p-ISSN: 2184-2205 e-ISSN: 2184-3414 ISBN: 978-989-35106-0-5 © 2023
https://doi.org/10.36315/2023inpact071

FROM IMPASSE TO DIALOGUE IN PSYCHOTHERAPY: TRAINEE PERSPECTIVES ON USING PSYCHOANALYTIC THINKING IN TERTIARY PSYCHIATRIC SETTINGS

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Abstract

Psychotherapy in tertiary psychiatric settings necessitates structured, symptom-focussed approaches which can be applied by trainees and staff. However, given the complex presentations, impasses in psychotherapy are common, and may result in unplanned termination if unaddressed. Containment in supervision, and using elements of psychoanalytic thinking may be especially helpful in such situations; here we discuss trainee perspectives from a tertiary psychiatric institute in India.
Patient presentations at the institute include chronic and severe psychiatric illnesses including dissociation/conversion, personality disorders, substance abuse and self-harm, and psychotic conditions; commonly low-education and low-income; a complex history of previous psychiatric/psychotherapeutic consultations; from across the country and neighbouring countries. Clinical psychology trainees at the institute undertake a two-year full-time advanced training, with a focus on diagnosis, psychopathology, assessment, and psychotherapy. The psychotherapy training emphasises structured, manualised treatments (e.g., cognitive-behavioural, dialectical behaviour therapy, mindfulness), which are suited in these settings for providing a structure and framework, building trainee confidence, and quick symptom relief.
However, trainees frequently encounter impasses in psychotherapy, such as patients displaying excessive verbal compliance without matching insight or action, too much/too little verbal content in sessions, frequent crises, boundary violations, hostility/antagonism, and splitting of the multidisciplinary team. When "the techniques don't work", trainee therapists often struggle with feelings of 'stuckness' and self-doubt, resulting in avoidance and potentially, unplanned termination.
In supervision, psychoanalytic thinking offers several insights. Firstly, for trainees burdened by outcome expectations, there is immense relief in noticing and verbalising a difficult therapist-patient dynamic. Secondly, containment in supervision allows for a greater tolerance of the patient's affect in the session. Third, shifting the focus to listening and 'not-knowing' allows the patient to explore previously forbidden experiences. Trainees highlight the experience of "using no technique at all…only the basics of therapy", using themselves and the relationship as vehicle of change. These elements of psychoanalytic thought appear to stabilize trainee therapists when the ground shifts, and manual-based techniques fall short. More importantly, when used within a multidisciplinary team, psychoanalytic thinking may make room for an understanding of the patient's internal psychic reality as it plays out in external events, rather than acting on it.
Trainee psychotherapists may lack skills to navigate roadblocks, particularly with difficult-to-treat patients, in tertiary settings. This is a critical gap to be bridged in training and supervision, and indeed, training of supervisors. It is important that psychoanalytic thinking be accessible and usable alongside other psychotherapeutic approaches in tertiary settings.

Keywords: *Impasse, tertiary settings, psychoanalytic, supervision, containment.*

1. Introduction

Tertiary psychiatric settings often manage severe and long-standing psychiatric conditions with a complex history of previous consultations. Psychotherapy in such settings often comprises structured, short-term approaches. Such approaches are suited for quick symptom relief, and are suitable for use by trainee psychotherapists in appropriate stages of the training.

However, given the breakdown in symbolic functioning which is the hallmark of chronic and severe mental illnesses (Evans, 2016; Lucas, 2013), psychotherapy with such presentations may often run into difficulties, which challenge the structure and framework. Such impasses in psychotherapy may result in unplanned terminations, adding to the general sense of helplessness surrounding such patients.

Supervision focused on containment and elements of psychoanalytic thinking may be uniquely helpful in such situations. Psychoanalytic thinking offers a mode of thinking that takes into account the unconscious forces that influence various aspects of psychotherapy - relating to the symptom presentation, the therapist, the therapeutic relationship, and the enactments within the treating team. The psychoanalytic model can especially be helpful in restoring the emotional meaning to concrete acts or enactments (Evans, 2016).

