Personal Psychotherapy in the Training of a Psychiatrist?

We invited Dr John Cox, Professor Isaac Marks, Father Louis Marteau and Dr John Steiner to reflect on this controversial issue.

John L. Cox, Senior Lecturer in Psychiatry, University of Edinburgh

At first sight, comment from a general psychiatrist as to whether or not personal psychotherapy is necessary for the training of a psychiatrist would seem as inappropriate as for a Presbyterian minister to decide whether the 'laying on of hands' is essential for the ordination of a priest. In both situations, objective facts about efficacy are hard to establish, and historical tradition transmitted by meaningful ritual is of considerable importance. It could be argued, therefore, that this debate should be confined to those who are familiar with these traditions from the inside. However, on closer reflection, there are several reasons why this important matter should be considered by general psychiatrists and not restricted to a psychotherapist's debate alone.

Firstly, this unresolved debate still causes anxiety for trainees, is divisive between the 'haves' and the 'have nots', and any psychiatrist may be asked for advice. Furthermore, although these peer group discussions may be maximal in London, where psychoanalysts are thick on the ground, they are also heard elsewhere. One Scottish trainee, for example, said that the current controversy was whether or not a 'five star' analysis was necessary (i.e., London based) or whether the Edinburgh package was also acceptable. How complicated—as if a trainee has not enough on his slate already, in coping with mental handicap and research experience, without having to weigh up such imponderables as the correct pecking order between different psychotherapy trainings.

Secondly, because general psychiatrists will have an interest in recruitment to their sub-specialty they should be aware that for some trainees a personal analysis is the first step away from the rough and tumble of an acute admission ward to the more selected Psychotherapy or Child and Adolescent Psychiatry clinical settings. There is a risk, moreover that such training analysands may unwittingly perpetuate the erroneous belief that psychotherapy is only for the psychotherapist, and that the appropriate integration of psychodynamic, behavioural and biological models (none of which is totally explanatory) should either not be attempted at all, or be dismissed as vague eclecticism.

Thirdly, a general psychiatrist should know how a psychotherapist is currently trained and have a working knowledge of the theoretical and practical training this psychotherapy colleague has undergone. Empathy with "being analysed", and understanding the influence of this training on subsequent clinical attitudes will certainly facilitate communication.

It is an advantage for all psychiatrists to obtain some knowledge of psychodynamic psychiatry and to have insight into their own style of personal interaction. The ways in which this more limited personal insight can be gained are multifarious. Regular group or individual psychotherapy supervision may provide this opportunity by discussing the therapist's feelings towards his patients, which may or may not be affecting clinical progress. Staff sensitivity groups, which are distinct from a pyramidal structure of clinical responsibility, are also of value and may allow an experience somewhat similar to that of an out-patient group. However, psychotherapists with an interest in arranging this training experience are scarce. Collaboration with a general psychiatrist who has an established interest in interpretative psychotherapy may therefore be useful, and will have the additional advantage of symbolizing to trainees that this aspect of routine clinical work is not restricted to named psychotherapy specialists alone.

For some psychiatrists, personal insight is best gained in less conventional ways—such as discussion with a trusted confidant, participating in a marathon weekend, or taking part in a systematic meditation. The use of these more fragmentary methods, however, will largely depend on factors such as personality, marital status or possibly the religious belief of the individual. These less ambitious personal therapies, though different in kind from a personal analysis, may have the advantage of being less likely to distort subsequent clinical perspectives or priorities. There must always be a risk that a formalized psychotherapy training which does not include adequate experience in general psychiatry or constant contact with unselected patients, may narrow clinical horizons and make liaison with other specialists more difficult. Furthermore, psychotherapists with a broad training will also retain the necessary skills of presenting their theoretical material in a way that can be understood by others, and will recognize when a psychodynamic approach is of limited value only—or possibly of no relevance at all.

For some psychiatrists, however, a consideration of these pros and cons of a personal psychotherapy are redundant, since for them the advantages of this costly experience will always far outweigh any possible snags.

