

## Identity and Psychiatric Training

J. L. G. DE RIVERA, M.D.\*

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*Undergraduate and post-graduate medical/ training may be considered as "psychosocial moratoria", providing time and opportunity for the development of initiative, autonomy and sense of mastery through work, which are the hallmarks of a firm sense of ego-identity. This nonspecific beneficial effect balances the emotional strains related to the demands and hazards of training with the important exception of post graduate psychiatric training. As opposed to other specialties, psychiatry does not offer the beginner a clear set of rules or reliable means to assess performance. Although exposure to mental suffering and reactivation of conflicts are the usual explanations for the so called "beginning psychiatry training syndrome", the relative inadequacy of psychiatric training to support the self-identity process should also be considered. Identification with admired members of a given psychiatric doctrine may be a common defense against fears of identity diffusion, and it may promote excessive respect for authority, with disregard of scientific observation. The formation and acceptance of psychiatric theories may be influenced by emotional factors related to psychiatric training and more attention to those factors is needed in order to assure the development of psychiatry into a unitary scientific discipline rather than a constellation of beliefs.*

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Natural Science begins with taxonomy. Psychiatry, for ages, a custodial and moralizing endeavour, was fully recognized as a science and a medical specialty after the monumental classificatory effort of Emil Kraepelin. However outmoded its content, Kraepelin's *Lehrbuch*<sup>9</sup> has still today an important point to make, namely, that the bases of science are the observations of and the orderly distribution of data. This new spirit took psychiatry out of the previous

stagnation and provided the opportunity for tremendous growth, unarrested ever since.

The history of modern psychiatry is one of continuous increase in the understanding of the human mind and behavior, and of continuous development of powerful therapeutic tools. But it is also a story of emotional struggles, sectarianism and confusion.

To a greater extent than any other medical discipline, the development of psychiatry has been marked by conflicting schools of thought, intolerant to anything but their own body of theory. Birk<sup>2</sup>, commenting on this phenomenon, signals that leaders in psychiatry tend to be innovative and creative, but that their students direct their attention more toward discipline, seeing the leaders as an 'Authority', almost as a paternal transference figure. As a consequence, they are more concerned with the preservation of the leader's theories than with the progress of science; the principle of scientific inquiry is replaced by devotion, and a new school of psychiatry, oblivious of the others, is born.

The purpose of this paper is to suggest that this clinging to authority and disregard of scientific observation is mainly due to emotional reasons and that this attitude may not be the best for the progress of the discipline of psychiatry and that most conventional training programs tend to perpetuate it.

### THE CONFLICTING STATE OF PSYCHIATRY

Dynamic psychiatry was a major breakthrough in psychiatric theory and practice of the early twentieth century which met with strong oppositions which were to a large extent determined by emotional and irrational attitudes, chiefly the fear of the threatening discovery of the unconscious. This still holds true today, and we find a whole array of schools which fully reject psychoanalytic theory. For instance, a

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\* Associate Chief, Department of Psychiatry. National Center for Medico-Surgical Research, Ministry of Health, Madrid. Spain.

prominent behavior therapist dogmatizes as follows:

"...(There is not) any such unconscious causes..., there is not neurosis, but merely the symptom itself."

Learning theory at least acknowledges some psychological factors but the so-called 'organic school', following the old dictum "No thought without phosphorous", keeps searching for the contemporary equivalent of phosphorous, oblivious to any other possible factor in mental disorder.

The psychoanalytic school has not been more fortunate in terms of tolerance to other theories. Even Freud, the accurate clinician, the courageous scientist who confronted the whole world to defend his discoveries, allowed his scientific contributions to crystallize in doctrine, to the point of having Bleuler, in his letter of resignation from the Psychoanalytic Society, describe the Society's atmosphere as more appropriate for religious sects and political parties than for science.<sup>1</sup> Freud's attitude is understandable, taking into account the extreme isolation of the early pioneers of psychoanalysis. It is possible that psychoanalytic methodology would never have developed until now had it not been for the cohesiveness of the initial group. This cohesiveness and mutual support enabled the earlier psychoanalysts to stand for their findings despite overwhelming external pressure.

