Original Paper

Psychother Psychosom 1992;57:83–87

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The Training of the Psychiatrist in Relation to the New Trends in Psychiatry

Key Words
Education
Psychiatry
Training

Abstract
One of the most important things to realize about modern Psychiatry is that many factors are involved in the pathogenesis and especially in the evolution of mental diseases. The results of epidemiological research and the development of different schools with separate specializations have shown the importance of extrasubjective factors such as family environment, social context, life events and life stressors, and therefore the need to find therapeutic strategies which are able to influence the different areas. From this wide spectrum arises the necessity for a functional integration of the different therapeutic areas in the operative context, also because of the nonhomogeneity and the frequent random choice of reference models by the operators and the mental health services. In this study we propose a training model which allows the achievement of this integration ability at an operative level, and which at the same time defines its limits.

The training of young psychiatrists is influenced by two factors, one cultural, that is the prevailing conception at a given moment of the mental illness and its causes, the other connected with the organization of the Welfare and Health services in a given social context. In Italy as well as elsewhere, it seems that the prevailing cultural orientation is connected with the conception of a multifactorial origin of the psychotic disturbances and their consequences. The organization of the health services, on the other hand, is oriented towards the replacement of mental hospitals and the development of health services in the community.

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0573–008352.75/0

In Italy, in particular, as a consequence of law 180 the greater part of mental hospitals have been closed down and replaced by local health services in which there are operators who often have different orientations and experiences (psychiatrists, psychologists, social workers, occupational therapists). These two factors require, first of all, an integration or a choice between the different instruments and techniques of intervention [1, 2].

In Italy the services have developed in ways that are not homogeneous: in some areas a conception of a sociological type prevailed which aimed at the integration of the patient in the community and at the reduction of the disability caused by the illness by means that are predominantly social (finding a home, finding a job, experiences of resocialization and of life in the community, economic and practical support).

In other areas the influence of psychodynamic conceptions has been remarkable. Individual or family psychotherapy is the nucleus of intervention. Finally, in other areas, which are frequently areas of minor economic development, 'poor' community services have employed mainly psychopharmacological interventions. The psychopharmacological treatments are in fact widespread in all three areas, although with different modalities.

In the areas of 'social' orientation there is a moderate use of drugs, whereas in the areas with a psychodynamic orientation drugs are used in combination with psychotherapeutic treatment. In the poor areas there is a prevalent use of drugs, the dosage is high, the drugs most used are the long-acting ones and recourse to admittance to hospital is more frequent.

In the absence of a shared and validated practice, the main problem which presents itself to the trainee psychiatrist is that of acquiring the capacity to evaluate the different factors which influence mental illness and consequently to choose between the different techniques of therapeutic intervention, integrating them so as to construct a therapeutic project which is adapted to the individual patient's needs [3, 4].

From this arises the problem of learning and teaching these modalities of work in the context of formative programs. In addition to the common theoretical and clinical elements, which are part of the cultural baggage of the modern psychiatrist, it is necessary to provide a training through forms of learning which are more directly linked to experience, and which enable one to learn to establish a relationship with the patient, always with a therapeutic aim in view.

The Postgraduate School of Psychiatry of the University of Milan has implemented an experimental training program making use of audiovisual and role-play techniques. The students of the school are divided into groups of around 8 people. The members of each group must be heterogeneous as regards the area of research they are engaged in, and their clinical and theoretical orientation.

The group is formed of students who are oritented towards psychopharmacology and biological research, or towards psychotherapy and students who are working more on social aspects in the community. The meetings are held every week during the academic year. The group is led by a supervisor who is a psychiatrist and a group psychoanalyst. The meetings last 1.5 h and are split up into three fundamental parts:

1 Videorecorded role play lasting for 20 min at the most;
2 Group discussion using the videorecorded material; and
3 Summing up by the supervisor.

The factors which structure the training group are the setting, the tasks given by the supervisor to the group, the elaboration of the material that emerges during the work of the

group and the objective which this work pursues.

The task is defined by the obligation of each member of the group to portray in role play the interaction between doctor and patient [5, 6].

Each member of the group is invited to act out with another member the roles of doctor and patient. The member playing the patient is he who presents the case which for him is problematic and in it he plays the part of his patient. The person who plays the doctor is another member of the group, and he must, during the 20-min talk with the patient, succeed in forming his own hypothesis of the solution of the problem. At the end of the role play the 2 actors must express the feelings they experienced towards each other during the play, the patient what he felt towards the doctor and the doctor what he felt towards the patient. Simulation permits the expression of personal elements since the messages which are exchanged take place in a context that is not real [7]. The persons know they are not what they represent, but they identify with the personages represented since the interaction is real, as well as the feelings experienced within the role played.

