Supervision and Training of Psychotherapists in an Indian Therapeutic Community

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Abstract

The process of getting therapy supervision while working in a therapeutic community setting with persons suffering from chronic mental illness differ from those working in other clinical settings. In therapeutic communities, the demands on therapists are much more complex, multidimensional and result in significant emotional stress or 'burn-out syndrome'. For this reason, the therapists need to undergo intensive training, supervision and personal work on a regular basis. The present article applies a descriptive-single case study method, focusing on the process of supervision of psychotherapists in a therapeutic community in India. We explore the process of practical training and supervision of psychotherapists and describe our approach to developing a budding therapist's skills and sense of autonomy.

Introduction

The process of getting therapy supervision while working in a therapeutic community (T.C.) setting with persons suffering from chronic mental illness differ marking from the supervision process occurring in other clinical settings. In therapeutic communities, the demands on therapists are much more complex, multidimensional and result in significant emotional stress or 'burn out syndrome' (Freudenberger 1975). For this reason, the therapists need to undergo intensive training, supervision and personal work on a regular basis (Meinrath and Roberts 2004). The present article, applying a descriptive-single case study method, focuses on the process of training and supervision of psychotherapists in a therapeutic community in India.

Literature Review

Chronic mental illness or mental disorder is a serious and debilitating condition of an individual, which prevents the individual from making adequate adjustments to meet the demands of the society, be it occupational, social or personal. Current interventions from the medical and pharmacological fields are not adequate to deal with chronic cases. These conditions need to be addressed eclectically, taking into consideration medical, psychological, occupational, socio-cultural and economic perspectives. The treatment of persons with chronic mental illness requires not merely relieving of symptoms, but also rehabilitating them into mainstream society as effectively as possible. Halfway homes, rehabilitation centers and therapeutic communities aim to serve this purpose.

Definition and Principles of Therapeutic Community

A therapeutic community is a tertiary preventive measure to help reduce the impact of maladaptive behaviour in which rehabilitation efforts are focused more from the environmental perspective (Carson and Butcher 1992).

Northfield hospital started the therapeutic community movement to treat soldiers suffering from psychoneurosis during Second World War under the leadership of Tom Main (1946). He defined therapeutic community as:

> An attempt to use a hospital not as an organization run by doctors in the interests of their own greater technical efficiency, but as a community with the immediate aim of full participation of all its members in its daily life and the eventual aim of re-socialization of the neurotic individual for life in ordinary society (1946, p. 67).

These ideas were further developed by Maxwell Jones (1959) at the Henderson Hospital and described a therapeutic community as:

> Distinctive among other comparable treatment centers in the way the institution's total resources, both staff and patients' are self-consciously pooled in functioning treatment. (Jones 1973, p.427)

This implies, above all a change in the usual status of patients in collaboration with the staff, they now become active participants in the therapy of themselves and other patients and in other aspects of the over-all hospital work in contrast to their relatively more passive, recipient role in conventional treatment regimes.

In a recent article, the authors defined therapeutic community as a treatment center, where resources of staff and patients are 'pooled together' to enable a therapeutic process. (Srinath and Kumar, 2007).

Even though therapeutic communities are extensions of hospital and after-care centers, they differ in their values and treatment process. Kennard observes the special potential of therapeutic community as:

> In one sense TCs can be seen as all about continuous risk assessment and management, where episodes of destructive behaviour or threats of it are regularly discussed, analyzed and commented on by staff and clients in the small and large groups. In another sense TCs can be seen as allowing levels of risk that units with seclusion rooms, close observation policies and rapid tranquilization avoid- at the cost of no one learning anything about changing self-defeating ways of thinking, personal responsibility or concern for the effects on others (Kennard, 2005, i).

Principles of Therapeutic Community

Rapoport (1960), an anthropologist, who studied the Henderson hospital between 1953 and 1957 with his team of psychologists and anthropologists, observed four themes in the hospital, which are distinctive ideologies of the community: communalism, democratization, permissiveness and reality confrontation. Kennard (1998b) defines these principles as follows:

> **Communalism:** Stressing the importance of doing things together and respecting each other.
>
> **Democratisation:** Involving patients as far as possible in their own treatment planning; encouraging all patients and staff to be involved in therapy and the running of the unit and to express opinions.
>
> **Permissiveness:** Being able to express one's distress and use staff and other patients to understand and contain it rather than to act out and transgress boundaries.
>
> **Reality confrontation:** Encouraging patients and staff to recognize the reality of their situations and the necessity of boundaries and rules in communal life.

