Psychotherapy training in a therapeutic community.

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Abstract

This paper outlines the formal aspects, academic and clinical, of a three-year training in psychotherapy offered in a psychiatric hospital which functions as a therapeutic community. The trainee's adjustment to the community is described, with reference to the overlap and intersection with the patient's experience in the community. Consideration is given to individual and group processes within the entire community. Erikson's concept of developmental stages is used, as well as a paper by Baird Brightman, to examine how crises in the training experience are managed by the trainee.

Introduction

The Ashburn Clinic (formerly Ashburn Hall) is a small psychiatric hospital founded in 1882. In 2007 we celebrated our 125th birthday and commissioned a local historian, Dr Cameron Duder, to write the story of Ashburn. My introduction draws on this book. Dr Duder traces the consistent theme of respect for the patient which informed the original model of 'moral-treatment', through to the present day model of the therapeutic community which became fully developed by the 1970s. The term 'therapeutic community' was first used by psychiatrist Tom Main in 1946 to describe the treatment milieu used at Northfield Military Hospital in Birmingham towards the end of the second world war. David Kennard (1998) identifies a core list of therapeutic community concepts. They include:

- An informal and communal atmosphere
- The central place of group meetings in the therapeutic programme
- Sharing the work of maintaining and running the community
- The therapeutic role of patients and residents
- Sharing of authority
- Certain shared values and beliefs

The clinic is staffed by psychiatrists, psychosocial nurses, psychotherapists and occupational therapists. It draws on the services of other professionals, for example general practitioners, a dietician and a local psychologist. The clinic has two inpatient units providing 24 hour nursing care, and a day psychotherapy unit with self-care living in an on-site hostel. Our total

bed capacity is 56. The clinic provides treatment across a broad range of diagnostic categories, including psychosis, personality disorders, eating disorders, addictions, depression and post traumatic stress disorder. The age range of patients is from 17 through to 70 plus.

The hospital has many links with the University of Otago, in particular with its Medical School, which established training in child psychotherapy in the 1970's. This was the first full-time training in psychotherapy to be offered in New Zealand. The first director of training, Dr Roy Muir, served as Medical Director of Ashburn Hall from 1984-1988.

With this background it is not surprising that the clinic has itself become involved in teaching the theory and practice of psychotherapy. In 1994 we established a full–time three-year training position. To date (June 2008) eight women and four men have embarked on the training. Nine have graduated, two are currently training and one person withdrew after two years. Most of these graduates are involved in psychotherapy practice and several have since become full members of NZAP. Since 2002 the clinic has been approved by the Royal Australasian College of Psychiatry to provide a two-year specialist training in psychotherapy to senior registrars. To date three people have undertaken this training.

Selection for training

The basic entry criteria are a minimum age of 25 years and completion of a tertiary degree course, or evidence of a capacity to work at university level. In practice most trainees have been over thirty and one trainee started in his mid-forties. It is a condition of training that people undertake their own therapy at this time.

Applicants are invited to submit an autobiographical letter in which they also consider their motivations for becoming a psychotherapist. This can be a helpful tool for assessing psychological-mindedness. Two or three candidates are short-listed and each is invited to spend a day at the clinic so that they can have a comprehensive introduction to the community at work. The candidates meet with current trainees. Both staff and patients are invited to provide feedback on the candidates. At the end of the day there is a formal interview with three senior members of staff. At this time we introduce some core concepts to the candidates:

- Conscious and unconscious processes;
- The central role of relationship in the work of individual therapy;
- The therapist's use of self as her or his basic tool in the work of therapy.

Outline of training

Aspects of the training have changed over time. A basic principle has been the value of learning within a group. This is in tune with our focus on the role of the group in treatment.

The first year of theoretical teaching is now provided by fortnightly tutorials, which are open to all clinical staff. We use a series of classic papers, which are presented to the group by trainees and other staff, in particular nurses, who attend to their professional development in this way. Papers on the therapeutic community and group work lead the way, with an introduction to the ideas of Bion. Other papers cover assessment and the therapeutic context, stages of therapy, and key concepts such as transference, countertransference and defences. Discussion from different professional viewpoints enhances the learning.

