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PSYCHOTHERAPY PROGRAMME FOR PSYCHIATRY RESIDENTS AT NIMHANS - 1. A DESCRIPTIVE ACCOUNT

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SUMMARY

A formal, mandatory psychotherapy training programme for psychiatry residents at NIMHANS was started in 1983. It has made qualitatively encouraging progress. It has also focussed on issues demanding attention in the years to come. This paper is a descriptive account of the programme.

INTRODUCTION

Psychopharmacological discoveries have revolutionized clinical psychiatric practice, but a large proportion of clients continue to require modalities of psychotherapy, where the skills of even a simple modality as counselling requires training. Yet, teaching of psychotherapeutic skills in India has not been consistent either cross-sectionally across the country, or longitudinally over time.

It was over this background and when there was no formal training in psychotherapy in the Department of Psychiatry, NIMHANS in the late seventies that the first author (Shamasundar, 1981) conducted a series of pilot programmes starting in 1978 to stimulate the awareness and interest in psychotherapy among the faculty and psychiatry residents:

i) Once a week exercises in psychodynamics of interviewing for the post graduate students in a clinical unit.
ii) Once a week ward-group meetings, separately on male and female blocks.
iii) Once a week self-experience group for 8 volunteer residents in psychiatry.

These exercises gradually brought about a change in the prevailing atmosphere such that more and more residents began to seek individual supervision in psychotherapy. Consequently, a formal psychotherapy training programme for psychiatry residents was started at NIMHANS in August, 1983.

STRUCTURE OF THE PROGRAMME

I. SUPERVISORS' GROUP:

In August 1983, 11 psychiatry faculty members volunteered to function as psychotherapy supervisors. They met once a week as a group, one of them functioning as a programme coordinator and group leader for 1-2 years rotationally. The objectives of the supervisors' meetings were to:

a) Formulate, implement and continuously monitor the programme.
b) Develop and maintain interpersonal rapport, cohesiveness and unity of purpose.
c) Facilitate peer review learning by discussing:
  i) Own therapy material
  ii) One's supervision material
d) Discuss and deal with administrative and other issues relating to the programme.

The supervisors' group decided to promote Brief Dynamic Psychotherapy in supervisory practice. Each resident was required to complete a minimum of 25 supervised psychotherapy sessions per year of his course. Each supervisor was allotted 6 to 7 residents for supervision.

II. PHASES OF TRAINING:

a) Preparation: Each new batch of residents was given a reading list introductory to psychotherapy. This was supplemented by a series of lectures on:
  i) description of the training programme;
  ii) Principles and stages of Brief Dynamic Psychotherapy.
b) Clarification: Each supervisor spent 3 to 4 sessions with his residents discussing about various theoretical and practical issues in order to deal with the residents' anxieties, misunderstandings, doubts etc.
c) Interview exercises for familiarizing the residents with the psychodynamics of interviewing over 5 to 6 sessions. Each resident, in rotation, presented for group discussion one of his interview sessions with a non-psychotic patient, using transcripts or audiotaped material. The emphasis during discussions were on:
  i) identification of affective and latent meanings;
  ii) resident's inter-active styles, response-patterns, and the need to monitor own therapeutic behaviour;
  iii) relating patient's communication style and pattern to his behavioral and psycho-social antecedents.
d) Supervision of psychotherapy: This is described below under a separate heading.
e) Theoretical reinforcement: At the beginning of their second year, the residents were exposed to a series of tutorials on different schools of psychotherapy to broaden their understanding.

III. SUPERVISION:

Individual supervision: In order to gain some initial collective experience in supervision, the programme was restricted in the first year of its inception to only 2nd year M.D. residents. Each supervisor met one resident once a week, for individual supervision.

Group supervision: From September 1984 onwards, the training was made mandatory to all the residents, and 5 to 7 of them were allotted to each supervisor who met their respective groups once a week for group supervision.

Supervisory sessions: In consultation with respective supervisor, each resident took up a suitable patient for psychotherapy after informed consent.

The psychotherapy notes of each session were either transcribed from a recorded tape or written down from memory. Also, a brief summary of each session was recorded on a one page proforma. By rotation, each resident presented his psychotherapy material to the group for discussion. Thus, a resident could discuss in detail only his 5th or 6th therapy session. However, the supervisor flexibly offered sometime in each supervisory session to briefly discuss the therapeutic problems of any resident. The targets of attention during the supervisory sessions were:

i) further refinement of interview skills;
ii) identification of patient's core-conflicts as well as positive and negative aspects of his personality and psychosocial environment;
iii) formulation of therapeutic objectives that are practicable;
iv) guiding the therapeutic interaction towards the objectives.

Both the presenting resident and the supervisor maintained own notes of the supervisory sessions. Though the preferred mode of psychotherapy was brief psychodynamic psychotherapy, other modes of understanding the patient's dynamics were also discussed as the opportunity arose. The residents were allowed freedom to conduct their therapies in a manner they spontaneously felt comfortable with at any given moment so as to maintain the therapist's genuinity.