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Isaac Marks, Professor of Experimental Psychopathology, Institute of Psychiatry

It has recently been said that 'No practitioner in any of the professions, no matter how private the practice ... is in business for himself or herself.' This emphasizes the accountability to the public of all practitioners, psychotherapists included. Though self-exploration is a fascinating activity for most of us, a recommendation that personal psychotherapy should be part of a psychiatrist's training can only be justified if such experience is clearly shown to enhance the trainee's therapeutic abilities. This has never been done. The final proof of the pudding lies in the satisfaction of patients ministered to by the student and the outcome of their condition. At the moment the only training programmes in psychotherapy which link training to therapeutic outcome concern behavioural psychotherapy, e.g., the national courses run by the AUTP for senior psychiatrists, and by the JBCNS for nurse-therapists. In these courses trainees have to demonstrate on rating scales that their patients have improved after therapy. Substantial gains by patients are found in cases where the trainees have had no personal psychotherapy.

Assertions that personal analysis must be part of psychotherapeutic training rests on doctrine rather than evidence. Such assertions usually imply that personal analysis increases awareness of our feelings, and that this helps us to understand and to treat others. Neither of these implications is borne out by data. Furthermore, there are much more economical ways of training for personal sensitivity, e.g., by personal supervision in groups, and by action techniques such as sensitivity, psychodrama, gestalt and encounter groups and their congeners. There is no reason to believe that these are any less effective in increasing sensitivity than is personal analysis, and they are certainly briefer and less expensive. Nevertheless, until these methods are shown to enhance the psychotherapeutic prowess of trainees, they too can hardly be recommended as a necessary part of training.

Many experiences help trainees to see the patient's problems through the patient's eyes. After being in hospital for treatment themselves, doctors can become more alert to the patient's point of view. Child psychiatrists often understand children better when they are parents themselves. Obstetricians who have borne and given birth to their own babies may empathize more with pregnant and parturient women. Personal psychotherapy may help trainees in a similar way, but this is no argument for its regular inclusion in training for psychiatrists or even for psychotherapists.

Most trainees are in reasonably good psychological health and do not need therapy in their own right. Intensive personal psychotherapy has serious drawbacks for training, quite apart from its expense and questionable effectiveness. It can do harm by taking up so much of the trainee's time that he has none left to broaden his psychiatric experience and learn several approaches. There is a danger of producing a doctrinaire mind overcommitted to one school. Inhibitions acquired during training may produce a therapist unable to practise more than a single method of therapy and, worse, one who is hostile to alternative approaches. But different patients demand different therapeutic approaches. The best care-giver should have a wide range of skills which can be drawn on according to the patient's needs, not according to the theories instilled into the trainees.

About 30 years ago psychotherapy was characterized as 'an undefined technique applied to unspecified problems with unpredictable outcome ... For this technique we recommend rigorous training' (Conference on Graduate Education). Today there is better evidence for the efficacy of some forms of psychotherapy with specified problems and defined techniques, but these do not require an arduous training. The more rigorous the training which is recommended for a particular psychotherapeutic approach, the more tenuous the evidence seems to be for its value. Highly trained psychotherapists have often achieved no more with their patients than those with far less experience (Strupp and Hadley, 1979; Liberman and True, 1978). Indeed, empathy and understanding, which is so highly regarded by most psychotherapists, has been rated as being present more in behavioural than in psychodynamic therapists (Sloane *et al*, 1975), despite the latter's greater experience of personal psychotherapy.

Psychotherapy is tainted by the same restrictive tendencies as any other profession. Professionalization unduly degrades the valuable role which can be played by everybody in helping distressed relatives, friends or neighbours (Chabot, 1979). If we are interested in treating as many sufferers as effectively and cheaply as possible, then we need to demystify the art of care, to state simply what we can do so that all can understand, and help design a service based upon society's human values (Mahler, 1975). It is inhumane to deny treatment by making training so lengthy and expensive that there are not enough therapists to go round.