Here we discuss perspectives from psychotherapy training and supervision using psychoanalytic thinking in a multidisciplinary team, at a tertiary psychiatric institute in India.

2. Method

2.1. Setting

The study was set in an adult psychiatry unit at a 1000-bedded tertiary care facility dedicated to mental health and neurosciences, serving the whole of India and neighbouring countries. Adult psychiatry units at the institute offer inpatient and outpatient services through a multidisciplinary team comprising psychiatrists, clinical psychologists, psychiatric social workers and psychiatric nurses, with a three-tier system of clinical care and training.

Psychiatric presentations at the institute span severe and chronic illnesses including dissociation/conversion, personality disorders, substance abuse, self-harm, and psychotic conditions. Patients are commonly low-education and low-income, and often have multiple previous psychiatric/psychotherapeutic consultations with little success.

2.2. Participants

The participants in this study were postgraduates in clinical psychology (having previously completed a Bachelor’s and Master’s degree in Psychology). The postgraduate course in clinical psychology offered by the institute is a two-year full-time advanced training comprising theory lectures and supervised clinical work, with a focus on knowledge and clinical competencies in psychiatric diagnosis, psychopathology, assessments, and psychotherapy. Across the two years, trainees go through rotations in adult psychiatry, family therapy, child and adolescent mental health, neuropsychology, cognitive and behaviour therapies, psychiatric and neurological rehabilitation, addiction medicine, and community mental health.

The psychotherapy training emphasises structured, manualised treatments (e.g., cognitive and behavioural approaches), which are suited in these settings for providing a structure and framework, building trainee confidence, and quick symptom relief. All trainees are required to submit records of psychotherapy work carried out, including a case summary, case formulation based on a theoretical model, assessments, and details of psychotherapy goals, techniques and process, followed by their own reflections.

The eight participants included in this study were supervised by a single supervisor during their clinical rotation, at different points in their 24-month course, and worked in the multidisciplinary team led by a senior consultant psychiatrist. Supervision for trainees was offered individually, and integrated didactic, therapeutic and parallel process models (Thorbeck, 1992). Following their three-month clinical rotation, the trainees moved on to other postings, but most of these participants continued providing therapy to these patients. The supervision space was left open, and was accessed flexibly by each of them throughout their course. The supervisor was a consultant clinical psychologist, attending weekly group psychoanalytic clinical and reading seminars, led by an experienced and qualified psychoanalytic psychotherapist.

2.3. Data collection and analysis

The data was collected between Dec 2019-Dec 2022, and comprised trainees’ psychotherapy case record reflections, and responses to an additional set of semi-structured questions described below.

The eight trainees were at various stages of the course when they were first allotted the cases with the current supervisor (five were in the first six months of the course, and three in the final six months), but all submitted their case records at the same stage (in the 21st month of the course). While the minimum mandated sessions for the psychotherapy case records is eight sessions, the participant submissions used here had 15-70 sessions, seen across 3-20 months, in either inpatient, outpatient or both settings.

Given some similar themes noticed in the therapist reflections, and in supervisory discussions, all eight trainees were invited, (after course completion, with no implications on their examination scores) to respond to a set of questions sent out by the supervisor to facilitate deeper reflections on the process. This included questions regarding their stage of training, previous experience of being a therapist, difficulties encountered in the current case, experiences in supervision, reflections on learning, and shifts in approach if any, vis a vis their own other cases. Two of the trainees returned the completed reflections, in addition to their psychotherapy case record reflections.

The data was qualitatively analysed through an iterative reading of trainee case records, supervision notes, and responses to the set of reflective questions, noting common themes.

3. Results and discussion

The study aimed to understand trainee experiences with psychotherapy in tertiary psychiatric settings, and the usefulness of psychoanalytic thinking in supervision, through an analysis of trainee reflections on their psychotherapy case records and additional reflections on the process of supervision with a single supervisor.

