from the seclusion room, over two-thirds of patients were quiet and constructive in their behaviour (nevertheless, a quarter continued to be disruptive).

In conclusion, the poverty of the literature on seclusion (Wilkinson, 1983) shows clearly that the topic has been neglected as a subject for open discussion. There is little cause for us to believe that such neglect is justifiable.

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Trainees' Forum

The Experience of a Psychotherapy Trainee*

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I am very pleased to have this opportunity to share with you my experiences as a trainee at the Maudsley Hospital. This training differs from many in that I am a part-time Senior Registrar and a part-time mother. Unlike most children, mine actually opened the doors to my professional aspirations. I became a trainee in a specialty whose clinical approach not only corresponded to the one I wanted to practise, but one which also promised to increase my understanding of human behaviour.

I came to psychotherapy with a French philosophical background and a degree in Biological Sciences. The first has instilled in me the importance of a theoretical basis to my clinical work; practice and theory must constantly be seen to interact with one another. The biological sciences gave me a scientific approach, a knowledge of systems, ecology and ethology which all contribute to my knowledge of human beings.

On reading the Report of the Joint Committee on Higher Psychiatric Training, I found that my training aspirations were very much in line with those recommended. I was fortunate in not only being able to pursue my various interests, but also in getting support and guidance from my seniors.

My history in psychiatry starts with Professor A. Clare. I was doing my elective in the Maudsley when he metaphorically took me by the hand and said in his inimitable Irish way, 'Forget all you have learnt and just listen to what the patient has to say.' I then met Dr M. Jackson and worked on his ward. Here was a man who talked, listened and understood patients as no one had before, in my life. He made sense of so-called 'madness' and he gave me hope (a crucial ingredient to training). Through him I became aware of the need to engage in the long-term psychoanalytic psychotherapy of severely disturbed patients. My early intuitions and curiosity found in the individual psychotherapeutic session a 'laboratory' for the study of human communication.

It was also on Dr Jackson's ward that I became fascinated by the interactions between psychosomatic patients and their therapists. They made me realize, more than any other patients, how ineffectual is the dualistic mind/body paradigm when it comes to understanding mental illness. Through this experience, I learnt how important it is, in the face of so little knowledge, for the various therapeutic approaches both to remain in contact and learn from each other. This realization led me to explore the possibilities offered by family therapy. I had seen how useful it was in its simplest form in the management of chronic patients in community psychiatry. I then discovered that the more refined systems-oriented techniques were therapeutically advantageous to a certain class of patients, such as anorexics.

Family therapy can appear to those outside the field as a jungle of methods and approaches; therein lies its richness and possibly its dangers. Driven by my need to reconcile practice and theory rather than go for the more empirical, I found myself increasingly interested in the Milan approach formulated by Professor Palazzoli and her team. This is an approach created by experienced psychoanalysts steeped in systems theory and geared to the treatment of psychotic patients. I was able to attend their course in Italy and to practise their method in the Maudsley.

Throughout my training in psychiatry I witnessed the potential effectiveness of group therapeutic techniques

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applied to both patients and staff. I followed up this interest by supervising a group run by nurses on a general ward. This provided the least threatening form of staff group being overtly geared towards the running of their patient group. I have also assisted in the running of a staff group in the new District Services Centre. Both experiences have highlighted for me the need for specific skills on the part of the 'facilitator'—some of which are not adequately provided by the experience of working with patient groups. I think that there is a need for further supervisory work in this field.

Part of my training includes a research session which I use to explore the field of bi-lingualism. This interest was sparked off by an incident which took place when I was an inexperienced SHO on a locked ward. I found myself in the presence of a very disturbed thought-disordered manic man. He was almost unintelligible until he suddenly picked up my telephone and began to speak in Spanish (I am myself half Spanish). To my amazement his speech became quite clear; the thought disorder had disappeared! We then spoke in English and he returned to his thought-disordered jargon. This happened twice. I was amazed, but I didn't know what to do with my findings. I am now researching into this field of polyglottism and mental processes which has implications for psychotherapeutic work and neurology.