Haigh (1999) writes about principles or universal qualities of a therapeutic culture in therapeutic communities as based on object relations' theory, self-psychology and group analysis. Haigh's prerequisites

of a therapeutic community which are called as the quintessence of a therapeutic environment include the following concepts:

Attachment - a culture of belonging
Containment- a culture of safety
Communication - a culture of openness
Involvement - a culture of participation and citizenship
Agency - a culture of empowerment.

'Burn-Out' Syndrome in Psychotherapists

Therapists working with severely disturbed individuals require a diverse kind of orientation and training compared to working in other hospital contexts. Intensive emotional involvement of the therapist with the patients can cause a great deal of stress for the therapist. Meinrath and Roberts, 2004 write:

> The demands of being a good or ideal staff member can take a tremendous toll of a therapeutic community worker. Deprived clients often seem to ask for everything that they never had as a child and the community seems to demand an incredible dedication from the staff member (2004, p. 321).

Transference and counter-transference occurring between the patient and the therapist can bring about a number of issues. At times the therapists will have to withstand the brunt of negativity, hostility and rejection by the patients with whom they work intensively. These factors along with passive behaviours, violence and dependency can lay the foundation for burn-out for the therapists as a tremendous amount of emotional energy is invested while encountering each of these problems. For instance, after spending a great amount of time and energy working with a patient, the individual - as a part of their negative coping mechanisms - reject the therapist and choose to work with someone else. This can cause hurt and create despondency in the therapist who will need to deal with their feelings of anger, rejection, internal conflicts and feelings of inadequacy. The following example will illustrate:

> Mr. Karan, 24 joined our community in 2002 with a diagnosis of paranoid schizophrenia. As this TC functions on the basis of attachment and bonding, this …[young man] got attached to me and vice versa was also true. With the attachment, he improved in his social behaviour, his symptoms decreased and he was looking at career options. Meanwhile, I was out of the country for a period of six months. I was in touch with him through emails. I could sense there was something missing in his mails. When I got back to India, he had turned very hostile towards me abusing and accusing me of several things. I could not connect to him like I did before and every time we spent together would end up in arguments and fights. As time went by, he became more and more controlling of my time with the other patients. His nastiness was affecting my relationship with other members of the community. The statements he made were venomous and hurt me deeply to the extent that I felt my self worth was taking a plunge and I started having paranoid ideation thinking that other people were disapproving of me….(Senior therapist, Personal communication, January, 2004).

Another challenging issue facing therapists is the way they may be held responsible for the patient's life as well as the welfare of the members of the community. Passivity and discounting (Schiff, 1975) by the therapist can lead to a dangerous situation which may result in patients inflicting serious harm to themselves and others. This could have major repercussions to the morale of the whole community in general and on the concerned therapist in particular.

Freudenberger (1975) observes that this kind of work makes the staff members feel less enthusiastic, become increasingly rigid and readily provoked, which will lead to 'burn-out syndrome' and can affect staff member's performance on the one hand and disrupt the therapeutic community on the other hand.

Meinrath and Roberts (2004) suggest and emphasize careful staff selection, adequate training and personal therapeutic experience as a remedial measure for burn out syndrome. For this reason, a section is kept for staff training and supervision in '*Service standards for therapeutic communities'* (Keenan and Paget, 2007; Healy, 2007).

Objectives of the Study

The present study explores the process of practical training and supervision of psychotherapists in a therapeutic community setting in India.

Another objective of this study is to describe our approach to enabling and developing a budding therapist's skills and sense of autonomy which can be manifested as capacity for awareness, spontaneity and intimacy (Berne, 1966).

Methodology

Research Design

The present study utilizes a case study approach (Yin, 2003) where the purpose of the study is to describe the phenomena and process of training and supervision in a therapeutic community. It adopts a single-case design with a single unit of (holistic) analysis. The study could also roughly be categorized as a revelatory case because of its nature of observation and process. Within this design, self-reports of participant-observations by therapists and trainees are used as data.

Procedure

We have described in detail the functioning of the supervision programme from the time of selection of the staff member to the completion of his/her training as a therapist. These are presented against the backdrop of theoretical information, case studies and personal experience of therapists/trainees (all names have been changed to maintain the confidentiality).

Setting

Athma Shakti Vidyalaya - a residential therapeutic community - was founded in 1979 in India by Ms. Jacqui Lee Schiff, a pioneer in 'cathexis school' of Transactional Analysis. The community provides treatment for persons suffering from chronic mental disorders using varied theories and practices of counselling, psychotherapy and democratic principles. Athma Shakti Vidyalaya (ASV) is a Sanskrit derivative of the Cathexis school. Cathexis means the act of shifting of psychic energy. 'Athma' meaning soul, 'Shakti' strength and 'Vidyalaya' school: The name of our community therefore translates into 'a school which trains people to empower themselves during their treatment process'.

