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What Psychotherapy Training Gave Us

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Abstract

The significance of structured psychiatric training was discussed based on the author's experience of training in dynamic psychotherapy in the 1980s, when there was a growing interest in psychotherapy, and a roundtable discussion with three current psychiatrists (one in their 50s and two in their 60s) who were trained at the same time.

Encounters with psychiatrists in student practice and residency training are important not only for learning psychotherapy theories and skills, but also because they affect the later life of the young psychiatrist. In those days, the core of the author's training was "transference" and "introspection".

Four implications of structured psychotherapy training were clarified in the roundtable discussion. The first was "structural recognition". The therapeutic structure theory (Keigo Okonogi) and educational structure theory (Tetsuya Iwasaki) for understanding the place of psychotherapy and therapeutic relationship were useful not only in psychotherapy, but also in current ward management, hospital administration, and training and education. The second was "introspection". The introspective attitude of 'thinking about myself' is maintained today through attending psychotherapy and supervision. The third was "the significance of team medicine". The team medical experience as a young physiatrist makes one aware of the nurses, social workers, and psychologists as peers, and makes one feel that they are in the same boat. This was connected to the attitude of talking to

each other. The fourth was "psychiatrists as humans". Due to the structured training environment, we were not limited to an apprenticeship system. We were able to encounter "psychiatrists as humans" freely. The personality, such as "sensitivity", "objectivity", "flexibility", and "empathy", is prepared through psychotherapy (Wolberg, L. R.).

Keywords: therapeutic structure, educational structure of psychotherapy, structuring, supervision, psychiatrists as humans

Introduction.

After more than 30 years of clinical practice, the author is unable to clarify what the skills of psychotherapy consist of in the first place. Dialogue-based therapy is not the same as reading and acting out a text or script. With advances in science, technology, and information sharing, many medical techniques will be replaced by machines and AI (artificial intelligence) in the future. But psychotherapy, with its focus on dialogue, will always survive. This is because analog communication between people involves many elements, and psychotherapy is structured by unconscious interactions that go beyond language. Reading books on psychotherapy will not be enough to provide adequate psychotherapy. Psychotherapy is the act of using our minds to bring about some kind of change in the patient's mind, like a drink brewed by a blend of education, training, and personality. An essential component of training is direct interaction between psychiatrists, including supervision, case studies, jury sessions, meals, and drinking.

However, as a psychiatrist who underwent "structured education and training", I have written this paper in the hope of conveying the “significance of the experience” to the members.

I. 1980s to present

The characteristics of patients and the way that they are treated are influenced by the higher system that encompasses them. The 1980s was the heyday of analogs, when atypical antipsychotics and selective serotonin reuptake inhibitors (SSRIs) had yet to be introduced, the Showa era (1926-1989) was over, the term "postmodern" was in vogue, and books on philosophy and thought were selling well. It was a warm time for psychotherapy. Many

books related to psychoanalysis and psychopathology were published, and magazines such as Eureka and Gendai Shiso had special features on psychopathology and psychoanalysis, giving psychiatry a cultural flavor. In psychopathology, there was much discussion about the psychopathology and presence of schizophrenia and depression, while in psychoanalysis, there was much discussion about the pathology and treatment of borderline personality disorder. In 1983, the Japanese Society for Morita Therapy and the Japanese Society for Group Psychotherapy were founded, followed by the founding of the Japanese Society for Family Research and Therapy (now the Japanese Society for Family Therapy) in 1984. It could be said that at this time psychotherapy was in its prime.

In the 1980s, psychiatrists focused not on patients' symptoms, but on patients as people and consumers, groups, and families. In the following 30 years, however, the widespread use of electronic medical records, respect for evidence-based medicine (EBM), and revolutionary advances in pharmacotherapy led to changes in both patient and practice characteristics (Figure).

II. Department of Psychiatry, Tokai University School of Medicine in the 1980s

I was at university during the 1980s. It was a glamorous time, heading towards the bubble economy. I do not have many good memories of my college days. I could not keep up with the medical students who were driving luxury cars and having fun in the city, and I rarely attended classes, and was once asked, "Is he really in medical school?" I was an insidious student who listened to music and only read books. I was associating with students from the Faculty of Letters and the Faculty of Engineering, calling my difference from my classmates an "inferiority complex".

I was in my 6th year and had to decide which department I would join. I visited the room of Professor Tetsuya Iwasaki, whom I admired. When I told the professor that I wanted to enter the Department of Psychiatry, the professor just said "I see" and hardly asked any questions. I remember leaving the professor's office with a feeling of "Oh, I guess I can't get in here either". However, when the professor saw me in front of the cafeteria, he raised his hand and smiled at me. There were times when I waited for the professor to come to the cafeteria so that I could see him. I was happy because there were no professors in the university hospital who knew me.

