

Learning Psychotherapy: A Developmental Perspective

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IN 1974, Hans Strupp noted that the field of clinical psychology may have unduly emphasized the structure and contents of training programs while ignoring facts about the learning process and personal development of the student. The following is an attempt to investigate an important part of this ignored area by examining the process of learning psychotherapy as a developmental experience along which we can mark out certain milestones or stages. The material for the study has been generated from in-depth interviews with those most intimately involved in the process—namely, trainees and supervisors. Though many of the issues described here are familiar to those in the field, I believe that their organization in a developmental perspective is innovative. Further, I would assert that such an understanding of the level of functioning of the student therapist is central in the teaching of psychotherapy and occurs intuitively among good teachers. I believe that an elucidation of the process would be useful in teaching and learning in this area.

METHODOLOGY

The material for this essay was generated through interviews with 36 graduate students and 8 supervisors in clinical psychology graduate programs. I asked the interviewees to share with me some of their conceptions of how learning psychotherapy took place and what important issues came to mind. I then attempted to discern redundancies or patterns in the wealth of information the interviews provided and to describe them in terms of a limited set of themes. The accounts were retrospective and subject to all the limitations as well as strengths of that approach.¹ Although the

¹ It is surprising how little has been said about the systematic use of clinical methods in psychology for the purposes of theory generation, especially in contrast with the vast literature on the use of experimental and quantitative techniques. The works that come

most powerful influence on the students interviewed was modern ego psychology, they had contact through course work and supervision with other theoretical approaches and techniques.

I became aware in examining the interviews that students mentioned certain conceptual milestones that were important in their development as clinicians. These milestones, even in students quite sophisticated about theory, were often experienced as a radical change in perspective that provided

closest to this that I am aware of are Glaser and Strauss's *The Discovery of Grounded Theory* (1967) and Maslow's *The Psychology of Science* (1969). See also Erikson's "The Nature of Clinical Evidence" (1958); Seeley's "Psychoanalysis: Model for the Social Sciences" (1962); and my own *The Clinical Method* (1976). An example of the use of clinical and qualitative methods for research in the area described here is Doehrmann's (1976) monograph.

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This paper was originally presented at the Western Psychological Association Convention, April 5, 1979, San Diego.

a new and more powerful paradigm for therapy. In trying to organize the milestones in some type of framework, it struck me that these experiences could be roughly ordered along a developmental continuum from concrete and commonsense conceptions about psychotherapy to more complex ideas that required a greater degree of abstraction and introspection. Thus, it seemed possible to describe the process of learning psychotherapy as a developmental experience that the milestones marked out.

THE DEVELOPMENTAL STAGES

The literature on teaching and learning psychotherapy, despite its richness, gives few descriptions of the process of learning psychotherapy. For example, probably the most influential work in this area is Ekstein and Wallerstein's volume, *The Teaching and Learning of Psychotherapy* (1971). They develop a model that describes how the learning process is affected by transference and countertransference phenomena not only in the therapist-patient relationship but also in the therapist-supervisor relationship, and the parallels between the two. But their approach is almost exclusively process-oriented in that it attempts to understand interpersonal distortions in learning psychotherapy and does not focus on the actual experience of learning from the student's perspective. Doehrman's (1976) excellent monograph, in the Ekstein and Wallerstein tradition, also provides little information on the developmental experience involved in learning psychotherapy.

From the theoretical perspective of client-centered psychotherapy, a number of authors describe some of the desired outcomes of learning psychotherapy but do not give us a sense of the development that it entails. For example, Truax and Carkhuff (1967), Rogers (1967), and Carkhuff (1969) describe the characteristics of a successful therapist and also present a useful set of ideas about how these skills might be developed. But they do not explicate the stages that the student goes through in acquiring those skills.

Perhaps the description that comes closest to the patterns I identified was that by Havens (1973), who sets forth four general approaches to psychiatry: the objective-descriptive model, the psychoanalytic, the interpersonal, and the existential model. Havens notes that while he set out to describe the evolution of psychiatry itself, he saw many therapists go through a personal evolution similar to the stages he outlined—a sort of ontogeny recapitulating phylogeny.² Jerry Lewis (1978) develops a similar set of ideas in his book *To Be a Therapist: The Teaching and Learning*. He notes with regard to his experience training psychiatric residents that they start with a medical, disease-oriented model, which relies on the signs and symptoms of psychiatric disorders; then, after exposure to psychoanalytic thinking, they adopt certain aspects of that viewpoint; and finally they move to a more interpersonal, or existential approach.

