Trainees' Forum

Contributions are welcome from trainees on any aspects of their training

Training Needs in Psychotherapy

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This paper offers some personal experiences and views of the training needs of specialist psychotherapy posts within the National Health Service, with some consideration of the needs of non-specialist trainees hoping to learn psychotherapy skills. There are many levels on which one can consider psychotherapy training needs, a most important one being to identify what techniques should be learned, in what depth, and over what period of time.

I think the psychotherapist in the National Health Service will need a firm basis in fairly intensive individual therapy, because many of the central psychodynamic ideas of mental functioning originate from work in this setting. But he will also need the ability to run groups, do family and marital work, and offer what help he can to treatment teams working in other areas; general psychiatry, counselling and others. Another important part of most National Health Service posts will be supervising and training people who are not specialist psychotherapists, but do psychotherapy as part of their work; who need some knowledge of psychotherapy as an approach, or who spend part of their training in a psychotherapy unit. General psychiatry trainees are a particular group for whom guidelines have been issued by the College.[1] I think we can try and specify the sort of experience and training needed to equip someone for these tasks, and in general I take a broad rather than a narrow view of what this should include. Much work has been put into this difficult area by the Psychotherapy Advisory Sub-Committee of the Joint Committee on Higher Psychiatric Training, whose latest document appeared last year.[2]

However, the question I want to ask is how such a training is made possible, what all these identifiable and specifiable areas of training rest on. In my view they do not and cannot exist without a foundation on factors which are far less easily described, but have become very much clearer to me personally by working in a peripheral Region. Considering what was most important to me in my own training, it seemed to me that the answers I got had little to do with required training, and could not be easily operationalized in a job description. The answers were personal, but if I feel that they are so central, perhaps they are worth considering. It was a similar feeling to trying to identify important factors in a psychotherapy session. Somehow the technique or model never seems adequate when it is written down in black and white. It always seems to me that a lot of other things go on. Subtle interplays of feeling and empathy, personal closeness and distance, which cannot be done justice to by technical language, although this sort of analysis is a vital part of thinking about it later. The recognition by Rogers of such non-specific factors was important, as was Truax's work; my theme is to offer for discussion an awareness of similar factors in training. The problem is how to keep the essential nature of psychotherapy while attempting to talk about and perhaps set down training needs and requirements in a more technical way. I think the traditional safeguard has been our own need for the therapy experience, but without detracting from this in any way I do not feel this is necessarily the whole answer.

What might such non-specific factors in training be? The first essential for someone training in psychotherapy is space. By space I mean freedom from intrusive and disruptive emergency duties and the ability to structure one's time. This is largely non-controversial, and such a problem of space should not arise in properly set-up specialist training posts. However, significant problems may arise if, say, a rotational trainee is trying to keep an on-going patient and attendance at supervision sessions during a busy and demanding attachment elsewhere. If non-specialist or rotational trainees are to hope for anything like the sort of exposure to psychotherapy training recommended by the College, their need for space will have to be recognized. I will leave this topic by adding a comment made by one of my general psychiatric colleagues on this issue. It is nicely two-edged but was said honestly, without malice: 'The person in your job needs to be allowed to waste his time.' This does at least recognize the need for space: the implication that one ought to have tangible results leads indirectly on to my second main point.

This is to do with the realization that psychotherapy is under considerable pressure. It is a pressure that comes from many quarters, most close to home from psychiatric and other medical colleagues. Its context is the growth of a particular notion of science and truth, forged from stringent, controlled research methodologies embodying a particularly materialistic and statistical way of viewing reality. The purity of this position—set out by Sir Karl Popper, and taken much further by those whom Thomas Kuhn would call 'normal scientists'[3]—carried a great moral judgmental strength. The individual, subjective reports, feelings, internal conflict, dynamic changing systems, particularly psychodynamic ones, do not easily fit in. But those things are what psychotherapy is about.