During the second and third years teaching is provided via four semesters of evening seminars, held weekly. These seminars are also attended by members of the public who satisfy our study criteria. We offer four modules of advanced theory:

1. Stages of Human Development
2. Models of Psychotherapy
3. Major Theorists
4. Abnormal Psychology

At the end of each semester trainees submit a brief essay on a topic related to one or more of the seminars. At the end of the third year trainees submit a long essay in which they display understanding of theory and the capacity for independent research and thought.

There are written requirements for the clinical training. The trainee keeps a daily diary for the first six months as a record of initial adaptation to the therapeutic community. After some months the trainee submits an account of morning meetings in an inpatient unit. This 2,000 word account examines the overt and covert tasks and processes of the meeting. In the final year the trainee writes a longer account of work as a co-facilitator in a small psychotherapy group.

The trainee's development is assessed via oral and written presentations of work with individual patients. A senior member of staff provides weekly supervision for each trainee. There is a weekly group supervision meeting for psychotherapists and psychiatrists in which the discipline of case presentation and formulation is practised and modelled. Once a month the

training group meets with the mentor of training (myself). This meeting has various functions: monitoring of progress, support, debrief, a place to vent feeling and express anxiety, and to address relationship issues.

Placements

The trainees spend a year in each of the three units. The year one trainee now starts in an inpatient unit – as do the vast majority of our patients. Initially he or she sits in on the full range of groups and other activities. The charge nurse for the unit decides when the trainee is ready to become a co-facilitator, working with a nurse, in a twice-weekly small psychotherapy group. The trainee also attends meetings of the multidisciplinary clinical team, which provide ongoing case discussion using psychodynamic models. Three times weekly he or she attends meetings of the whole community.

Mother-infant observation

A key component in the training is a mother-infant observation, using the Tavistock model pioneered by Esther Bick in the training of child psychotherapists. Once a week for a year, and then fortnightly until the child is eighteen months old, the trainee observes a mother and baby at home, together with the comings and goings of other family members. This observation of very early development brings to life the complex psychoanalytic theory with which the trainee is grappling. It is an observation of the baby's first relationship, the prototype for subsequent relationships.

The trainee is likely to be surprised by the powerful feelings that are evoked by proximity to a mother and baby pair. There may be pain at being excluded from an intimate relationship. Old longings may be revived. Anxiety and anger are aroused by failures of maternal empathy. Critical and judgmental attitudes may be uncovered. Two deep fantasies may be discovered: the wish to be the baby or the wish to have the baby.

The complex experience provides a form of rehearsal for the work ahead with an individual psychotherapy patient, in which personal feelings, anxieties and fantasies have to be contained, but thought about as deeply as possible. Tutorials led by myself focus on both the theoretical and experiential aspects of the study. The work is written up and evaluated.

The training experience

Joining the Community – Dislocation

The hospital comprises a set of buildings nestled together in several acres

of gardens, orchard and paddocks, framed by large old redwoods, planted over a century ago. The setting impresses the newcomer. Our present trainees have come to us from other parts of New Zealand and from beyond these shores. They appreciate the natural environment of the community and the ways in which we incorporate the setting into the therapeutic work.

The second year trainee acts as buddy to the new trainee, offering a mix of practical information and emotional support. (This practice copies a system whereby new patients are buddied by a patient in the same unit). New trainees are likely to venture some tentative but appreciative thoughts about how staff relate with patients. Despite feeling confused, overawed and maybe emotionally overloaded at this point, they tend to speak of the clinic and its staff with respect and some idealisation.

However, the opposite may also be the case. Sometimes strong negative emotions are felt and expressed, in a manner that may be raw and unrestrained. Doubt, uncertainty, vulnerability are all felt intensely. It can be a painful time. The trainee has been chosen on the basis of personal competence and perceived potential. But in the community setting, which is unsettling in all sorts of ways, the trainee is likely to feel not just a beginner, but an incompetent beginner. This is partly shaped by the trainee's unrealistic fantasies of herself or himself. Other things are at work too.