If we were to set our minds to it, training could be greatly simplified. There is abundant evidence that communication skills and empathic understanding can be taught quickly, often in a few hours (Maguire, 1980; Ivey, 1980; Bird *et al*, 1980, reviewed by Matarazzo, 1978). This is done by direct instruction, modelling, roleplay, observed practice with immediate feedback and audio/video taping with replay and feedback. Variants of this training package have produced interviewers superior to those without such instruction, though this superiority has not yet been related to patient outcome. Research indicates that 'the therapist should be warm and reinforcing, attentive and understanding, should encourage the client to do most of the talking, should demonstrate good listening ability, and should be genuine, emphasize the client's assets, and encourage discussion of the specific' (Matarazzo, 1978). Training requires 'clearly

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stated objectives, progressive stages of learning, measurement of achievement, and feedback to the student'. In addition, the therapist must also possess information about patterns of psychopathology and other knowledge which he can impart to the patient, e.g., sex information, communication skills for marital and social success, understanding of vocational difficulties and opportunities, as well as skill in confronting and reassuring the patient.

The psychotherapies have advanced considerably in the last decade. Much of the area remains an impenetrable mystery, and some patients will continue to need long-term therapy, while some *perhaps* do better with therapists who have had personal psychotherapy. However, we can now treat many problems simply, briefly and effectively (Marks, 1981). Most training programmes have not yet recognized what research has already demonstrated, that understanding, communicating and other psychotherapeutic skills can be taught over a short time in appropriate training programmes. Long waiting lists for suffering patients are inhumane. A humane care system requires brief effective systems of training which will yield enough capable therapists to help all patients. This is now eminently feasible.

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Louis Marteau, *Psychotherapist and Lecturer in Pastoral Psychology, The London Hospital*

The spectrum of patients seen by psychiatrists ranges from those who are suffering from mental illness in the strict sense to those whose emotional development is unable to cope with their present environment. The problems will likewise vary from the complexities of neurology and endocrinology to the rarified arena of existential philosophy. Sometimes the diagnosis may also vary depending on the basic views and assumptions of the psychiatrist himself. We may add to this list the vast number of medical disorders which now also appear to include at least a limited psychosomatic element. It would be contentious to discuss what proportion of each of these groups is likely to predominate in the future practice of any individual psychiatrist, although I would maintain that each category would be large enough to merit the title of 'significant'. This, then, implies that such a significance should also be seen in the training of the psychiatrist.

A major problem arises, however, from the fact that the spectrum contains a difference not merely in species but also in genus. The emotional distress is not simply a lesser form of mental illness, but is a specifically different entity. From this fact we have to accept that both the diagnosis and the treatment are also specifically of a different nature to those appertaining to mental illness, strictly so called. The diagnosis and treatment of illness which stems from neurological, physiological or endocrinological causes relies on strict objective scientific research and remains fundamentally a medical and scientific process.

But the understanding of an individual person's development, reaction to early trauma, and present-day idiosyncratic language and behaviour is fundamentally an art. True, there are some apparently scientific theories upon which the art may flourish, but they remain theories. There cannot really be a science when we are primarily concerned with a unique individual's personal inner life and reactions. Thus we have a second major difference. In the diagnosis of mental illness we may be helped by a variety of scientific instruments in measuring the neurological, endocrinological, and physiological functions. These produce objective, scientific data; but in working with the emotionally disturbed we have only one instrument—ourselves and our own personal reactions. In considering treatment, we see the same difference enlarged. Where in mental illness there are prescribed treatments, in emotional disturbance the treatment is also through our own personal reaction and interaction with the disturbed patient.

This major philosophical distinction between the two

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categories of patients must imply that the psychiatrist should be able to use both the science and the art and distinguish between the needs of either category. I would go even further: in all medical work there are many who would say that the most important therapeutic agency is the relationship of the doctor and the patient. The more 'scientific' the medical model has become, the more this art may be taking a back seat.