My description bears striking resemblance to these formulations, but most prominently differs by being empirically generated from the experience of students learning therapy. I was able to discern roughly four milestones in the process of learning psychotherapy, which approximately parallel the developmental continuum I've described. These milestones are:

- (1) Learning the role of the psychotherapist as a nondirective expert.
- (2) Adopting a *patient-centered* approach that is global, patient-centered, and concretely content-centered.
- (3) A *relationship-centered* approach that involves the discovery of psychotherapy as an interpersonal process.

² Both Havens and Lewis have remarked on the parallels between the historical development of psychiatry and the development that takes place on an individual level in trainees. Another interesting parallel was brought to my attention by George Muench (1979), who described the development of client-centered therapy. He sees this field moving from a client-centered stage, to a relationship-centered one, to finally an existential position, paralleling the stages I've outlined. This type of phenomenon has been noted before in the history of science, especially by Piaget (1929).

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- (4) The development of a *therapist-centered* approach in which there is increasing awareness of the usefulness as well as the limitations that the therapist's own feelings impose.

The first conceptual task many students identify is mastering the role of expert in psychotherapy. The beginning student, like most members of our culture, views the psychotherapist as an expert of some sort but what that expertise consists of is often quite unclear. An expert by conventional definitions is able to provide authoritative and definitive solutions to certain problems. The prototype of this model is perhaps the image of the internist, who on the basis of some authoritative medical diagnosis, is able to prescribe a medical intervention that will ameliorate a somatic disorder. The approach of dynamic psychotherapy, however, is very different. It is at heart a collaborative relationship in which the therapist offers the patient an enhanced understanding of central life conflicts and an increased awareness of alternative life choices rather than definitive answers to the problems of living.

The beginning student will often function at least initially in therapy as if he or she were an expert in the commonsense meaning of the term, not only because of his own expectations but often because of those of the patient as well. Trainees often try to fulfill the expectation that they are experts by acting as if therapy were a situation where you provide advice; often they feel that if an hour has finished without giving the patient something concrete and tangible, then it was a failure. Again, this tendency is often accentuated by the patient's own understandably pressing need for some immediate remedy to the distress he experiences.

The expectation that the trainee should fulfill the conventional role of an expert can be seen on a more subtle level in the initial interviewing style of some trainees. As an expert, the trainee often feels that he or she should take charge of a situation, ask concrete questions, and otherwise structure the interaction, because this is how experts are supposed to act. Enelow and Adler (1972),

in discussing the open-ended interview, describe this behavior in a related context. They note:

Our observations of physicians in post-graduate courses and of house officers in university hospitals led us to conclude that the average medical interviewer is likely to seek information by the most direct possible manner—by asking a great many questions. . . . The physician has a long "list" of items in mind about which he wishes to have information. . . . In a number of observed situations, certain consistent effects of this interviewing style were noted. The patient has a tendency to become quite passive. Often the patient makes some early efforts to bring in personal concerns, then ceases the effort, and limits his communication to supplying the information being sought. [pp. 32-33]

An important milestone for the beginning therapist is understanding the use of the open-ended approach and learning to use it as one aspect of the psychodynamic interview. It is a first small step in abandoning more commonsense definitions of the role of the expert. One student recalls the impact of dealing with the issue of structure:

As I have let things be more unstructured, my therapy has improved a lot. When I started therapy I had some reservations about how change took place. I wanted to explore this, and I was kind of on the fence. I was unsure of how useful therapy was. I knew that telling people what to do and structuring things for them doesn't work all that well, but I wondered what would.

Another student describes this issue in the following terms:

I began to realize that what I began to do when I got anxious over a silence in the hour or over a question I had difficulty answering, was to structure things immediately with the patient. I didn't tolerate a little anxiety coming to the fore. I learned to sit back and tolerate some anxiety and to be a little less active and allow things to come out of the other person.