One of these is the matter of language. The language we use can include or can exclude and alienate. Unfamiliar terminology does the latter. At Ashburn we have two overlapping terminologies, that of psychiatry (including pharmacology) and that of psychotherapy. Both have to be learned by the trainee, but can only be mastered gradually. As well, there is the jargon of the therapeutic community, used with fluency by staff and patients alike. Some terms may have a short life span but pepper our dialogue until we all begin to shudder. A lot of terms and phrases endure, but seem peculiar to the outsider: pairings, exclusive relationships, the addictive mind, isolating, avoiding the group, being in relationship, sitting with your feelings. The trainee rapidly becomes aware of having joined a powerful culture, with a focus on talking about feelings and some marked conversational patterns, for example the habit of rarely answering a question directly and frequently answering by posing another question.

The pervasiveness of the language patterns may suggest a coercive belief system and may even smack of a cult. This is likely to have a particular impact on someone who feels strongly and defensively rooted in his own ideology or faith. A trainee may need to protect this faith and may fear brainwashing. There is time to brood on such matters since initially the trainee will have a

lot of unprescribed time, whereas other staff members seem relentlessly busy, rushing from one group or meeting to another. Even morning and afternoon tea breaks are used as structured meetings. The trainee can feel lonely and somewhat guilty for occupying him/herself with reading.

The trainee's interest becomes focused on the patients in their unit, whose stories are becoming familiar. They impress the trainee with their capacity to be emotionally articulate and may inspire him/her to do likewise. But here again there is a difficulty. The patient is encouraged to express distress but the trainee is expected to manage feelings internally until they can be taken to therapist, supervisor or mentor. The patient is accorded empathy, care and understanding; the trainee may wish, even long for, something similar. So at one moment the patient is an object of envy, the next moment strongly identified with by the trainee; at one moment more a sibling rival, at the next an ally in adversity.

Around this point there is often a significant event involving the trainee and a patient or patients, in which, unwittingly, the trainee is caught in a conflict or dilemma, often about a boundary matter. The event is put under the microscope and becomes an example of 'examined living'. Much comes to light: the covert agenda of the patient in which the least powerful staff member is consciously manipulated; the relative naïveté of the trainee vis-à-vis the patient; the hostile impulse hidden behind surface friendliness. In a sense this event is the initial 'blooding' of the trainee. It can cause shock and confusion. The trainee can feel duped and humiliated, or pressured. But it provides an instance in which the complex psychodynamics that are being learned about in theory suddenly become real and actual. It signals the transferential complexities ahead when trainees start individual therapy with their first patient. It requires trainees to think about the negative feelings the patient will harbour about being assigned to work with a beginning therapist.

The pain of this period is also experienced by some as a loss of innocence. Trainees hear stories of neglect, violence and abuse. In a community meeting they sit beside a woman whose arm bears the scars from being repeatedly cut, by herself. They learn about extreme and persistent forms of self-harm, which may incorporate bizarre, perverse and eroticised elements. Up close an anorectic patient may look like the images they have seen of concentration camp victims. These things are shocking. The prevalence of tales of childhood sexual abuse is likely to have an impact on the trainee's sexual self. But most powerful of all is the ever-present possibility of suicide which becomes a greater risk as patients grapple with psychological pain and conflict. Patients

often come to Ashburn with a history of multiple suicide attempts. The trainee soon becomes aware of the anxiety and vigilance carried by staff and how this can escalate in a flash. And the trainee learns about the pain carried by staff; pain about the patients who have committed suicide while at Ashburn; pain about those who take their lives after leaving. These patients are remembered for many years.

The trainee witnesses the particular awfulness of being closely connected with a patient who commits suicide. There develops a dread of one's own therapy patient taking his or her life. At least two trainees have had to deal with this.

Inside the Community – Relocation

So how does the trainee shift from mental dislocation to relocation? Recently a trainee pointed out to me that when a joint is dislocated it is relocated (ie. returned to its rightful position) as quickly as possible. This process is briefly very painful but followed by rapid relief. But the dislocation of the trainee requires relocating to a new place and there is ongoing pain and difficulty and no return. The process of becoming a psychotherapist involves even more inner learning than academic learning. It requires close examination of one's aggression and hatefulness, the shame-filled dark corners of the mind. All this is happening in the community setting and some of the trainee's most difficult moments may be witnessed by staff and/or patients. Privacy cannot be counted on.