The common themes emerging from analysis included trainees' experience of difficult moments in therapy. These included a sense of *"therapy not going according to plan"* or *"structured techniques not working"*. This often occurred with patients being either openly hostile and antagonistic in session, attacking the trainees' most vulnerable area - their lack of experience; or, in contrast, displaying excessive verbal compliance without matching emotional engagement, insight or action. Trainees also struggled to manage too much/too little verbal content in sessions, and frequent crises. Enactments were common and often shook therapists off balance – for instance, one patient was convinced he had a diagnosis of attention deficit hyperactivity disorder but refused to engage in diagnostic exercises or a dialogue around it; belittled all the therapist's suggested techniques, and surprised the therapist by turning up unplanned with an overbearing mother in tow, as if 'presenting' her for the therapist to 'experience'. Another patient with depression and polysubstance abuse, dressed only in dark muted colours with the curtains always drawn, would sometimes face the wall and refuse to speak for the entire session. Several trainees experienced patients who challenged the framework of therapy by frequently missing scheduled sessions, turning up just before/after the session had ended, furious that the therapist had not "reminded" them, and demanding additional sessions. Some patients reached out to therapists several times between sessions, requesting to talk "just ten minutes" to manage a crisis, and resisted efforts at holding the therapy framework. One trainee had to deal with the patient calling in a crisis (despite having a crisis plan that included emergency contact), just before the trainee was about to go in to an exam. Trainees struggled to think, in sessions with patients who blindsided them with personal remarks or overtures and fused them to it concretely. One trainee was celebrating a minor gain that a patient with dissociative mutism was actually beginning to talk in sessions, and fielded a seemingly innocuous comment on the therapist's similarities in age and cultural-linguistic background (striking in India, where diversity is the rule rather than the exception). The patient then revealed that she had a 'secret plan' post-discharge, and refused to disclose further details unless the trainee promised unconditional confidentiality. Such moments were particularly striking because they often occurred over the long-term, in the presence of a strong therapeutic alliance, leaving trainees even more bewildered and frustrated. Trainees often grappled with feelings of 'stuckness' and self-doubt, feeling detached in sessions, or resentful and burdened by the patient's incessant demands on therapist attention. This was often accompanied by an urge to avoid sessions with such patients. As one trainee wrote, *"Without a framework in mind, nor an engaging relationship, the therapist felt unsure of this patient… did not wish to continue seeing him and/or was tempted to be mechanical with him".* Such feelings of the therapist, if unaddressed in supervision, potentially lead to unplanned and violent terminations, or frequent presentations to emergency or inpatient care, adding to the patient's already complex history of consultations and sense of futility (Evans, 2016). The themes also highlighted the usefulness of using psychoanalytic thinking to understand the dynamics within the session, discussed in detail below.

Trainees were unanimous in noting the emphasis on dialogue and the process of thinking together, (rather than directive/didactic supervision), which they were able to carry back into the therapy session in a parallel process (Thorbeck, 1992). Such dialogue facilitated a shift in the focus of therapy - from the outcome to the process, from the end goal, to the 'journey' of therapy. Trainees highlighted the power of *"using no technique at all", "only the basics of therapy"* using themselves and the relationship as vehicle

of change (Freud, 1993). One trainee wrote, *“My biggest take away from this case was choosing to build a therapeutic alliance over the use of explicit techniques. As a novice therapist, it was easy for me to stand behind techniques, blaming them for not working in improving the client…”*