This article is a revised version of a paper read at the Psychotherapy Trainers/Trainees Conference in Nottingham in June 1980.

There is still some debate and resistance to this new dogma (which to distinguish it from science has been called 'scientism') from psychoanalysts[4] and social psychologists, particularly those who call themselves 'Symbolic interactionists'[5,6]. There are still papers in most journals continuing this essential discussion.[7] The difficulty was personally highlighted when I gave the same talk about basic psychodynamic ideas to two different groups, within twenty-four hours. A group of intelligent housewives and mothers understood without difficulty, but a group of scientifically trained medical students were unable to listen to what seemed to them abstract and woolly speculations, without material reality.

Some workers are trying hard to present psychotherapy as open to acceptable scientific investigation, and are pursuing research of this type. If this can be done honestly, and retain the basic tenets of psychotherapy, it can only be positive. But others see the problem as very much to do with the relative philosophical bases of science and psychotherapy. They would argue that psychotherapy is closer to history,[8] or even literary criticism, than to the experimental method. Alternatively (e.g., Bannister[9]), it can be argued, using a hierarchical model, that psychology in the broadest sense can never be subsumed or explained by other more narrow and limited physically-based sciences. It can also be claimed that the ability to make sense of whole interactions, or gestalts, is qualitatively different from reductive experimental analysis.

This is not setting a false conflict between psychotherapy and science. I see them as equal but different ways of looking at reality, which at best can be complementary. What I am saying is that paradigmatic Popperian scientific research does not exhaust or comprehensively explain what reality is. This is particularly so for the sort of reality which is to do with the constant experience of a person (with all that that word implies) living in the world. It is one particular essential and valuable view among others.

Based on the above, my view is that no psychotherapist can survive easily without considerable acquaintance with the philosophical basis of what he is doing. Neither uncritical acceptance of 'scientific truth', nor insular retreat within one's chosen castle, dogma, or self-justifying metapsychology are adequate long-term answers. Specialist and non-specialist training, therefore, has to do a great deal of justice to this area.

The final point is, I think, the most important, particularly for regional training and for peripheral consultant psychotherapists, and also because it has broad implications for planning psychotherapy training in general. It is that, with distinguished exceptions, psychotherapists do not work happily in isolation. By definition they cannot be trained in isolation. What any training has to involve is a setting which includes a group or body of people with experience in the field, and such a broad training as I suggest needs people with broad and varied backgrounds. But the real issue is not just that people need to be taught by others. The practice of psychotherapy involves a subtle relationship between our own objective and subjective functions—both of which are vitally important—which in many ways is parallel to the problems of the relationship between science and psychotherapy. The objective need to be critical, to use theories and models, to think of alternatives, and to have the capacity to take a cool look when things are difficult, is central. This would include the need for proper scientifically based research and the use of such data bases as videotapes despite many drawbacks and criticisms of these methods in psychotherapy. However, equally important are our empathy, feeling with the other, our ability to respond in an emotional and free-floating way to material; and above all our own commitment to the other person and his individuality. It is more than simply recognizing, in some theoretical way, that countertransference feelings can be useful. It is the recognition that, whatever training or insights we have, our basic tools are aspects of our own personalities.

So a great deal of psychotherapy training needs to be experiential, to deal with the area of our own feelings. We need our own therapy. We also need supervision experiences which take into account our own feelings and recognize their importance, and this latter is particularly important for non-specialist trainees who may have neither the time, opportunity, inclination, nor even money for personal therapy, but I think it involves more than adequate supervision and formal personal therapy. If psychotherapy (whatever method we use) is to do with people's feelings, fantasies and fears, and we need to be able to deal with and learn to use our own, what sort of work setting is required to foster this approach? I feel that our colleagues are very important here. If we relate well, can talk reasonably openly with each other, and can help with each other's difficulties, the soil is one in which the psychotherapeutic method can grow.