A second task we can identify in learning psychotherapy is the initial adoption of some theoretical approach in therapy within a nondirective framework. Generally the student adopts a theoretical approach

in an undifferentiated and concrete fashion that reflects the student's own conceptual development in this area. This interviewing style was reflected in the protocols of a number of students who had a quite sophisticated theoretical background, as this excerpt from one student indicates:

Even though I read Sullivan and Fromm-Reichmann, it was difficult for me to use that approach. It was too complex. So initially I found myself being a Rogerian. I had read Rogers and at least I understood him. So I started out being what I thought a Rogerian was, pretty much trying to clarify what the patient was saying and feeling.

Another student notes in a similar vein:

When I started therapy my conception of it was fairly Rogerian. My mantra was empathy, warmth and unconditional positive acceptance. I felt that if I could keep repeating that to myself, even if I didn't know what the hell was going on, that everything would be OK. I thought if I did that, that somehow the person would grow. Just how they would or why, I didn't know. What I didn't realize was that I wouldn't feel unconditional positive acceptance toward everybody I met and that some patients I would downright dislike.

As the students above illustrate, there seems to be a conceptual fit between what the neophytes feel they can do and what they interpret a Rogerian approach to be. The first example also illustrates the patient-centered approach: what is occupying his attention at this time is primarily the patient, what the patient is saying and feeling. The inclusion of the therapist's feelings must await later development.

This concrete and largely patient-centered style can also be seen with trainees first beginning to use psychodynamically oriented approaches. The primary aim of these therapies is to promote understanding and an increased sense of autonomy and choice through insight. Therefore, some beginning students assume that the patient will understand and use insight in some relatively straightforward and linear way. The trainee sees his function as putting together in the most elegant fashion

bits and pieces of the puzzle of the person's life. One student expressed this sentiment in the following fashion:

The concept I originally had was something like a Sherlock Holmes type of thing. I visualized it as the therapist doing a lot of detective work in his head and providing the patient with insight. I saw it as making some profound type of discovery with the patient and sort of marveling over it. The therapist's job was to solve the riddle of the person's life.

Still another notes:

I started out doing therapy with the idea that I was to convey insight and I felt that the power of my therapy was directly related to the elegance and precision of my formulations. One thing I learned rather quickly was that patients didn't pay that much attention to what I said, and didn't regard every comment I made as golden. Patients can resist the therapist and resist changing. My original understanding was that by virtue of hearing somebody who was objective they could change their behavior.

A third conceptual milestone for trainees is the discovery of what is perhaps the core of dynamically oriented psychotherapy—psychotherapy as an interpersonal process involving the feelings and reactions of both therapist and patient. It represents a movement from a more concrete approach that focuses on the content of the hour, what the patient said and did, to a *relationship-centered* approach that focuses on the metaccontent of the hour—that is, the feelings and emotions developed in the patient-therapist relationship which generated that content. Most human relationships have a taken-for-granted quality and communication on this metalevel is largely unconscious and beyond critical examination. The discovery of the metalevel of communication comes to many students as a novel and powerful stage in their development, even those knowledgeable about theory, just as it was in the history of psychoanalysis. Fromm-Reichmann (1950) has commented on this point from the historical and personal perspective:

Only those psychiatrists who have done psychotherapy both before and after being ac-

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quainted with Freud's concepts will be able to realize the full extent of the significance of the discovery of the laws governing the interpersonal interchange between doctor and patient. I personally remember only too well the time when I dealt psychotherapeutically with mental patients, before I was acquainted with Freud's teachings. I realized with distress that something went on in the patients' relations with me, and in my relations with them, which interfered with the psychotherapeutic process. Yet I could not put my finger on it, define it, or investigate it. [p.3]

A number of students commented with much the same sense of discovery on the importance of this perspective in their own development as clinicians.

Supervision of course plays the crucial role in this area, for it is the supervisor who directs and redirects the trainee's attention in this area. As one student recalls:

I started out being very Rogerian and making clear what the person was saying. But I quickly found that my supervisor was focusing on the relationship between me and the patient. I didn't have a concept of how important that was, because I thought the content of the hour was the most important issue. But my supervisor quickly moved to focusing on the process, that is, the interactions between me and the patient, and that was kind of my first realization. If I was feeling anxious, we would try to find out why, or if I was feeling angry, why was I feeling angry. Before, I never knew I was supposed to think about such things.