Shifting the focus to listening and ‘not-knowing’ may allow the patient in therapy to explore previously forbidden experiences. Not-knowing, as described by Bion, refers to a therapist’s willingness to tolerate frustration and uncertainty (Green, 1973), and when cultivated in supervision, may allow for a greater tolerance of the patient’s affect in the session. As one trainee put it, *“My experiences of therapy were heard. I had a space, much like this patient, to express my opinions without being shot down for them”.* Containment in supervision also allowed therapists to stay with their own anxiety (Thorbeck, 1992), rather than, as one trainee put it, *“being in a hurry”,* trying frantically, with one technique after another, to move things along to the next level. According to one trainee, *“In other approaches, I’m the director of the sessions: I ask, I educate, I teach skills. Here, I take the back seat, see the world… as the person sees and experiences the world, no matter how it may seem to my principles”.* This may relate to recognising the distinction between the patient’s ‘need for understanding’ and the ‘need to be understood’ (Joseph, 1983). Another trainee therapist, daunted by a hostile and antagonistic patient who had terminated with over a dozen previous therapists wrote, *“I was more aware of my feelings this time… and used this… to try and put myself in the patient’s shoes, trying to see how it would feel…being invalidated all the time, feeling lonely and disliked”.* Therapists were also less avoidant of conflicts in session, *“…bringing more relationship conversations into the sessions… to increase tolerance of conflicting viewpoints, staying with the conflict.”* Acting as the third point in the therapist–patient–supervisor triangle, the supervisor provides the space to reflect about the impact of the clinical work and reduce the pull towards re-enactments. Importantly, perhaps, the psychoanalytic framework ‘makes room for madness’ (Evans, 2016), allowing the patient a safe space to reveal his/her unique difficulties, and the more infantile parts of the self, and for therapists to understand and tolerate these.

Evans (2016) discusses that effective work in mental health settings is dependent on professionals allowing themselves to be disturbed by the patients and their presentations while still maintaining a professional stance - this includes the therapist being willing and able to respond to the various forms in which these present during the course of treatment - denial, avoidance, deceptions, enactments within the teams - and the important role that supervision plays in helping the therapist find a safe space from which to take in the whole experience. Through this, psychoanalytic thinking may also shift the focus from the ‘outer reality’ (concrete behaviours and enactments) to the ‘inner reality’ (significance of behaviours). As one trainee therapist wrote *“I’m more aware of the meaning of events in and out of sessions. I’m able to “connect the dots” and reflect with myself and the patient on conflicts, patterns, and meanings”.*

In a busy multidisciplinary team, it was also not difficult for patients to recruit team members and staff to work against their appointed therapist. Trainees often had to deal with patients’ splitting of the multidisciplinary team into ‘good’ and ‘bad’ objects, and had to manage the resultant confusions, miscommunications and ruptures with teammates. Psychoanalytic thinking may be particularly helpful for clinicians to appreciate the ways in which the aspects of the clients' internal world/self can be located in various external objects - therapists, nurses, psychiatrists and other members of the treating team (Evans, 2016).

The striking feature in supervision in all of the eight cases was the long-term nature of treatment, and the nature of dynamics, not often evident within short-term therapies. This, of course, highlights trainees’ commitment and persistence with the cases beyond their three-month clinical rotation, along with their reflective capacities and sensitivity to the dynamics evolving moment-to-moment in each session, and their authenticity in bringing these to work through in supervision. Complementing these necessary and noteworthy attributes of a good therapist, however, may have been the mode of thinking offered by psychoanalysis in supervision, which allowed these eight trainees to persist with their cases long beyond submission requirements, or what was typical of the setting. Foremost among these, for trainees burdened by outcome expectations, there is immense relief in noticing and verbalising a difficult therapist-patient dynamic in supervision, and in thinking together around the emotional symbols of concrete events. These elements of psychoanalytic thought used in supervision appear to stabilise trainee therapists when the ground shifts, and manual-based techniques fall short, regardless of the approach to therapy being used.

Trainee psychotherapists may lack skills to navigate impasses, particularly with difficult-to-treat patients, in tertiary settings. This gap needs to be bridged in training and supervision, and indeed, training of supervisors, to minimize poorer outcomes in treatment. Crucially, within a multidisciplinary team, psychoanalytic thinking may allow for an understanding of the patient’s internal psychic reality as it plays out in external events, without necessitating concrete action. This underscores the utility of psychoanalytic thinking, even alongside other psychotherapeutic approaches in tertiary settings.

p-ISSN: 2184-2205 e-ISSN: 2184-3414 ISBN: 978-989-35106-0-5 © 2023

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