If we accept that the psychiatrist needs to be adequately trained in diagnosis and treatment of mental illness, with full knowledge of the scientific tests available, and with a proper understanding of the types of biological treatment that are available, we have also to have some regard to the other group of patients. Here he needs to have a full knowledge of his diagnostic instruments—himself—and a proper knowledge of the way in which he can make use of his therapeutic agents, which again are based on himself and his relationship with the patient. If this is so, we have to examine in what way he may be trained for this second task.

My primary contention is that the task is an art rather than a science. A student of music would be of little use to the orchestra if his sole study of music had been purely academic—if, for instance, he knew the theoretical background of every one of Beethoven's sonatas, while never having laid a hand on a musical instrument. For our psychiatrist the musical instrument is himself. We need then, to question how far he needs to understand and practise the use of himself. This appears to be the basis of my discussion, not whether, but rather to what degree?

If we continue to take our illustration from music, I would hazard a guess that most people asked to give a public performance would do so in a style suited to their individuality and would choose a piece of music which was well within their personal capacity. In private, they might attempt more advanced pieces, but for the public it would be safer to keep well within their limits. I would suggest the same for any discussion of personal psychotherapy. We should train and tune our own personal instrument a little more deeply than we are prepared to use it with a patient. We should have gone through the experience personally at a greater depth than we would take another person through it.

To summarize, I would argue that psychiatrists are faced with two different types of problems. The one can be diagnosed and treated scientifically while the other is an art, even if it has some scientific backing. The instruments of diagnosis and treatment in each case are also fundamentally different. In the first case, they are objective, and in the second personally subjective. Knowledge and use of a scientific instrument can be mastered scientifically; of an instrument of art only in the practice. The degree of practice in the art will depend on the degree to which the individual intends to display it.

John Steiner*, Consultant Psychotherapist, The Tavistock Clinic*

As psychiatrists, we are more exposed than are our medical colleagues to the danger of being excessively affected by the problems of our patients, in part because of our helplessness in the face of the demands that patients make, and in part because these so often touch on personal issues in our own lives. Because of these stresses, we tend to react either by becoming too closely involved, or by retreating to an over-detached position which may be equally damaging to the clinical relationship. At times the stress is sufficient to threaten our integrity, our identity and even our sanity; so it is not surprising to find that quite powerful defences may be brought into play.

It is likewise not surprising that clinical work puts us in touch with personal problems with which many of us have found personal psychoanalytic therapy of great value. In addition many of us have entered psychiatry because of a curiosity and interest in the functioning of our own mind and that of others.

Here, however, I want to emphasize other reasons for valuing personal therapy, especially in relation to the need to find an internal model to turn to as a source of support and strength in our clinical work. I believe we all need something to guide us between the extremes of over and under-involvement, but the particular model each individual chooses depends on his history, personality, values and preferences. Some find an ally in the traditional medical model, some in the physical sciences, some in philosophy, religion or literature; and the choice, whether overt or not, will have a critical bearing on clinical attitudes. Among these models many of us have found psychoanalysis to be especially valuable, not only as a means of understanding the patient but also to help to understand the stresses we ourselves are subject to.

The psychoanalytic attitude sets great store on observation of the patient, not only his symptoms and behaviour but also his wishes, moods and anxieties and the way these are dealt with and communicated to us. There is a parallel requirement for self-observation on the part of the therapist who tries to understand his own reactions and to link these to the current interactions with the patient. The psychoanalyst uses these observations to help formulate interpretations, and for him a personal analysis is an essential part of his training. The psychiatrist will not engage in this kind of detailed self-examination; nevertheless, he cannot remain an uninvolved observer and needs to find a way of coping with his own emotional and intellectual reactions.