The relocation work takes place both consciously and unconsciously. During this period the dream life of the trainee is likely to be vivid and the Ashburn experience readily identified in the dreams. It may take the work of supervision and personal therapy before unconscious anxieties become conscious. The trainee also needs help with the conscious aspects of the relocation work. Just as the patient has to be engaged in a treatment alliance the trainee has to be engaged in a training alliance. Central to this is the experience of being understood, respected and cared about – alongside the expectation that trainees manage themselves within professional limits.

The mentoring process is a common teaching modality within medical fields. It provides a mix of observing, teaching, nurturing and guiding towards a specific goal – in this case the acquisition by the trainee of knowledge, competence and confidence. In addition to the formal monthly meetings of the training group I meet as required with individual trainees. Sometimes a home situation, such as the illness of a family member, has implications for work at the clinic. More often it is a work situation that has evoked a lot of

feeling. Such feeling may be connected with another staff member, or trainee, or with myself, in particular with regard to my role. I can be at the receiving end of both positive and negative maternal transference. Part of the mentoring task is to hold and contain these experiences, sometimes to metabolise them. This can be analogous to the maternal task observed by the trainee visiting the mother and baby pairs.

The trainee group is also a natural setting for sibling rivalries. I remember this well from my own training and how unnerving it can be to experience the primitive force of such feelings. The combination of training and the community setting creates something of a hothouse experience in which either friendship or hostility can develop very quickly.

Quite early on I give trainees a copy of what is to my mind a classic paper: "Narcissistic Issues in the Training Experience of the Psychotherapist" written by Baird Brightman in 1984. He identifies the fantasies of those who enter the helping professions: to be hero, sage and healer; powerful, wise, benevolent. These aspirations make up the trainee's 'grandiose professional self'. They are severely threatened by the destabilising adjustment to the training experience. Defences are mobilised against the threats to self.

Brightman outlines these under five main headings: The obsessional defence (the trainee attempts to attain a sense of intellectual control over the experience); the hysterical adaptation (the trainee rejects an 'overly intellectual' approach, glamorises intuition and the release of affect); the acting adaptation (the trainee avoids feelings of helplessness with a high degree of 'doing something' to the patient); the paranoid adaptation (difficult feelings in the trainee are displaced on to someone else); the schizoid adaptation (the trainee uses psychological withdrawal to maintain equilibrium).

Brightman also identifies "a significant depressive experience organised around a sense of helplessness and hopelessness of achieving professional aspirations" (1984-85, p. 305). Most of our trainees have some form of depressive reaction and manage the necessary recovery. There is a developmental aspect to the training and core developmental conflicts are likely to re-emerge. Erikson's normative crises are helpful in identifying the problem (1965, pp.239-261). For one trainee the core conflict will be 'initiative versus guilt', for another 'industry versus inferiority', for a third 'identity versus role confusion' or ' autonomy versus shame and doubt'. The difficulty may emerge with the challenge of working alone with a patient (autonomy); or in supervision when trying to describe a clumsy interpretation (shame); or with guilt about finding it hard to warm to a patient. Feelings of inferiority may erupt in response to the marking of a case study. Identity

confusion can develop because of the visibility of the nursing role as a model, compared with the relative invisibility of the therapist role.

Training in a therapeutic community is a particularly demanding experience (parallel in many respects to the demands of treatment in a therapeutic community). There is considerable risk in exposing the self to change and challenge. Just as we are unable to help some patients so the training experience may be less than satisfactory for all involved. Difficulties may emerge and get no resolution. Training may be formally completed but a training alliance never really experienced, by either staff or trainee. Sometimes the difficulties for the trainee seem to belong to conflicts that are earlier in development and more entrenched than those identified above. Here Erikson's discussion regarding 'basic trust versus basic mistrust' seems relevant and helpful. In the following quotation the word 'trainee' can be substituted for the word 'child':

> A sense of trust...forms the basis in the child for a sense of identity, which will later combine a sense of being 'all right', of being oneself, and of becoming what other people trust one will become...There are...few frustrations in either this or the following stages which the growing child cannot endure if the frustration leads to the ever renewed experience of greater sameness and stronger continuity of development, towards a final integration of the individual life-cycle with some meaningful wider belongingness (1965, p. 241).