This needs a settled group of people engaged in similar work, who are committed to it, and to each other, in something rather more than a purely professional sense. This sort of culture-carrying group is important for giving non-specialist trainees the flavour of psychotherapeutic work in an authentic way, but it is essential for the training of a specialist psychotherapist; and (I feel) for many consultant psychotherapists to continue doing good work. It also implies the concept of a 'critical mass' of psychotherapists, as has been suggested in previous discussions of psychotherapy training, and I suspect that the critical number to provide such a group is about six.

In summary, then, my view is that for psychotherapy training to work well the trainee needs an adequate foundation as follows: primarily—adequate space. This in a physical sense can easily be written into a specialist job description, but may be a problem for the rotational non-specialist trainee. Similarly specifiable, though not yet always attainable, is a description of the techniques and sort

of training needed in terms of quantity of exposure to different methods and experiences. But more important, and not so easily laid down, the trainee needs two particular but related things: firstly, a tough but resilient personal acquaintance with the philosophy and *raison d'être* of psychotherapy and its world view, as well as an awareness of its place in the broader context of the scientific and medical community. Secondly, a group of colleagues whose relationships embody a flexible, humanistic ability to tolerate, understand and help with sometimes very difficult personal feelings in themselves and others. Irrespective of particular methods, that sort of activity embodies in practice the basic principles of psychotherapy.

References

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News Items

A Tribute to John Conolly

St Bernard's Hospital celebrated its 150th Anniversary last year and marked this occasion by paying tribute to John Conolly, Resident Physician and later Visiting Physician to the then Hanwell Asylum from 1839 to 1852.

The Croonian Lectures by John Conolly, delivered in 1849 to the Royal College of Physicians, London, represent a landmark in the field of psychiatry and still present fascinating reading today. First printed in the *Lancet* in 1849, six lectures have been reprinted by the hospital and are available in a commemorative bound edition of 85 pages for £3.00 each (including postage—UK only) from St Bernard's Hospital, Uxbridge Road, Southall, Middlesex. Profits will go towards the Anniversary Appeal which is to provide enhanced rehabilitative facilities on site.

Money for Projects, Money for Research

In the year ended 31 March 1981 the Mental Health Foundation (8 Hallam Street, London W1N 6DH) gave away over £180,000 for general projects, and over £260,000 for research in psychiatry. The projects covered a wide range of activities: salaries for people helping in a centre for the prevention and treatment of alcoholism; shelter for young people at risk in London's West End; a training scheme for rehabilitating the confused elderly; audio-visual equipment for training in family therapy; purchase of mini-kitchens and provision of therapeutic workshops; and a whole series of grants to help mentally handicapped children and adults, whether by publication of instructional pamphlets or help with transport, play equipment and staff costs.

Research grants of anything from £700 to over £28,000 (over three years) and of Fellowships were given for the study of the effects of long-term neuroleptic treatment on dopaminergic transmission; the study of the treatment of daytime enuresis; studies of the families of schizophrenics (two separate inquiries); attitudes of patients and relatives to compulsory admission; and women with illness in the year following childbirth (two projects).

Although the majority of research grants went to people in university departments, there were also grants to two ordinary psychiatric hospitals and a social services department. The Research Committee prefers investigations of a clinical nature, and has for some time had on offer a research Fellowship for study of chronic psychiatric conditions, without finding a suitable worker. The General Projects Committee wants to support pioneering and innovative community mental health work, with an emphasis on self-help, prevention of disability and rehabilitation.

The Foundation is a charity of growing importance. It has been successful in raising money and help from the banks, firms such as European Ferries, Ultramar, Trust House Forte and many others. But it also needs regular help from individual supporters and, as a national body, from all over the country. County and regional organizations are beginning to grow. Psychiatrists should think of the Foundation not only as a provider of funds for projects and research, but as a body to be helped locally. One form such help can take is to remind ex-patients and their families who may wish to express their gratitude for successful treatment that a gift to the Foundation, especially if covenated (even though small in size), is a way of helping other sufferers.