Rather than being a one-time discovery, the development of a relationship-centered perspective in psychotherapy defines an area for continued work and attention throughout the therapist's professional career. As the last student's comments indicate, it also lays the groundwork for the final area of development described in the interviews—an increased understanding of the therapist's own feelings and reactions. This entails not only an increased ability to use feelings in the therapeutic process but also an awareness of the limitations these feelings impose. The final arena of development can be called *therapist-centered* in contrast to the earlier patient-centered or even relationship-centered perspectives.

The emergence of this stage in part depends on an increased sense of confidence and self-esteem in the student and a greater ability to trust his or her own reactions as a source of information rather than an unwanted and anxiety-provoking intrusion into the therapeutic process.

For many students the ability to use their own feelings, reactions, and intuitions in a more spontaneous way is connected with becoming more comfortable in the role of a therapist. When students first begin doing therapy they often feel as if they are putting on a mask or persona. This is frequently accompanied by the nagging feeling that the therapy they are doing does not really match up to what "real therapists" would do. One student described this experience in the following way:

Knowing day after day I have not used all my energy being anxious but could begin doing the type of work that was expected of a therapist was important to me. I got rid of the idea that I didn't have to act with somebody like a therapist, to play the role of a therapist. It was an important step when I began to feel that I could just be myself, that I had some way to use myself in therapy and was effective, and could use my sensitivities and intuitions. I got used to the idea that being a therapist wasn't something beyond or above me. I was initially scared to let my patients know I was a beginning therapist. But gradually the mystery of mental illness and my particular role dissolved for me. The whole thing became a continuum and I was able to put myself more at ease in the situation and feel relaxed. For example, one person would say to me, "Could you speak louder—I can't hear you over the voices." I felt more comfortable in my role as a therapist and coping with the novelty of crazy people.

Another student relates similar feelings:

I was doing conjoint therapy with an experienced therapist, and working with him I learned to use myself as a tool and to trust my reactions and feelings, and not just be a passive omniscient type of person. I feel freer to deal with my own doubts about myself and whether I can work with people. The more comfortable I've gotten with people the less I need to project a front. I can be willing to encourage people to express their feelings about me now, whereas before it

was something I wouldn't even consider. Cutting my beard was an important thing for me. With it, people would think I was 35 and was an experienced shrink and I wouldn't do anything to discourage them.

Being able to use one's own feelings and reactions in therapy is related to significant developments in the conceptual realm as well. Learning to trust one's intuitions and reactions can take place in part because the trainee can understand their usefulness in a self-conscious way. One student comments about this development in her clinical training in the following way:

When I look back on it, I felt that I was really lucky to get less complicated people at the beginning of the year, but I realized that it was me and not them who had become more complex. I would first do something intuitively because it seemed right but not have any idea if it was. Later, I had to try to learn to figure out why I did it. It took time to be able to learn to trust my reactions. Eventually, I could learn to understand what I was doing, as I was doing it, and why I was doing it. The fact was, I could only handle what I could see and be aware of, and once I had an understanding of why I was feeling nervous or annoyed or whatever, I could really use that feeling.

Another issue that students encounter along these lines is that of the limitations that their own feelings impose on what they can do in therapy and whom they can work with. Initially, many trainees assume that they can do therapy with anybody about almost any issue, and this assumption is often reinforced by the realities of most outpatient clinic settings, where students are usually expected to treat all cases that are assigned to them. Understanding what types of problems and patients they can and want to work with requires an awareness of their own needs and limitations in doing therapy. As one student put it:

At times you find you can't deal with issues the patient brings up because these are your current conflict areas. You can deal best with the areas you have just conquered. It might be good for someone to experience intense anger toward you, but it can be hard on you personally, and wasn't something you wanted to take on all

the time. Doing therapy gave me the sense that you have to take care of yourself before you can deal with other people.