IV. ASSESSMENT:

The resident's performance in psychotherapy during his course constituted a part of his internal assessment which is a part of his final grading.

a) Initial assessment: After the lectures and tutorials, the residents' responses to a set of simple "short notes" questions were independently scored by two or more supervisors and the scores averaged.

b) Supervisor's assessment: Each supervisor rated the performance of each of his resident in terms of:

i) adherence to the programme;
ii) participation in discussions, interest, initiative etc

Besides, the resident's preferred style of therapeutic functioning, viz., supportive, cognitive etc. was noted.

c) Final assessment: Towards the end of his course, each resident submitted his psychotherapy records about any case that he considered his best performance in the prescribed format (Appendix). These records were assessed by 2 or more supervisors (who had not supervised him), coupled with a viva-voce to assess:

i) Empathy, and sensitivity to subtle aspects of communication;
ii) Ability to introspectively monitor own therapeutic behaviour;
iii) Ability to put psychodynamic understanding to therapeutic use;
iv) How well the core-conflicts have been dealt with.

At the end of the academic year, the supervisors jointly reviewed the residents' performance as well as the programme.

OBSERVATIONS

Under this heading are included many collective experiences and a few speculations considered reasonably viable.

GROWTH OF THE SUPERVISORS' GROUP:

The supervisors' group had many anxious moments. Within two years of its inception, five supervisors left the programme due to insufficient time to pursue other academic commitments. Two more members left the programme a few years later on change or job, and six "new" faculty members joined the group at various times. During its first year, the group had many occasions to introspectively examine some issues:

a) Each member's self-image in the role of a supervisor.
b) A search for commonality amidst the diversity of each individual's modalities and orientations.
c) Tendency to avoid or postpone dealing with painful issues.
d) Periods of "mourning" or "depression" in the form of long silences whenever there were dropouts or thin attendance.
e) Development of an attitude of objective critical but tolerant mutual appraisals.
f) Recognition and acknowledgement of the group's authority by general consensus in an informal atmosphere.
g) Acceptance of mutual accountability.

TEETHING TROUBLES:

Some residents failed to meet their supervisors for weeks or months, probably related to bias and anxiety. This was overcome by evoking the Department's support.

Some residents showed an initial difficulty to find suitable cases either for interview exercises or for psychotherapy. This problem was solved by maintaining a centralized list of suitable cases for allotment.

Occasionally, a resident would assume a passive, defiant and uncooperative attitude by not participating in the programme. By evoking the Department's disciplinary machinery, they were persuaded to complete their tasks, and the respective supervisors offered them extra sessions for the purpose.

Whenever counter-transference was identified in the resident's therapy material, the supervisor's role was confusing: Should he assume the role of a therapist? It was decided that the phenomenon of counter-transference in a respective therapeutic situation should be discussed and that the subsequent responsibility was the resident's. If the resident wished to resolve this problem with outside help, the supervisor could decide either to deal with the matter himself or to refer to a colleague.

PSYCHOTHERAPY PRACTICE:

Within each batch, there was an overall, progressive increase both in the quality of psychotherapeutic work as well as the enthusiasm and participation of the residents in the programme. The same trend was seen longitudinally with successive batches of residents.

A consistent observation was that the residents varied widely in their tendency to adopt a particular individual mode or style of relating to the patient in spite of the general orientation to promote brief psychodynamic psychotherapy.

i) At one extreme, a few residents showed an innate sensitivity to psychodynamic understanding and relating from the beginning;

ii) Some were insensitive or even resistive to psychodynamic orientation in the beginning, but became good converts towards the end of their course;

iii) Some others almost exclusively used either cognitive or supportive techniques irrespective of their ability to academically discuss psychodynamic concepts.

iv) At the other extreme, a few residents seemed unable to handle psychodynamic concepts, but conducted themselves with their patients just like a sympathetic friend or neighbor. Yet, surprisingly, their patients stuck to their therapy sessions regularly and got well!

Often, even those patients who were relatively less literate benefitted from psychodynamic therapy, which did not seem to suit so well some of the highly educated. Most likely, it is not the patient variable alone that influences the therapeutic mode adapted and its outcome. A natural consequence of the above observation is the following question:

Is it possible to teach a particular method of psychotherapy to a heterogeneous group of trainee therapists? If not, what should the training objectives be?

FUTURE DIRECTIONS

As at present, there are three main areas of future concern and attention: The first is the question posed above. Even if it is assumed that the future concern should be on measuring of and training in desirable therapist qualities (Shamasundar, 1986), the task of operationalizing them would be arduous.

The second is the issue of validating the training programme. This involves the complex and difficult task of analyzing the process and outcome of psychotherapy.

The third concerns the development of relatively short (say, 2 to 4 weeks) training workshops for those supervisors who do not have the facility for peer review learning (viz., one member departments).

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