III. Constructive Theory of

Psychotherapy Education

Professor Iwasaki used therapeutic structure theory for psychotherapy training and theorized it as psychotherapy education structure theory 1-3). Therapeutic structural theory 6) is a systematic theory proposed by Keigo Okonogi, and it is first important to clarify the difference between therapeutic structure and therapeutic structural theory.

The therapeutic structure is the structure of the various factors and conditions that govern the interaction between the therapist and the patient. In other words, in general clinical practice, the physical structure of the interview room (the position and number of chairs and desks) and the treatment contract (the number of interviews, time, and fees) are therapeutic structures. On the other hand, therapeutic structure theory consists of "therapeutic structure theory epistemology", which is based on the understanding of the psychology of various phenomena occurring in both the therapist and the patient from the perspective of therapeutic structure, and "therapeutic structure theory technique theory", which is based on the understanding of therapeutic structure, and is concerned with the structuring of treatment and its adjustment, in which a specific therapeutic structure is intentionally set for each therapeutic relationship.

An important point in the epistemology of therapeutic structure theory is the classification of therapeutic structures into three categories. (1) Those that are set intentionally by the therapist, (2) those that are given beyond the therapist's intention, and (3) those that are formed spontaneously during the course of treatment. Based on these points, Professor Iwasaki describes the structural theory of psychotherapy education. Additionally, he emphasizes that the theory of educational structure is not a theory of what psychotherapy education should be, nor is it a pioneering argument; its main significance is that both educators and those who receive education must first mutually recognize what the structure of their own psychotherapy education actually is, and what kind of educational relationships (transference and master-slave relationships) arise as a result 1). Educational structure theory is very useful in understanding psychotherapy training and education today.

Professor Kiyoshi Makita, the first professor of the Department of Psychiatry at Tokai University, was responsible for the introduction of dynamic psychiatry and child psychiatry into university education from its inception. Following this

philosophy, Professor Iwasaki and his predecessors deliberately structured the psychotherapy education system at Tokai University in the 1980s (Table 1, Table 2). The influence of the 1980s, an era that promoted the structuring of dynamic inpatient treatment beyond the intentions of the predecessors, may have contributed to this. In addition, the interest of those of us receiving training was also directed toward the psychological world of patients. However, even the best psychotherapy education structure is forced to change with the times. Professor Iwasaki retired, Dr. Kano moved out, and the educational structure changed.

IV. Observation of psychotherapy

Observation of psychotherapy is an important training method in psychotherapy education. It provides a live experience of the doctor-patient relationship that cannot be learned from textbooks or lectures. Although it is undeniably taxing on the patient, it is an effective place for the observer to learn about the breathing, facial expressions, pauses in conversation, and unintentional attitudes of doctors and patients. Discussions with doctors, residents, and students after observation of psychotherapy will deepen the understanding of psychotherapy.

I have had two observations of psychotherapy that left a strong impression on me.

I observed Professor Iwasaki's outpatient clinic during my 5th-year student training. One young man, who was about the same age as me at the time, brought his mother, who had become psychotic. He came to the university hospital, feeling like he was grasping at straws after moving from one hospital to another. The doctor gently told him like a father, "You're going through a tough time with your mother, but it will help you grow up". The doctor understood and advised not only the son, but also the psychological state of his "parental love". This author, who grew up in a mother-and-son family, identified with the son and thought, "I must graduate and become a doctor as soon as possible". This experience was not only an opportunity for me to become interested in family psychology of the sick, but also the germ of my transition to a doctor.

The other time was when I was a resident. I had just gotten married, and life was a little manic and buoyant because I was now able to conduct psychiatric interviews. I was assigned to a hospitalized female patient, A, whom Dr. Rikihachiro Kano was in charge of as an outpatient. She had become depressed after marriage. During interviews in the ward, I often talked about music with her, and she

acted cheerfully, even giving me the impression that she wondered what was wrong with her. One day, the doctor asked, "Is Watanabe coming too?" The interview with Ms. A began in the outpatient psychotherapy room. Her facial expression changed into something she had never shown to me. The doctor said, "You feel sorry for your mother, don't you?" and brought out the conflict of being doubly bound by guilt toward her sick mother and guilt (she could do nothing about it) toward her husband. She cried aloud and that night, I was in a state of intense pain, for it brought up feelings that I had forgotten. I remember that I drank only because my feelings for my mother, who lived alone in my hometown, rose to the surface.