The group must verbalize the feelings and emotions evoked by role play, and the judgements formulated on the interaction of which they were spectators. Both the feelings and emotions as well as the judgements constitute the object of the work of the group, and so provide an opportunity for a discussion of the different feelings and evaluations. Simulation, moving in the 'let's pretend' situation, characteristic of the setting, saves everybody, actors and spectators, from the risk of narcissistic injury, and so allows a freer expression of the feelings and judgements. The objective is to build together an individualized therapeutic project which responds to the needs of the patients as they emerged in the interactive game.

This objective is pursued in a situation which is at the same time a dual interaction at the moment of the role play and a group interaction, in its context. The dual interaction offers the person who plays the part of the patient the possibility of improving his or her psychological knowledge of his patient, thanks to an identifying movement and through the interaction with the therapist. The person who plays the part of the therapist has the possibility of experimenting with the role of therapist, focalizing attention on the specific aspect of the interpersonal relationship.

Since the theoretic orientation is assumed also in relation to the structure of personality and to particular defensive schemes, the assumption of a different role, the identification with the therapist or the patient, the group discussions all tend to provoke a crisis of the defensive schemes and of the mental attitudes based on prejudice. The group starts from the discussion of what happened in the dual interaction between the doctor and the patient. This gives rise to interactions between different members of the group in which different points of view are discussed that lie behind the identifying movements with the actors. These identifications are not rigidly connected to the parts but vary according to the different situations.

When the group works in this way, it acts as a mirror of the emotive movements and verbal acting and gestures that escaped the notice of the actors or that were not taken into due consideration. The group interaction and the videorecording are contrasting, as recall to the objectivity, the subjective values of each member of the group [8, 9]. In particular objectivity is sustained by reference to the videorecording, which also corrects the distortions of the mnemonic representation of the dual interaction. The different reading that each member of the group gives of the situation of the patient corresponds to the dif-

ferent point of view of each, which in turn depends on different theoretical clinical orientations. The objective of the training is the formulation of an individualized therapeutic program, which is not in contrast to the diversity of orientations. This is the task assigned to the group and the supervisor guarantees its achievement. He does not propose a theory which unifies the different formulations, still less does he give his own interpretation, but he steers the efforts of the group in the direction of an understanding of the patients' needs. The proposal of therapeutic strategies will derive from these needs and not from the affirmation of a point of view in contrast to that of the others.

Thus it is a matter of settling, in the clinico-therapeutic dimension, the splittings and fragmentations of the psychiatric institution and of giving to the components of a culturally heterogeneous group the instruments, at least in concept, which will enable them not to continue to work maintaining the water-tight compartments [10].

This in fact happens when, for example, a scientist with biological training, after having reached the optimum of the monitoring of the drugs which hit the target 'symptoms', verifying the difficulties with which his patient still struggles, considers them extraneous to the symptom and therefore in the competence of other operators to whom he delegates their solution [11].

The delegate in his turn will treat the problems of the patient as a different reality from those which have been the object of the work of the pharmacologist in collusion with him in the maintenance of the splittings as regards the person of the patient and in the maintenance of an epistemological error as regards his own knowledge, that is the error of considering the symptom unrelated to the problems of the patient and failing to recognize that the symptom is an expression of them [12, 13].

Finally the proposal of a therapeutic strategy will need to take into account the effective resources of the welfare services so as not to construct ideal therapeutic projects whose distance from the reality of the structures and from the competences is such as to render them impracticable.

In conclusion, those who have taken part in this work have learnt to express their own emotions and feelings, to be in close contact with them and thus to interpret and use them in a more correct way in the therapeutic relationship. Furthermore the calling into question by the group of the defensive schemes and prejudices caused an increase in confidence and interest towards points of view which were previously unknown or seen as different from one's own and therefore extraneous.

Through reciprocal confrontation postgraduate students acquire the capacity to place themselves in the clinical and therapeutic perspective by softening conflicts, avoiding, in order to escape them, having recourse to the splitting mechanism that at an operative level implies the fragmentation of the therapy. They have also acquired the capacity of being complementary before the complex mechanism which underpins the choice of the orientation and techniques that can produce languages which are reciprocally and definitively incomprehensible.

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