When we invite a person to start training at Ashburn I think the question of basic trust is at the heart of the matter, and fundamental to what we are trying to assess at interview. Is this person 'all right' in herself? Can she become what we trust her to become...endure frustrations...renew the self...continue in development...towards a final integration of her individual experience before Ashburn, at Ashburn and beyond?

The Insiders

This paper was originally written for the 2006 Windsor Conference, whose theme was "Outsiders and Insiders". The new trainee encounters two sets of insiders: the patients and the staff. What do we as staff members bring, both consciously and unconsciously, to our encounters with our psychotherapy trainees?

Newcomers tell us that we are more friendly, polite and interested than staff in many other institutions. This is understandable. After all, attention to welcomes and to relationship is part of what we practise every day in the

therapeutic community. However, there are also various ways in which we keep the newcomer trainee at a distance.

In the first place, we have, like any other social group, a pecking order, which is defined around length of service and established groupings. The new trainee is at the bottom of the pecking order. We expect the trainee to be visible but not too vocal and not too opinionated. (The patients have similar expectations of the trainee.)

Secondly, the new trainee occupies the most recent position in the training history. They become to some extent the repository of hopes, fears and anxieties, based on the history with their predecessors. They are aware of being watched in this community where observation is central to our understanding of each other and to working together.

Once a week we meet for an hour, with an outside therapist holding the group process. It is not a therapy group but it is the time when we 'take our pulse' with each other, both individually and collectively. The meeting can feel difficult. At such times some trainees have experienced a different kind of being looked at.

They have felt certain that there has been a projective quality to this looking and, specifically, that they are asked to carry an anxiety for other group members. The experience seems to persist for some time and then to lessen. I think that the increasing confidence and robustness in the trainee, along with growing acceptance of and attachment to him/her both play a part in its diminution.

Leaving the Community

The twin themes of arriving and leaving are a daily part of community life at Ashburn, formalised with a space in the agenda of both unit and community meetings. Movement from an inpatient unit to the day programme is treated as both a leaving and an arriving, with encouragement to the patient to say a careful goodbye to significant staff members and to think about previous separations, farewells and losses, and how they were experienced.

Some patients leave us abruptly and prematurely. When this happens the goodbye is truncated. The worst form of leaving is, of course, when a patient commits suicide and there is no goodbye.

Trainees quickly realise that we pay a great deal of attention to endings of every kind. It takes longer, I think, to gain an understanding of how central the many and various experiences of loss are to a patient's difficulties and how much the work of therapy is about unresolved and unidentified grief.

The trainee's personal therapy is likely to amplify this theme.

The major challenges for the third year of training are to complete the academic and clinical tasks, to bring therapy relationships to a close, to say goodbye to the entire community, and to manage the pressure of being farewelled, by patients and staff, over several weeks. This process is usually challenging and meaningful. There is a particular intensity in the staff group meetings where we wish to say a warm and appreciative goodbye but also to say something about what has been difficult and painful. We hope that the trainee may be able to comment on a process that is likely to have been life-changing and which is still being integrated.

Some final remarks

As the training mentor, I have a particular insider experience, which has been a large component of my motivation in writing this paper. I have come to realise that the trainees are almost always somewhere in my mind, and that I may even have them more in mind than my individual patients. This seems to me not unlike Winnicott's concept of 'primary maternal pre-occupation' which he described as the mother's 'normal illness' (Winnicott, 1975).

I have needed to think carefully about my own transferential projections on to trainees. In this I have also been helped by their responses to me, which so frequently testify to their healthy and robust training development. I feel deeply appreciative of the personal learning and growth that has resulted from the mentoring task.

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