It was at this interview that I understood "counter transference" as an experience. I had been living in denial and manic defense, and had been sincerely obliterating my mother who lived alone in my hometown. I could not talk about "my mother" with my patients. I also remember the intense depression that followed.

What happened in the space where I was present for that interview?

I think that the split in the therapeutic relationship (split) between the over-adjusted Mrs. A and myself, who was splitting and eliminating the mother conflict, and the real Mrs. A and Dr. Kano, was clarified in the interview. I was planning to ask Dr. Kano whether the outpatient interview, in which I was shown the reverse transition and the split, was his "intentional structuring" or "unintentional structuring". However, sadly Dr. Rikihachiro Kano passed away on April 11, 2015.

V. What's left for psychiatrists after 30 years

We held a roundtable discussion with myself and three other doctors who had undergone the same training. The purpose was to have them talk freely about their memories of that time and the skills they use in their current practice.

Dr. A is a child psychiatrist in his 60s (he belonged to the Society for Child Psychiatry when he was a trainee). Dr. B is also in his 60s and is currently the deputy director of a psychiatric hospital (he belonged to the Society for Psychoanalysis when he was a trainee). Dr. C is in his 50s and is the medical director of a psychiatric hospital (he belonged to the Wednesday Club when he was a trainee). Although they received the same psychotherapy education and training, they are now psychiatrists with different areas of expertise.

Much of what was said in the roundtable discussion was about the personalities of the senior members. I

omit quite a few parts because I cannot disclose them, but for example, "I almost had an asthma attack when I had a super vision in the room of a certain doctor who was a chain smoker", "A certain doctor interviewed the wrong patient and told me, 'Doctor, that person is not me', but the therapeutic relationship was maintained". Or, "A certain doctor always bought me the most expensive lunch after attendance", "A certain doctor gave a resident a copy of 'Weekly Fishing News' that he had read and fished him into the medical office", and “A certain doctor told me that I should become a child psychiatrist because of my round face”. The only thing that was spoken of with nostalgia was the human part of the person. While this was significant, the following three points remained common to all four of us even after 30 years in the field. First, they began to think about structure and themselves; second, they believe that nursing records are extremely important information; and third, they agreed that the view that doctors and other staff are of the same level and of the same group is important. Based on the content of the roundtable discussion and my own experience, the significance of structured psychotherapy education is discussed.

VI. Considerations - What is still needed in training

1. Constructive understanding

According to Professor Iwasaki, the theory of educational structure is not an idealistic pursuit of what the educational structure should be, but emphasizes that the main significance lies in the structuralist recognition. The structural cognition acquired in education and training remained with the four psychiatrists many years later. They confirmed that (1) the recognition of structuring treatment, (2) the recognition of the already existing structure of the workplace, (3) the recognition that the structure of the place of work changes over time, and (4) the recognition of whether to allow, suppress, or promote the changing structure, are essential not only in psychotherapy, but also in hospital management and ward management.

Professor Iwasaki says that the absence of a training structure is also a structure. In Japan, as the word "apprentice" suggests, it has always been important to learn by watching what one's seniors do. However, Professor Iwasaki does not take a critical view of this. He says that both structured psychotherapy education and apprenticeship education are necessary for psychotherapy training, and stresses the need to recognize one's own educational structure from a structural perspective. The author

believes that attendance at medical examinations is one type of "apprenticeship" education.

Kano et al. 4) stated, "In the apprenticeship system of Japanese medical practice, residents identify excessively with one school or leader, which leads to exclusivity and conflict with other schools. They strongly advocate the need for a structured training system, stating that excessive identification is experienced as a treadmill to enter another school, and for this reason, a structured training system is necessary, in which the resident searches for his or her own inner purpose and conflicts."

2. Introspection

I n the classroom in which I studied, supervision was structured and mandatory, and having examples of psychoanalytic psychotherapy and child and adolescent psychiatry was a must. Dynamic psychiatry has left me with the ability to "reflect" on the feelings that arise in me. In those days, I often heard my fellow trainees say things like, "I get depressed when I see that patient", or "I don't like that patient", or "I'm turning into a completely scary father". At that time, however, when I talked with doctors from other universities at other hospitals, I noticed that they often talked about "symptoms" and "drug therapy". They did not include "I" in their thinking.

Even today, when I talk to young psychiatrists, I feel that they tend to talk about "the patient's symptoms and treatment" and not so much about "me" as the subject. I sometimes wonder if they only focus on the patient's symptoms, and don not think much about their own feelings and associations, or about the relationship between themselves and the patient. In psychiatry, we can talk about our own experiences and feelings, which is what makes us different from other doctors who focus on symptom management and disease prevention. If we learn to reflect, to notice the thoughts and feelings that arise in "me", we will develop an ego that we can work on, and this will remain as a clinical attitude for many years.