Some of the psycho-social interventions like Transactional Analysis (Berne 1961, 1966; Stewart and Joines 1987), Neuro-linguistic programming (Bandler andGrinder 1975, 1976; Bodenhammer and Hall

1999), Schiff's Reparenting model (1969, 1970, 1975; Childs-Gowel 1979), Psycho-physical exercises (Roberts andHouston 1978) to integrate body and mind and cognitive enhancement programmes are extensively used in the treatment process. This community has 26 patients at any given time with an age range of 15 to 45 years. The diagnostic categories are schizophrenia, bi-polar affective disorder, obsessive compulsive disorder, severe personality disorders and behavioural disorders. Staffing is required round the clock in order to monitor the adequate functioning of the community. As the therapeutic work is intensive, 2:1 patient to staff ratio is maintained.

Processes of selection and training of psychotherapists

This section of the paper covers the selection process and training of the individuals who opt to become psychotherapists. While deciding to work in a therapeutic community, careful and serious introspection will have to be done by the candidate before accepting the responsibility of such a magnitude.

Openness to Learn a New Approach: The First Criteria in the Selection Process

While selecting staff for training to become psychotherapists, it is important to check if the person is open to learning different treatment modalities rather than practicing 'arm chair psychotherapy'.

Candidates are required to have a post graduate degree in psychology or psychiatric social work. They are also expected to be 'reasonable persons' (i.e. they should have a functional '*Adult*' where they are aware of themselves and others).

Buddy System

As the therapeutic community functions in very different ways from other set-ups, the newcomers need someone to guide them. This acculturation process is taken on by one of the senior therapists who are referred to as a 'buddy' (a mentor who can guide the trainee and offer support). The buddy's role is to explain the structure and functioning of the community to the trainee therapist. A trainee from France expresses the experience:

> I feel so at home being guided by my buddy. She was there with me through the process of getting used to the food, culture, language and other nuances of the community. She gave me much needed security at the anxious stage and now I am coming every year to be with the members of the community (Personal communication, April, 2006).

Getting Into Work: Initial Training and Supervision

An orientation booklet is published by the community, which is to be studied by the trainee therapist. The senior therapists take them through the various diagnostic categories and stages in the treatment process with each patient. They are assigned two patients for observation and are expected to keep a record of affective, cognitive and behavioural responses of these patients. The supervisor checks these records and gives the trainee the necessary feedback.

As the trainee becomes more familiar with the community's culture and functioning plus the problems of the patients, they are entrusted with higher responsibilities. They are involved in joining in therapy groups and making relevant observations while liaising with their supervisors to clarify issues that may arise in the groups.

They are also given reading material and books. Book review sessions take place every week where the trainee report to the supervisor to have a discussion on what they have read.

Observation and Management

As some of the patients' behaviours are dysfunctional (for instance, the personal hygiene of some of the patients can be very poor), they need full time observation/supervision. Trainees are asked to observe how senior therapists handle such behaviours and how, at times, patients may become hostile, aggressive and violent, when put under pressure to conform to social/community norms. Trainees are taught to diffuse volatile situations and calm the patient down, as the following communication describes:

> When I was watching my supervisor teaching Kishen, a chronic paranoid schizophrenic patient to wash his clothes, Kishen started escalating and defying the senior staff. I was scared that he was going to hit both of us. But my supervisor did not show his fear or anger but dealt with the situation in a practical and mature way. The patient settled down and listened to the supervisor. I learnt that at that time I should not use authority or come from a scared position but come from a firm and caring position (Trainee, Personal communication, 2007).

In the following extract, a trainee describes learning to handle a difficult patient.

> When I confronted Hema for her inappropriate behaviour, she started hurling abuses at me. I felt inadequate as she had a great language ability and I felt very overwhelmed and scared as I thought I would make a bad situation worse. Then my senior colleagues entered the room and were just present. They did not interfere with my therapeutic interventions with Hema but I felt much stronger handling this situation. Later I was stroked for managing the problem situation efficiently and effectively (Trainee, Personal communication, August, 2006).

