A Psychiatrist's Personal Psychotherapy

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Introduction

Undergoing personal therapy has long been a part of psychodynamic training schemes across the world, with the aim being to provide trainees with vital experiential learning of the modality of talking therapy they will practice. Trainee psychiatrists are expected to undertake a psychodynamic therapy case, under supervision, as one of their core training competencies, and both trainees and fully qualified psychiatrists are expected to interact with talking therapies insofar as they will refer patients on as appropriate for talking therapy as part of their ongoing care.

It is unsurprising, given the above, that undertaking personal therapy (or, indeed, a more intensive analysis) was once commonplace within psychiatry; one study found that, in the 1950's, 70% of psychiatric residents in the USA had undergone their own treatment. This figure had reportedly dropped to only 32% by 2007 and to just 16% of UK psychiatric trainees in 2018. It is worth noting that, culturally, one could argue that 'psychiatric culture' has always been markedly different in the USA from a UK context and has developed down a more medical model from the first, however the reduction in psychiatric trainee exposure to personal therapy is still of note.

Aims and hypothesis

We aim to understand the **role personal therapy** plays in a cross-section of psychiatric doctors in one Scottish psychiatric hospital, in particular how personal therapy is **funded** and **facilitated** by the workplace and if any stigma is perceived. We hypothesise that few psychiatry doctors will be in personal therapy, in-keeping with the trends noted above, but that those who are will find it has a significant positive impact on their practice.

Methodology

As no standard assessment tool was found for assessing the prevalence and type of psychotherapy undertaken, one was made using the Microsoft Survey tool by a psychiatric trainee and a medical student, in discussion with two consultant medical psychotherapists who were also psychoanalysts. The survey was distributed electronically to **all medical psychiatric staff** (not only those in medical psychotherapy) , of all grades apart from foundation years and GP-trainees, in one psychiatric unit of a Scottish hospital in Aberdeen.

Results were analysed using descriptive statistics in Microsoft Excel. Answers were collected using a 5-part 'lickert scale' (a 5-point rating scale from strongly-disagree to strongly-agree) to try to capture nuance in opinions rather than just polarities, with some other questions containing 'blank space' answers for further exploration. The surveyed doctors were asked at the end of the survey if they would agree to take part in a short, semi-structured interview about the role of their personal therapy in their practice- the majority of respondents agreed, and this could be **an avenue for future qualitative or narrative work.**

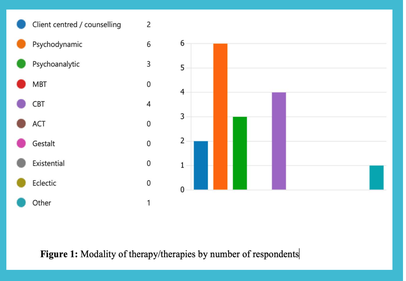

Figure 1: Modality of therapy/therapies by number of respondents

Results: Demographics

The survey was open for a period of 2 weeks and, of the

86 doctors surveyed

in one Scottish psychiatric hospital

45 (52%) responded
(one excluded due to not wanting data to appear in research).

Of 44 respondents, only:
11 (25%)
had engaged in their own psychotherapy

4 of the 44 (9%) were medical psychotherapy consultants or trainees.

Therapy specifics	
Did you undertake more than one course of personal therapy?	
Yes	55 (n=6)
No	45 (n=5)
Which modality/modalities?	**% of 14**
Psychodynamic	43 (n=6)
Psychoanalytic	21 (n=3)
CBT	29 (n=4)
Other	7 (n=1)
Frequency (of most frequent therapy)	**% of 11**
Once weekly	64 (n=7)
Twice weekly	9 (n=1)
Four times weekly	9 (n=1)
Once a month	9 (n=1)
Once fortnightly	9 (n=1)
How many sessions did your longest therapy last?	**% of 11**
0-12	36 (n=4)
12-20	18 (n=2)
40-50	9 (n=1)
50-100	9 (n=1)
> 200	27 (n=3)

Results

Personal therapy and psychiatric practice

Figure 2: responses to the statement: '*my personal therapy has had a positive impact on my practice as a doctor in psychiatry.*' by number of respondents

90% of respondents felt their therapy had a positive impact on their practice as psychiatry doctors.

6 out of the 8 respondents (75%) who had answered 'strongly agree' to the question of their therapy having a positive impact on their practice had undertaken a **psychodynamic or psychoanalytic modality**, whilst those who answered 'agree' or 'neutral' had undertaken CBT or counselling.

When asked to elaborate on the above answer (figure 2), the following responses were given.

'Thorough understanding of transference/countertransference, my own agenda and biases, and appreciation for my own patterns of behaviour/response to certain presentations. Assisted in understanding of the possibilities of my role as a psychiatrist, based on my own capabilities rather than the expectations of a psychiatrist within the service. Offered a more personalised approach to my career.'

'More awareness.'

'Personal therapy is a space for a close look at oneself and all interpersonal processes so affects all aspects of one's life, including work. Personal therapy allows to consider one's emotions and this really supports working as a psychiatrist.'

'It helped me give psycho education to my patients better about their illnesses.'

Supportiveness of workplace/ psychiatric training

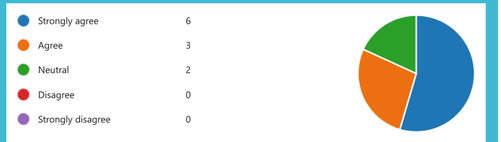

Figure 3: Responses to the statement: '*I felt my personal therapy was supported by my workplace.*' by number of respondents.

Figure 4: responses to the statement: '*I felt my personal therapy was supported by my training.*' by number of respondents.

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Barriers to access

When asked '**were there any barriers to doing personal therapy whilst working in psychiatry?'**, the following responses were given:

'timing. It's hard to get a psychotherapist that offers weekend sessions.'

'No barriers for me personally but there could be barriers on a practical level if there are no suitable local psychoanalytic psychotherapists/psychoanalysts. One's psychotherapist has to be someone not connected to the local Mental Health Service (e.g. hasn't worked there previously) in order to create a confidential space.'

'Time and travel barriers.'

Funding

When asked **how their personal therapy was financed**, the following answers were given:

'personally'

'Income and savings, or on NHS'

'Counselling was free on campus at university.'

'Self-funding'

'Partially self-funded and partially funded by the NHS.'

'2/3 funded through training programme. 1/3 funded myself.'

'I received a third from the deanery and a third from NES'

'Free counselling sessions and also was referred to (another service)'

'It was all ordered from occupational health and was free.'

'initially through practitioner health and then self pay'

Stigma

Five out of 11 (45%) of respondents agreed or strongly agreed there was stigma around personal therapy within psychiatry. Interestingly, all these respondents had undertaken psychodynamic or psychoanalytic therapies. Those who had counselling or CBT were either 'neutral' or 'disagreed' there was stigma.

Conclusions

- Relatively few psychiatry doctors are in personal therapy, likely even less than this survey indicates due to self-selection bias.
- It is felt by those who are to positively impact their work
- There is a degree of stigma felt by some.
- Time, financial and geographical barriers may contribute to the low numbers of psychiatric doctors in personal therapy - could/should more provision be made to facilitate personal therapy?
- A larger study nationally would be helpful.

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