3. Team medicine

In those days, dynamic inpatient treatment was used in psychiatric wards. Residents were assigned to a treatment team led by a supervising physician, who took care of hospitalized patients. About half of the patients had borderline personality disorder. I believe that these patient characteristics also influenced the maintenance of the team-based medical structure. Teamwork was easily disrupted by patients' aggression and as-if personalities, so weekly ward

meetings with nursing staff were essential to maintain teamwork. In addition, two or three times a week, the residents provided patients with about one hour of psychotherapy, and the supervisors and residents had discussions. For hospitalized patients, family interviews and group meetings were also conducted. The patients and the treatment team became like a family, and transitions and counter-transitions occurred, which were discussed again in the meetings. When my supervisor went to the ward first thing in the morning, he rarely looked at what I had written, but read the nursing records first. At the time, I thought, "Nursing records are more important than my medical records?", but now I can understand the importance of the nursing records, which contain a detailed record of the night's activities. Both doctors and nurses are members of the same team, and I believe that each of them was able to act with independence. In addition, the support of the chief professors and ward administrators, who embraced this kind of team medicine, was also significant. The basics of team medicine, such as respecting each other's autonomy and valuing information sharing, were rooted in us.

4. Psychiatrist as a person

Many memories of psychiatrists as people were shared in the roundtable discussion. As a result of the framework of the psychotherapy education structure, the personalities of the seniors may have been more prominent in the rest of the experience for the residents. It is an important experience in psychotherapy training to come in contact with the personalities of the seniors. In his book "The Therapist's Theory", Nishizono 5) introduces three types of preparation for psychotherapy according to Wolberg, L. R.: 1) educational preparation, 2) personality preparation, and 3) practical preparation (supervision). Wolberg lists sensitivity, objectivity, flexibility, and empathy as the first four aspects of personality preparation. I believe that these personality traits as a psychiatrist are internalized through daily conversations and interactions with senior doctors, which is an unstructured part of training. The experience of attendance at medical examinations of senior doctors and the experience of the medical office in my younger days have left me with an important element of "people" as a resident.

Conclusion.

In April 2019, I visited Professor Iwasaki at his home to prepare for the symposium. He was living with his wife while taking care of her. I met Professor Iwasaki, a psychiatrist, as a person. There he was, talking to his wife, "You

ate a lot today", "Do you want some tea?" His gentle personality has not changed. As I was drinking whiskey with him, I was in a good mood and asked him something I had wanted to ask him for a long time.

This is what happened when my mother came to the graduation party with my uncle. My mother came from the countryside of Gunma, wearing a dress she had sewn herself, and I was far away from her, looking at her with a strained look on my face. I was far away, but I was curious about her, so I kept glancing at her from a distance. My mother was wandering around without a chair. At that moment, Professor Iwasaki offered a chair to my mother, who was looking for a place to sit. I have wondered about his intentions for over 30 years. I wrote about this episode in the alumni magazine, but I wanted to know how Professor Iwasaki felt at that time.

When I asked him "Did you offer her a chair at the party because you knew she was my mother?", he smiled and replied "No, I didn't know that. I just wondered if there were mothers who came out from the countryside like that, and who were very caring to their children". I wiped away my tears as I drank the scotch the doctor had recommended.

In closing, I would like to give a few words to young psychiatrists.

- The disciple must not look at the master, but must look at what the master is looking at.

(From "Passing on the Arts and Crafts")