Working on Self: The First Step in Becoming a Psychotherapist

We believe, following Jacqui Schiff's approach amongst others, that the therapist should work on themselves before venturing into treating patients. To this end, psychotherapist trainees are expected to attend a '*Treatment Group'* to be aware of their feelings, attitudes and beliefs. The process of working on 'self' while being a therapist may create a 'role conflict' for the trainee. If they come from a conventional psychiatric background, they may have a belief that they have no problems and that the patients are the ones who have problems. They may not feel comfortable accepting the fact that they need to introspect on some of their personal issues and work on these in order to be an effective therapists. The process can be challenging as an ex-trainee admitted:

> When I was a trainee therapist, I had a lot of prejudices about patients from other religions. I was hesitant to open up in the group as I had expectations about myself being a psychologist, I should not have such prejudices. In one group I 'contracted' to work on my issue and get feedback so that I could change. When I worked on this in my treatment group, I got feedback about my attitudes and belief system which had to be looked into and changed (Senior therapist, Personal communication, March, 2001).

Senior therapists support the junior therapists to learn and cope with difficult patients. The following extract concerning our experience with a person suffering from borderline personality disorder shows

how a supportive structure is essential when working in our challenging environment:

> Ambuja, a 25 year old …[young woman] was admitted to our community with diagnosis of borderline personality disorder. She used to abuse and fight with staff members, putting them down, picking their weak points and using it at the most inappropriate times. She also used to accuse male staff members of sexual abuse etc. This was unnerving at times. She would convince people of her stories and we would be scared that people would believe her story. She would try to divide the staff and make them into 'good and bad staff'. In the staff treatment groups, when the staff shared their distress, they felt that their anxieties were shared by other members of the group also. This gave a lot of comfort as we found that we could share our feelings of inadequacies and we are not alone in feeling these feelings. There was a feeling of relief and cohesion amongst the members when the distress was shared. This brought the stress level down for many trainees and therapists (First author, Personal communication, June, 2005).

Learning to Take Initiative and Responsibility

It is important for trainees to take the initiative to learn and engage in both personal and professional development. Once the trainee psychotherapists get the necessary orientation concerning the functioning of the community, they are expected to look forward to taking on more responsibilities. At each step their supervisor would evaluate them before they move ahead to take on new tasks. This is assessed again in their treatment group and further support is offered for their growth. Here they receive feedback and encouragement relevant to the particular area of responsibility desired by the trainee. From here the trainee presents his/her agenda in the general staff meeting for another round of evaluation. After getting support from the rest of the staff, the community is informed of the change in responsibility for the patients to voice their opinions and feedback. The community functions on the principles of democracy and any member has a right to express his/her opinion freely. If the members of the community do not have confidence in the trainee's ability, expectations are put on the same to improve in certain areas where the deficiencies are noticed.

When they attain a responsible person's status, they are expected to fulfill the following responsibilities. They monitor the dysfunctional behaviours of patients and are helpful in enabling more positive functioning in different areas. The duration to attain this level of functioning at an average is about three months.

Once they are settled in the community, the trainees are taught basic principles of Transactional Analysis, the re-parenting model of psychotherapy, listening skills, risk management, neuro -linguistic programming, group dynamics and therapeutic interventions with different diagnostic categories. They begin to take individual therapy sessions in the presence of their supervisor and are expected to make notes and discuss the session with the supervisor within a theoretical framework so that theory and practice go hand in hand while working with the patients.

Role of a Psychotherapist in Managing the Community

In a therapeutic community each therapist has to take on a diverse variety of roles and be competent in each role. He/she will have to take on responsibilities such as being a significant parent figure to a few patients, being a manager organizing the day to day activity of the community, documenting observations of the patients, participating in annual psychometric testing of patients, writing regular reports of patients' progress, facilitating group therapy, having individual therapy sessions, being actively involved in various in-house committees and so on. They also need to provide information and updates

to the family and organize family therapy sessions.

The therapist's role is to encourage the patient to shift his or her distorted perception of self and the world that causes him or her to have adjustment problems in life. This becomes difficult without a relationship and trust between therapist and patient. The therapist needs to enter into a symbiotic relationship with the patient and work with him/her through the therapeutic process. The prerequisite of becoming an effective therapist is to relate to the patient as a human being and respond to his or her emotions and needs, rather than just as a professional providing accurate diagnosis and offering textbook solutions to their problems. A better prognosis has been identified when patients notice that their therapists are genuine in their interest in them.

Being a psychotherapist implies entering the patient's dark world and empathically reliving the experience with the patient so as to enable the therapist to understand the patient's experience both cognitively and emotionally. This will help to build a bond between the patient and the therapist helping to reinforce changes.

> Kavya, a 28 year old girl who was physically and sexually abused as a child was admitted to the community as she could not form lasting relationships and was severely depressed and suicidal. Through regressive work from Reparenting model, she formed an attachment to a therapist. She progressed in therapy after regressive therapy and was able function as a responsible person when she was discharged. She left the community 15 years ago and still has a bond with the therapist. She keeps in touch through telephone calls, emails and greetings. She is able to hold a job, take care of herself and her parents (First Author, personal communication, October, 2007).