My need to remain in touch with other conceptual fields impinging on our understanding of human behaviour makes me particularly interested in the development of present psychotherapeutic approaches and in the psychological advances brought about by Piaget and the applications of Systems Theory. The risk of such an open attitude is that of becoming a so-called 'eclectic', a potential 'Jack of all trades, master of none' with only a superficial understanding of the various therapies. This may be even more likely if one has an empirical attitude to psychotherapy, that is to say one where theory and practice are seen to be divorced.

An alternative view is to see an open psychotherapeutic approach as having the paradoxical effect of deepening one's understanding of human interactions. If one actually witnesses the successful results of treatments undertaken by therapists of differing specialties one begins to want to know why and how? How is it that a Professor Minuchin with a structural non-insight oriented approach succeeds in treating some of the most difficult patients we know—the anorexics? How is it that a psychoanalyst, such as Dr Jackson, can also achieve outstanding results with psychotic patients using an apparently quite different insight oriented approach? Even if the two therapists do share a psychoanalytic understanding of human behaviour, the first believes he produces change by creating alternative external experiences for his patients; the second believes he produces change by giving the patient an understanding of his inner world in interaction with external reality. Are both right? Can we actually stimulate long-standing change in human beings by differing means? And if so, what are the implications for our conceptual understanding of human behaviour? Or could we postulate that both therapists produce change in similar ways—unbeknown to each other?

There is no doubt that the experience of a multiple psychotherapeutic approach is very confusing. But it is necessarily so because we are dealing with differing underlying conceptual models of human psychology. At one extreme we have the view that people are mainly internally motivated; at the other extreme, that human behaviour is externally determined. We face another dualistic paradigm, the genetic/environmental polarization. I believe such an approach was once a most useful one, but it may be time to look at the other sources and learn to see things from an interactional point of view, an ecological or systems perspective. Such a viewpoint has the merit of taking us beyond the polarizations of the dualistic model whilst preserving present findings in both psychoanalytic and behavioural fields. The emphasis of the therapist, in practice and in theory, moves from a closed isolationist point of view to one that is eventually context-related.

This brings me to my final point—that of our present training. I see myself as an NHS doctor and would like to remain so. I also see psychotherapy as having a potentially increasing contribution to the running of present psychiatric services, but to achieve such a role our training experience may have to be context-related. We have to know the past, present and future setting in which we work; we may be advised to think of how to adapt psychoanalytic theory and experience to the NHS setting, not by diluting it as some would fear, but by making specific modifications and changes more in keeping with our work. We may, as a result, face exciting new discoveries. For instance, who would have believed that psychotic patients could be treated with twice a week psychoanalytic psychotherapy? It had to be seen to be done and some even say that it is the treatment of choice for these patients in a therapeutic setting.

I will conclude with a story taken from Sufi lore. Four travelling companions, a Persian, a Turk, an Arab and a Greek, were standing in a village street arguing over the spending of a coin which was all they had among them.

> 'I want to buy *angur*,' said the Persian.
> 'I want *üzüm*,' said the Turk.
> 'I want *inab*,' said the Arab.
> 'No,' said the Greek, 'we should buy *stafil*.'

Another passing traveller, a linguist, said 'Give me the coin —I undertake to satisfy the desires of all of you.' At first they would not trust him. Ultimately they let him have the coin. He went to the fruit seller and bought four small bunches of grapes.

> 'This is my *angur*,' said the Persian.
> 'This is my *üzüm*,' said the Turk.
> 'You have brought me *inab*,' said the Arab.
> 'No!' said the Greek, 'This in my language is *stafil*.'

The grapes were shared out among them and each realized that the disharmony had been due to his faulty understanding of the language of the others.

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