly, the patient may believe that as part of their treatment their desires should be validated. However, no matter how much we may want to reassure him/her or make him/her feel better, we cannot. We certainly cannot satisfy this longing for respect. Psychotherapy does not set out to offer this. It is very likely that having received our reassurance, this would soon prove to be insufficient and the patient would feel that he/she was in need of something else. The patient's desire is real, but psychodynamic psychotherapy aims to help the patient look at what he/she feels he/she needs from life, perhaps why this is so, or at least how this manifests itself. Eventually the patient may be able to understand, emotionally and intellectually, how to live without this constant reassurance from the outside world and perhaps have a more realistic inner respect for himself/herself.

In beginning to learn some of these skills, trainees of today should become more balanced, realistic and understanding psychiatrists of the future.

Reference

CASEMENT, P. (1988) *On Learning from the Patient*. London: Routledge.

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