For optimum functioning of the community, different committees are formed. The structure review committee, the party committee, the housekeeping committee, medical committee, therapy overview committee etc. The trainees are assigned to these committees depending up on their field of interest and are rotated so as to gain broader experience.

Therapist in Action

The trainee will take about a year to come to the level of functioning where they are able to do intensive therapeutic work with patients. They are encouraged to work at different levels with patients depending upon the relationship and quality of attachment they are able to form with the patient. Intensive psychotherapy involves patients working on deeper issues about their past, working on their scripts and making new decisions. They do this by forming a group of mentors to guide them through short-term and long-term goals.

They are also expected to lead some groups like the cognitive enhancement therapy group, psychophysical exercises group and the 'feelings group'. The therapist needs regular feedback and supervision about his/her work. So he/she is expected to present the work he/she is doing with a patient at the staff meeting once a week.

Open Communication and Confrontation: A New Way of Supervision

Communication and confrontation lead to better understanding of each other and foster healthy relationships in the community. This can be effective only when the following principles are practiced in the community. They are:

- I'm OK and You're OK.
- All communications and confrontations are expected to be open.
- Every member of the community is as important as the other.
- Any staff or patient has the right to confront any other member of the community who has violated any of the community structures.

The above principles provide a platform for maintaining high moral and ethical standards as well as awareness of each other's work professionally. The sharing of ideas with other members of the community gives an impetus in understanding the patients better. It also provides for a culture of constant supervision and therefore security for the community.

Awareness, Reflection and Flexibility: A Process of Continuous Learning

Being part of a therapeutic community, a therapist has a tremendous potential to grow personally and professionally. Continuous reflection on one's attitudes, beliefs, roles and involvement with respect to their personal and professional life will bring about transformation in one's personality structure as well as interpersonal relationships and dynamics. Psychotherapists need to be flexible with the following belief in practice:

> *I'm O.K. and you're O.K.*
>
> *Everyone has the capacity to think (except the severely brain damaged).*
>
> *People decide their own destiny, and these decisions can be changed* (Berne 1966).

Evaluation and Implications

Limitation of the study

The present study, as mentioned earlier, is based on the descriptive case study approach. We accept that our practices are culturally embedded. Other therapeutic communities in India as well as in the rest of world may well operate in different ways. However, we believe there is value in sharing experiences of good, successful practice. We also hope that Western readers will find this brief glimpse into our work and attitudes in India illuminating. While findings from our participant observation experience cannot be generalized beyond our therapeutic community, we hope that others may be able to draw upon and apply some ideas to their own situation.

We have described some of the subjective, experiential elements of our programme, drawing on the voices of trainees and therapists. Each trainee's experience with an individual patient is so diverse; a general pattern cannot be derived as it depends on many factors like the trainee's personality, mental makeup, cultural background, prejudices, etc.

Further qualitative research could be usefully conducted on exploring the supervisory relationship in more depth as well as on the trainees' journey. Further quantitative research could usefully compare our practices with those in other contexts and would be valuable for evaluating the effectiveness of our

approach and therapeutic outcomes.

Implications of the study

With the increase in need for counselling and psychotherapy due to changing demands of the society, people are seeking emotional support from professionals. While providing this emotional support, there needs to be a regulatory system in place to ensure that professionals do not take advantage of the patient's vulnerability and abuse their power and control over the patient. Intensive training and supervision methods described in the present study will improve the quality of therapists and the therapeutic process in keeping with high moral and ethical standards.

Increased self-awareness in a therapeutic community context is essential owing to the intensity of emotional interactions and involvement of the therapist with the patient in the healing process. This intensive training and supervision process should help in sharpening the trainee psychotherapists' awareness of themselves and others. This, in turn, should have a positive trickle-down effect, encouraging patients to be more aware of their own feelings, thoughts and behaviour towards helping them to function better in their lives as a whole.

Conclusion

The process of training/supervision of psychotherapists is complex and multifaceted. Rather than offering a top-down classroom teaching approach, learning takes place in the community environment and involves learning experientially to work with both attachment and involvement. Much of a trainee's development arises through relating at a practical and personal level with patients and the community. The process can be very energizing and gratifying at times, as well as depressing and frustrating at other times. A tremendous amount of commitment on the part of the trainee and therapist is needed to be involved in the therapeutic process. However, handling complex demands and relationships that come about during the therapeutic intervention will result in the overall development and growth of the individual.

We recommend our supervision-training process to be used in other fields including health and education contexts.

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