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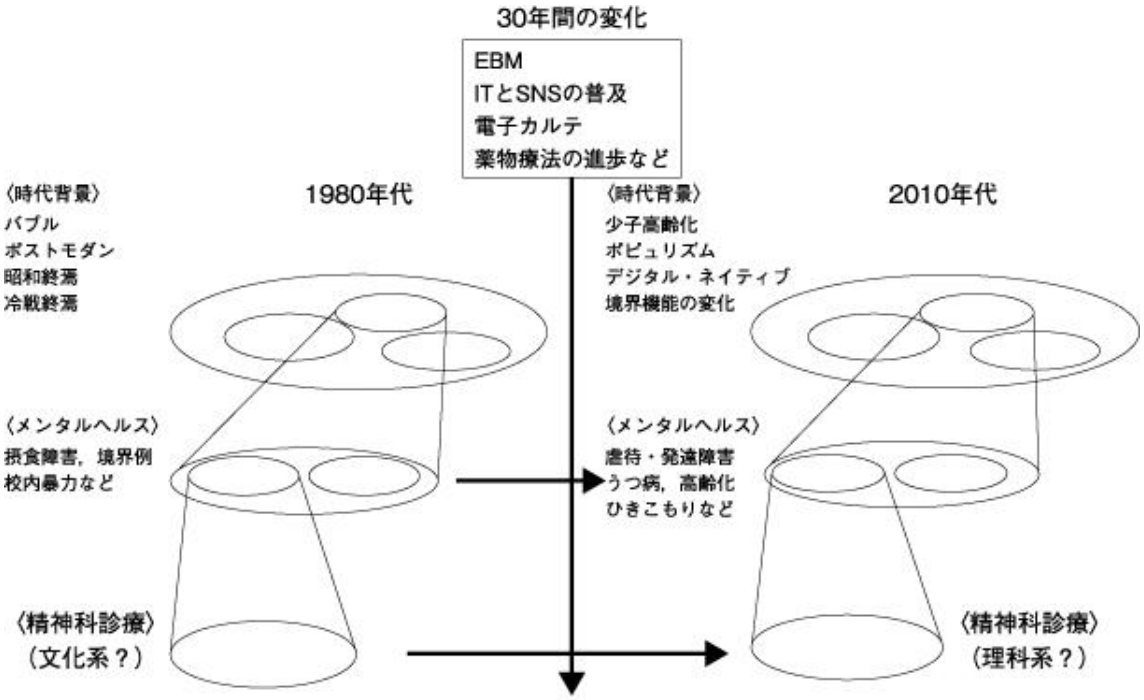

図　1980 年代から現在まで（システム論の観点から）

Figure: From the 1980s to the present (from the perspective of systems theory)

Thirty Years of Change

EBM

IT and SNS proliferation

Electronic medical records

Advances in drug therapy

<Historical Background>

Bubble era

Postmodern

End of Showa era

End of Cold War

<Mental Health>

Eating disorders, borderline cases
School violence

<Psychiatric Treatment>
Cultural?

<Historical Background>
Low birthrate and aging population
Populism
Digital natives
Changes in boundary functions

<Mental Health>
Abuse/developmental disabilities
Depression, aging
Withdrawal

<Psychiatric Treatment>
Science course?

表 1　1980 年代の東海大学精神科学教室

岩崎徹也教授
山崎晃資助教授，白倉克之助教授
狩野力八郎講師，橋本雅雄講師，林雅次講師
4 つの研究会
月曜日　家族療法研究会　狩野力八郎
水曜日　水曜会（心身医学，リエゾン）白倉克之
木曜日　児童精神医学研究会　山崎晃資
金曜日　精神分析研究会　岩崎徹也
病棟　約 50 床　力動的入院治療
指導医を中心としてチームに配属
助手-後期研修医-前期研修医という構造

Table 1: Department of Psychiatry, Tokai University in the 1980s

Professor Tetsuya Iwasaki

Assistant Professor Koji Yamazaki, Assistant Professor Katsuyuki Shirakura

Lecturer Rikihachiro Kano, Lecturer Masao Hashimoto, Lecturer Masatsugu Hayashi

Four Study Groups

Monday Family Therapy Study Group, Rikihachiro Kano

Wednesday Wednesday Meeting (Psychosomatic Medicine, Liaison), Katsuyuki Shirakura

Thursday Child Psychiatry Study Group, Kousuke Yamazaki

Friday Psychoanalytic Study Group, Tetsuya Iwasaki

Ward: Approximately 50 beds Dynamic inpatient treatment

Assigned to a team led by a supervising physician

Structure of assistant, second semester resident, and first semester resident

表2　精神療法の研修内容

前期研修（2年間）
外来見学
病棟チームに配属されて患者担当になる
研究会への参加
後期研修（3年間）
スーパーヴィジョン
→精神分析的精神療法と児童精神医学が必須
病棟で治療チームに配属
グループミーティング，家族面接，週1回の病棟チームカンファレンス
治療チーム：指導医-後期研修医-前期研修医
研究会への参加，外来の担当

Table 2: Contents of training in psychotherapy

First semester training (2 years)
Outpatient observation
Assigned to a ward team and take charge of a patient
Participation in study groups
Second semester training (3 years)
Supervision
→Psychoanalytic psychotherapy and child psychiatry are required
Assigned to a treatment team on the ward
Group meetings, family interviews, weekly ward team
Conferences
Therapeutic team: supervisor - second semester resident - first semester resident
Participation in research groups, outpatient clinic