

Innocent bystanders?: observation in psychotherapy

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We describe the operation of a psychotherapy clinic where a one-way screen is used in the assessment of adults for a range of dynamic therapies. While observation of psychotherapeutic encounters remains contentious as an activity in its own right, we attempt to illustrate how such a way of working can be helpful to patients and staff. The potential drawbacks of this approach are discussed and ways of minimising these are explored.

The practice of demonstrating psychological processes in the public arena has always been a contentious issue. Even Charcot's approach had its critics. The atmosphere of suggestibility and the attention given for the required symptoms and signs meant that Charcot was often the victim of major deceptions (Isbister, 1985). Yet it was, in part, through attending Charcot's demonstrations in 1885 that Freud began to develop his own ideas about the role of the unconscious.

This controversy over the role of observation remains in contemporary psychotherapy. The issue considered here is not whether assessment is in itself necessarily good or bad or has intrinsic moral value, but rather the manner in which it is done.

An approach involving a number of observers could provide patients with fuller assessments. It could distort the patient/therapist relationship. At its worst, it could amount to a mechanical demonstration of 'pathology' without empathic understanding of what the patient experiences. Observers could then be accused of colluding in bad practice.

In this article, we describe a clinic where observation plays a part in assessing adults for a range of dynamic psychotherapies. There are two separate but related functions of observation in this setting.

- (a) to provide full assessments
- (b) to educate trainees in assessment and provide feedback to more senior staff.

This approach contrasts with the way in which experienced therapists often work alone in assessing adults for psychodynamic psychotherapy but has similarities with family therapy, with its emphasis on teamwork. The article concludes with a discussion of the potential benefits and drawbacks of this novel approach.

The clinic

The weekly assessment clinic receives referrals from GPs and consultant psychiatrists. Two pairs of rooms are used for one session. Each pair is joined by a one-way screen and sound link. This allows interviewers to use earbuds. The team consists of psychotherapists, psychologists, psychiatrists and nurses. Initially, the team meets for 30 minutes to discuss the two patients to be seen in the session. Each patient will have been allocated to a team member in advance, who will have phoned the patient to explain how the clinic runs. Patients may decline the use of the screen at this stage. The team member will meet the patient in the waiting area and introduce him or her to the two observers, if he or she wishes.

After an hour's interview, the whole team reconvenes for discussion for 30 minutes. The outcome will then be discussed between each patient and his or her interviewer over 20 minutes. Occasionally, referring agencies are invited to observe and contribute.

The benefits

Patients benefit from this approach by being more thoroughly assessed. It is easier for observers behind a screen to see beyond the immediate content of the material presented. Observers may recognise established but unconscious and unhelpful styles of interaction which the patient brings to the session. Significant themes may keep cropping

up. Disparity between verbal and non verbal communication may be marked. Recognition of these aspects of the interaction provides a more complete picture.

A related benefit is that therapists receive direct supervision during the interview through the earbug. This helps therapists to develop their ability to listen and intervene empathetically. Supervisees can also watch a more experienced therapist at work and ask about the significance and context of specific interventions. Meeting after the interview allows for supervision in formulation and discussion of treatment options. It also allows the interviewers to share the impact of dealing with painful material in the session. Working as a team can make it easier to contain demanding patients. This is especially important if a referral has been seen as a last resort for those who would best be helped by a longer term supportive approach.

Understandably observation can be a source of anxiety for team members, e.g. fears of appearing incompetent, being controlled by the suggestions of others, and a sense that team members are not being themselves because of their awareness of the screen. Ely's 1982 study of 53 supervisees working in a similar fashion revealed the same anxieties. Forty-eight admitted to feeling initially threatened but then more positive about the method after gaining some experience in it.

As in Ely's study, we have found that our anxiety is diminished if observers provide positive comments and make their interventions succinct to avoid interfering unduly with the patient-therapist relationship. Interviewers have the freedom to use or discard suggestions as they see fit. Our hope would be that as team members become more confident with each other, that anxiety will diminish further (Speed *et al.*, 1982).

The drawbacks

The main concerns about this way of working follow.

The assumption that patients dislike being observed

A study by Burgoyne (1978) attempted to assess patients attitudes about being observed. Eighteen former psychotherapy patients who had been observed throughout their treatment for teaching purposes, were

interviewed by phone. At the start of their therapy, they had been given a choice of treatment by a less experienced clinic member or observed therapy with a senior practitioner. That they had chosen observed therapy means that their comments concerning it must be interpreted with caution. However, 17 of the 18 felt that the therapy had been worth the effort and 14 had gone on to have further treatment elsewhere.

Thirteen felt, like their therapists, that the treatments were close models of unobserved psychotherapy. Significantly, only four of these patients felt that being observed had altered the therapy in a neutral way. Only one patient felt that observation had been harmful, feeling that the team's presence had made the therapist more aloof and formal. The difficulty with these findings is that it is not clear whether patient perception correlates more with the nature of the presenting problem and outcome, than with an accurate grasp of the realities of working with a screen. The retrospective nature of the study and the small numbers of carefully selected patients involved should be noted.

In our clinic, observation is only used in assessment so it is hard to know whether our patients feel the same as in Burgoyne's study. However, we have tried to reduce potential worry about the screen by contacting patients in advance. The manner in which this is done has changed recently. In 1992 patients received a letter describing how we used the screen. An audit of a five month period in 1992 showed that eight of the 37 patients telephoned to decline the screen. In 1993 an allocated assessor phoned to give patients the opportunity to discuss assessment procedure. In the 1993 audit, none of the 32 patients offered interviews declined the use of the screen. The DNA (did not attend) rate was the same for both audits. Despite this finding, there have been problems for individual patients with this approach. For one patient, who remains in therapy after two years, the use of the screen is still an issue, representing a repetition of her earlier experience of feeling outside her family.

The screen alters the encounter with patients

The use of the screen may alter the encounter between therapist and patient even if patients are not consciously worrying about it. Burgoyne's 1978 study also looked at this

issue in the same group described above, again retrospectively. His patients did withhold some material but more often emotionally significant information was available although its reporting was delayed. Surprisingly, he found that his patients did not often project material on to the observers. If anything, the therapists projected their own anxiety about being watched on to the patients and identified with them. Burgoyne concluded that his patients' ability to use defences of denial, rationalisation and intellectualisation helped them to cope with being observed.

In our clinic's experience, members have also been concerned about how patients deal with the screen as well as admitting to performance anxiety. At times differences of opinion between the two sides of the screen about the assessment have been projected on to the screen itself. Use of the earbug connects the team across the screen and reduces splitting.

It is time-consuming

Such a way of working is time and labour intensive. Running several assessments in parallel increases efficiency. These considerations need to be balanced by considering this method's value in training and in providing valued feedback for experienced therapists. It encourages team building and attracts supernumerary staff who often go on to work as therapists.

Concluding comments

In our experience, this approach enables us to carry out a fuller assessment and helps

trainees develop necessary skills, demystifying the psychotherapeutic process. Patients' feelings about the approach are hard to assess. If subsequent attendance for treatment can be taken as a crude marker, it would seem that patients cope better than therapists expect. A potentially voyeuristic technique can be transformed and at its best enables observing trainees to witness for themselves the power of human contact in the face of suffering.

Acknowledgements

We would like to thank members of the Southmead Psychotherapy Assessment Clinic for their part in the preparation of this account.

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