REFLECTIONS ON TRAINING IN PSYCHOTHERAPY: A PERSONAL VIEW*

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The object of this paper is to set out some of the difficulties experienced in early training in Psychotherapy.

Undergraduate teaching tends to present the student with a view of the patient as a machine with a faulty part rather than as a person. This is reinforced during his period as a houseman. In order to function efficiently, he learns from his senior colleagues how to detach himself from patients so that he can cope with the dying or with investigations which are painful and frightening, or with patients who are chronically sick.

In effect, he builds up a number of defences to protect himself from personal involvement with his patients. Many of these traditional defences are removed immediately on entering psychiatry; the clinical white coat and the large ward round are frowned upon, and the symbolic stethoscope is seldom necessary. The trainee is now encouraged to spend a great deal of time with patients in a one-to-one situation. This close involvement and perhaps even the tendency to identify with patients, together with the apparently insoluble confusion of the subject, often arouses conflicts within the trainee. In general psychiatry it is still possible to retreat to the 'medical model' and this may manifest itself in a tendency to prescribe drugs or ECT even when there are no good indications for such treatments.

Psychotherapy is more frightening, however. Drugs are no longer allowable. The trainee is encouraged to be aware of and sensitive to the feelings of his patient. He may also become aware of his own feelings towards patients. Partly in order to combat these difficulties emphasis is placed on supervision in psychotherapy, but here again difficulties arise. There is, at present, a lack of trained psychotherapists, and as a result few centres are able to offer a good training experience in the principles and techniques of the psychotherapeutic approach. Unfortunately, these centres often seem to lack the ability to present simultaneously a sound training in a good organic approach to psychiatry, so that the dichotomy between organic and psychodynamic psychiatry continues.

As at most centres there are only one or two people who are interested in psychotherapy, many trainees have their first experience of supervision in a group setting. Lack of supervisors often result in these groups being of mixed experience. The most junior member of the group is therefore afraid to speak lest he should reveal his ignorance of the matters discussed, and the most senior member is frustrated at having to return to more basic topics.

Even if the group is uniform it can still be an odd experience. The dynamics of any group are there. Initially, the tendency is for little group discussion, each member looking to the supervisor for support and guidance for his particular problems. Gradually the group becomes more cohesive, but transference problems in relation to the supervisor arise. One such problem is that of sibling rivalry. Each trainee wishes to be the favoured child, so that members of the group compete for attention and perhaps feel rejected if this is not forthcoming. Another problem is that of the parent-child relationship; the feeling that certain things cannot be said to the supervisor and that the parent must be protected from the knowledge of the child's badness, otherwise he will be damaged and his support withdrawn.

Negative feelings towards the supervisor may also present difficulties; periods when the difficulties in therapy are reflected in the supervision sessions. There is a desire to be destructive and to make the supervisor admit that he is not omniscient. The group may experience anger mixed with guilt because they are attacking their parent, and real despair if he is unable to cope with it. The supervision group is indeed an odd one. The dynamics of a group are present, but interpretations of group behaviour are seldom made. This may be correct. It may well be too threatening to the new trainee to have his behaviour interpreted to him. It does, however, seem to reflect the eternal conflict of supervisors—whether or not supervision ought to be a therapeutic as well as a learning experience.

This conflict is perhaps best illustrated in the attitude to counter-transference. At an early stage of training the trainee will talk of technical difficulties in psychotherapy. He finds it difficult to know when to talk or how to tolerate silence. The

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main difficulty, however, is in knowing what is happening in a session. It is usually only at a later stage that the trainee is able to admit that one of the reasons for not knowing what is happening is that the patient arouses feelings in him, and this makes it difficult for him to withdraw and observe the interaction objectively. The term counter-transference now tends to be used rather loosely to describe all of the therapists's attitudes and feelings towards his patient, and even to describe facets of normal, non-therapeutic relationships. The Freudian definition is, however, that counter-transference arises in the therapist as a result of the patient's influence on his unconscious and that this should be recognized and overcome. If the therapist is aware of his feelings he may be able to use them to achieve a better understanding of his patient. If the feelings remain unacknowledged, however, a 'counter-transference neurosis' can arise with consequent 'acting out' by the therapist to the detriment of the therapeutic aim. Counter-transference can therefore be a hindrance or a therapeutic tool. Despite this, it is often not directly mentioned in supervision, and indeed there is very little in the literature as to how it should be dealt with in supervision. Where it is mentioned (1–4), it is usually in terms of whether or not the supervisor ought to enter into a therapeutic relationship with his trainee.

Tarachow (1) makes it clear that supervision should be a patient-centred experience. He expresses the belief that the trainee should not be encouraged to talk of counter-transference problems. It is, however, according to Tarachow, the duty of a supervisor to recommend that a trainee should seek a personal therapeutic experience if he observes him to have similar difficulties with a number of patients. Other writers are in sympathy with his viewpoint, e.g. Sloane (2) states that in a panel discussion among supervisors there was general agreement that the task of a supervisor is to teach and not to analyse. On the other hand, Fleming and Benedict (3) express the belief that a good supervisor must be both tutor and therapist. Ekstein and Wallerstein (4) go even further. They view supervision as a growth experience and see the interaction between supervisor and trainee as a means to discover counter-transference problems and learning blocks. All in all, most writers on this subject assume that talking of counter-transference problems will lead to a therapy situation and, as a result of this, many supervisors do not encourage discussion in this area.