In the reports of many students, an important factor in learning to use themselves and their own feelings in therapy is the students' own experience in therapy as patients. The results of such an experience are particularly striking with students who have never had therapy previously and undertake it sometime during their clinical training. This experience can be useful in a number of ways. One student recalled that a personal experience in therapy was particularly useful to him from a conceptual point of view, giving him a more coherent and useful model of what was going on in the complex and rapidly changing situation of therapy. He states:

Now people's lives and the way they act is more of a gestalt. It all makes more sense now. My being in therapy for a year really helped. "I" make more sense to me now. I can use my own therapy as a learning experience. The world is so multileveled that I need some sort of structure to my experience. In therapy, things can be so complex and seemingly chaotic that you can really get lost. My own experiences in therapy helped give me a guide. I want patients to be able to see like I did that the things they do make sense and that things they do were survival techniques they used at one time that are no longer useful to them. I want to convey to them that they have some freedom and choices now to do something different than they have in the past.

For several other students, therapy was also important in giving them a model of what it feels like to be a patient. Certainly gaining empathy is a major goal of clinical training, but empathy is best gained not just through *knowledge* of what the other person feels but through a similar *experience* of one's own. Clinical students come upon this finding as an unexpected and fortuitous consequence of personal therapy. One student commented, "Knowing the pain from the other side made me much more sympathetic and understanding with people who came in." Another student said:

My own therapy is a model for what I do. It's

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a situation where I can deal most openly with my own work as a therapist and the doubts I have. My style is close to my own therapist's and what my own therapist would do in a situation. It also gave me a feeling of what transference is about from the patient's side, and did away with my skepticism about the intensity of the feelings the patient could have about me by meeting just once a week.

For this student, therapy gave him a greater ability to "take the role of the other" in the therapeutic situation and know that role through an intimate experiential contact. But it also gave him something more—a concrete illustration of how a mature therapist might function. Several students reported that not only with supervisors but also with therapists a sort of identification occurred and that this was an important influence in learning psychotherapy. A central experience for many students was to see, and not just hear about or read about, how someone else did therapy.

IMPLICATIONS

It seems evident to me that some type of important psychological development takes place in learning psychotherapy, but how can we classify it? Is it "just" cognitive development, only touching encapsulated intellectual ways of knowing? Is it something separate from cognition, some emotional freeing process independent of conceptual categories? Several theorists, most notably Loevinger and Wessler (1970), suggest eliminating the dichotomy between cognitive and characterological or affective dimensions. Loevinger and Wessler's theory basically describes the stable concepts the person has about herself, others, and her place in society and they call this type of development "ego development." The changes that trainees report seem to be a facet of ego development—that is, enduring changes in schemas about the self and others.³ As Loevinger and Wessler note, ego

³ In examining the four stages described retrospectively by students I was struck that the continuum of development they described, from more concrete and undifferentiated to more sophisticated and introspective, resembled a general developmental model proposed by several authors. In addition to the Loevinger and Wessler theory, most prominent are Piaget's cog-

development occurs slowly since such schemas are relatively stable and only develop through exposure to experiences more complex than existing constructs can readily handle.

In suggesting that learning psychotherapy can be viewed as a developmental experience in which trainees move from a focus on the concrete, patient-centered content to self-aware and introspective analysis of relationships, I recognize that formal theoretical training plays a role; however, the development that takes place in learning psychotherapy occurs primarily on the experiential level, through doing therapy and receiving supervision.

Perhaps what graduate education can do best to promote this type of development is to provide rich and supportive environments within which it can take place. An important part of providing such an environment is an appreciation of the various conceptual levels at which students may be functioning. A student at a given level of sophistication in his functioning as a clinician can best understand and use theoretical constructs that match his own conceptual level. Ideas which are too complex will make the student either bewildered or anxious, and ideas which are too simplistic will not enhance development. Supervision and training ideally should always be at or just one step beyond where the student is now, as some supervisors and training programs know intuitively. The continuing challenge of clinical training is to facilitate the professional development of the therapist through a sophisticated understanding of his or her experience and capacities as a learner.

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nitive developmental model (Flavell, 1963) and Harvey, Hunt, and Schroder's (1961) cognitive complexity model.

Rogers (1959) has also described stages in the process of the patient's development in psychotherapy similar to those I observed. Rogers describes the process as movement from a position where personal constructs are relatively rigid, concrete, and focused on externals, where feelings are global and undifferentiated, to an increasing differentiation of feelings and their interpersonal origins, and increasing understanding and self-feelings.

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