To illustrate the nature of the stress resulting from every-

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day clinical work in psychiatry, I would like to focus on only one aspect of the patient-doctor relationship. I have elsewhere (Steiner, 1976) described how common it is for the patient to come to the psychiatrist with the express aim of getting rid of a burden. He carries his depression, his sense of inadequacy, his persecutory fears, his anxieties, his sexual preoccupations or his guilt, and he longs only to be free of these, to lighten his load and unburden himself. To achieve this unburdening, he makes use of a mental mechanism called projective identification (Klein, 1946) which enables him to believe, through an omnipotent unconscious fantasy, that he can split off an unwanted part of himself and get rid of it by attributing it to his doctor. This may require the creation of a particular mental state in the doctor which will correspond with the mental state the patient wants to get rid of. In some cases, the way this is done can be easily recognized, as when the patient tries to make the doctor angry or depressed, but more usually, such burdens are transferred in subtle ways and the only hint that this transfer has occurred may be that the patient leaves the room feeling lighter and the doctor leaves feeling burdened. Projective identification can also be a means of attacking and controlling the doctor, and it is common for the patient to have great anxiety about the doctor's capacity to cope with these projections. More recently, especially through the work of Bion (1962), we recognize that it is also a form of primitive communication by means of which the infant succeeds in making the mother go through an experience similar to his own and hence to know what it feels like to have a particular state of mind. Through this mechanism we can experience something of what it is like to be in the patient's situation and can sometimes bring things together in a meaningful way for the patient and help him understand what is going on. In order to do this, we have to know something about our own mental processes and anxieties, so that we can begin to distinguish between states of mind which result from interactions with the patient and those to do with our own lives. Of course, there is always a mixture of the two, but it is vital to have some means of judging if our mood was connected with the row we had at breakfast, the anger at some professional disappointment, or the way the patient has been interacting with us. Personal psychoanalytic therapy can help us make these distinctions and can also help to contain the feelings provoked by patients and avoid some of the more damaging reactions to them. While gross forms of acting out, such as sexual involvement with patients or being violent to them are mostly recognized and avoided, more subtle seductions, cruelties and over-involvements with patients are difficult to avoid and can be damaging to both participants. Sometimes when the patient projects his feelings, the doctor is unable to contain his reactions and acts them out with his patient, his colleagues or his family.

The opposite danger, that is of excessive withdrawal and distance from the patient, is perhaps more common, especially in more experienced psychiatrists, some of whom have had their fingers burnt through earlier enthusiasms and over-involvements. They may avoid being disturbed by the patient's projections by becoming distant, aloof, mocking or contemptuous, by shutting themselves off behind a wall or screen, by filling their minds with other preoccupations or by stripping the meaning from the patient's communication. Sometimes the doctor needs to wear a white coat, carry a stethoscope, or have a desk and case notes to create a barrier between himself and the patient, using such supports to remind himself who is the patient and who is the doctor. Sometimes the direct contact with patients is left to junior staff and the patient is only seen in the relative safety of a ward conference. Sometimes the psychiatrist becomes interested in the form of the patient's responses, preferring aspects that can be measured and replicated to those that have personal meaning. All these may have damaging consequences for both participants. The patient feels misunderstood, and the doctor cannot learn through experience of the patient's personal problems how these might be understood. Patients tend to experience the first type of over-involved doctor as someone who reacts to projection by counter-projection and to the distant doctor as a brick wall or inanimate object.

In principle, the extreme reactions I have described can be avoided by creating a setting and an atmosphere which makes room for meaningful communication from the patient. The anxieties so communicated must be contained, and so too must those which arise in the doctor so that acting out can be avoided. If the patient feels the psychiatrist can make himself available and yet not be overwhelmed, he is often able to establish a treatment alliance with the doctor in which the two of them can examine the patient's situation and begin to tackle the problems the patient brings. Of course, in practice all kinds of difficulties may intervene. Nevertheless the psychoanalytic attitude can help to achieve such an approach, and a personal therapeutic experience can provide the personal insight and the internal strength which makes the containment possible.

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