An interesting study is that of Goin and Kline (5) who observed videotapes of twenty-four different supervisors in their supervision sessions (5). Nineteen of these supervisors were candidates in or members of psychoanalytic institutes and the other five had dynamic psychotherapy as their primary theoretical orientation. Only four of these supervisors talked openly and directly about problems of counter-transference and spent more than 10 per cent of their supervision time so doing. Twelve did not mention it at all although there were opportunities for this, and the remaining eight spent very little time on the subject or tended to bring it up in an indirect manner. An important finding was that open discussion of the trainees' feelings did not lead automatically to a deeper probing of their intrapsychic conflicts; nor did it elicit anxiety, a fear which has frequently been expressed by supervisors. From their observations the authors thought that the opposite was probably the case, and this was confirmed by discussion with the trainees. These authors concluded that difficulties which remained unspoken created more anxiety by the very fact that they had to be hidden or only hinted at. This paper would seem to dispel one of the myths of supervision, and there are obviously other myths.

The whole question of supervision and supervisors would seem to warrant further investigation. A good psychotherapist does not necessarily make a good supervisor, although in many instances this assumption is made. Just as it is necessary to learn the techniques of psychotherapy, so is it perhaps necessary to learn the techniques of training. Psychodynamic principles and techniques are rather amorphous and therefore difficult to grasp. Most psychiatrists agree that an understanding of the psychotherapeutic approach to patient care is an essential part of training, even if they do not subscribe to a view of psychotherapy as a therapy in itself. Despite this, the subject is often badly taught. This leads to a situation in which the trainee struggles in a maze of ignorance, hampered by the feelings which this sort of approach arouses. It is unfortunate that in many instances his struggles may be hindered rather than helped by the attitude of the supervisor. It appears that the traditional supervisor-trainee relationship is modelled on the therapist-patient relationship. The supervisor remains rather aloof and tends to be silent. He reflects the ideas of the trainee back to him and makes judicious interpretations or interventions designed to make the image clearer.

If the role of the supervisor is to be teacher rather than therapist one must question whether this is the most appropriate model. The main advantage is that the trainee will take the supervisor-trainee model into the doctor-patient relationship, but there would seem to be at least two objections to this approach. Firstly, it would not seem unreasonable to suppose

that a teacher would be more active and less therapeutic in pointing out areas of difficulty. Returning to the work of Goin and Kline it would appear from their paper that a more direct approach to problem-solving does not elicit anxiety and is, indeed, preferred by trainees (5). The second objection to adopting the therapist-patient model must be that the trainee will inevitably see his supervisor as being more than a teacher. This will raise expectations of therapy and if the supervisor sees himself as only a teacher, will cause problems.

To sum up; there would appear to be two distinct needs in early training, especially training in the psychotherapeutic approach. Firstly there is the need to acquire knowledge and skills. Secondly, there is the need to verbalize and work through the difficulties and anxieties aroused by entering psychiatry and undertaking patient care. It may well be possible for these two separate needs to be met by the same supervisor in an experiential learning situation, but this depends on the skill and orientation of each individual supervisor. At the very least, however, there must be some acknowledgement that there are different needs.

There are many papers on the problem of early training (6, 7, 8, 9) including Merklin and Little's excellent paper, 'Beginning Psychiatric Training Syndrome'. It is perhaps worth noting that much of the literature emanates from the United States. This almost certainly reflects the different orientation in North America, where there is a greater emphasis on the psychodynamic approach. One could speculate that because this approach is more widely used the trainees' problems are intensified and therefore more overt. The other side of the coin is, however, that because of their approach they are perhaps more sensitive to the needs of their trainees and make greater efforts to help them with their difficulties.

With the advent of the Royal College of Psychiatrists a great deal of time and effort has been expended upon the preparation of training programmes. The College has, rightly, emphasized the importance of the psychotherapeutic approach as part of the armament of the general psychiatrist. Perhaps, it is therefore an appropriate time to consider how this can best be accomplished.

One important issue worth considering is the timing and type of exposure to the subject, since this is an approach which arouses conflicts. The trainee perhaps needs the rigidity of the organic approach before he is secure enough to tackle this kind of treatment. Yet another need is that the subject should be taught in as straightforward a manner as possible, some of the mystique being lost, perhaps, for the sake of clarity.

References

1. Tarachow, S. (1963) *An Introduction to Psychotherapy*. New York: International Universities Press.
2. Sloane, P. (1957) The technique of supervised analysis. *J. Amer. Psychoanal. Assoc.*, **5**, 539–47.
3. Fleming, J. & Benedict, T. (1966) *Psychoanalytic Supervision*. New York: Grune and Stratton.
4. Ekstein, R. & Wallerstein, R. S. (1963) *The Teaching and Learning of Psychotherapy*. New York: Basic Books.
5. Goin, M. K. & Kline, F. (1976) Counter-transference: a neglected subject in clinical supervision. *Amer. J. Psychiat.*, **133**(1), 41–4.
6. Merklin, L. & Little, R. (1967) Beginning psychiatry training syndrome. *Amer. J. Psychiat.*, **124**, 193–7.
7. Ungerleider, J. (1965) That most difficult year. *Amer. J. Psychiat.*, **130**(4), 463–7.
8. Halleck, S. L. & Woods, S. M. (1962) Emotional problems of psychiatric residents. *Psychiatry*, **25**, 339–46.
9. Waring, E. (1974) Emotional illness in psychiatric training. *Brit. J. Psychiat.*, **125**, 10–11.