The fact remains, that even such a strong character as Freud needed the warm and unconditional support of a group of followers. This points to a basic human need, the need for belonging to a group, the need to share a part of our identity with others.

Posteriorly, the formerly monolithic psychoanalytic school fragmented in many schools of dynamic psychiatry which, like competitive sisters, still quarrel among themselves and with the common source, orthodox psychoanalysis.

As the psychoanalytic movement consolidated its position, new interest in the social sciences and in the interpersonal factors of mental disorder became increasingly influential, creating awareness of the importance of the family and society at large in the genesis and maintenance of psychiatric disturbance.

Following the current rise in social consciousness, psychiatrists have extended their role beyond the clinical boundaries; attempting to treat not only the conventional psychoses and neuroses, but human misery and misfortunes at large. On the other side of the same coin, the whole concept of mental illness has been rejected, and psychiatry has been accused of being an instrument of oppression.<sup>15</sup>

In the face of so many conflicting trends, more and more psychiatrists are trying to be conciliatory, adopting an eclectic position. In its more extreme

form, this is a very pragmatic approach, which disregards the theoretical basis of practice, and is concerned only with the use of the more appropriate therapeutic techniques for each case. This orientation has the major drawback of lacking a coherent theoretical background and it has been considered by Eysenck as "a mish-mash of theories", a form of dilettantism that touches to every fad without real profundity.<sup>5</sup>

Not only are there conflicting theories in our field, construed in a mutually exclusive way, but there are also of necessity conflicting ways of practising psychiatry and the reflection of the diverse conceptual approaches into practice produce different patterns of 'being a psychiatrist', which can be easily recognized in any setting allowing an eclectic approach.

Embodiment of a particular theoretical orientation seems to correlate with specific personality characteristics and with specific ways of approaching patients, colleagues and probably life in general.

## RESIDENCY TRAINING AND EGO-IDENTITY

According to Erikson,<sup>4</sup> the formation of ego-identity involves choices and decisions which lead to a final self-definition, to irreversible role patterns, and thus to commitments for life. Normally, this should happen by the end of chronological adolescence, but for some people more time is required, and for them society offers institutionalized psychosocial moratoria.

Medical training, with its well-organized routine, its specific tasks to be accomplished and a clear system of positive and negative sanctions, seems an optimal moratorium to develop the initiative, autonomy and sense of mastery through work that are essential to a firm sense of ego-identity.

However, some physicians may not feel contented with the amount of knowledge, respectability and poise acquired in medical school. They are not yet ready to commit themselves to the demand of their professional identity and occupy a definite place in the structure of society; they want to continue learning and experimenting until they achieve the strength and distinctiveness of work identity they require.

For those physicians, whose identity is not yet crystallized, society has a new moratorium to offer – Postgraduate Residency Training.

This need for further self-definition is a promise of future achievements and a more developed personality organization if all goes well. But it is also a sign of a still weak identity and a warning of future trouble if something falls.

The prospective resident has just gone through the

pains of a hard undergraduate education and has gained the right to an important place in society, but his lofty ego-ideal is not yet satisfied. He cannot accept his present work identity, which is not quite enough for him, and he has to apply for more training in order to achieve a complete sense of identity.

It is not surprising that Sharaf, in a well-known study on psychiatric residents,<sup>13</sup> has found them engaged in a quest for omnipotence. According to him, the resident views his teachers as possessing different expressions of omnipotence, and he follows professional training seeking to emulate them.

### THE EMOTIONAL TRAP OF PSYCHIATRIC TRAINING

In general, residency training is almost a continuation of medical school training, with defined duties, sanctioned competitions and a more clear potential integration with the hierarchies of expectable jobs and careers. The formation of the sense of identity continues in the same direction initiated at the undergraduate stage and follows the same basic rules.

There is only one important exception in this second medical moratorium – psychiatric training.

In opposition to other specialties, psychiatry does not offer to the neophyte either a clear set of rules or reliable means to assess his performance. The conflicting and mutually exclusive theories and ways of practising psychiatry confuse the residents, who complain of "...not knowing what psychiatry is all about"<sup>6</sup>. New and vague expectations destroy the confidence built in the resident through his previous competence as a medical student or general practitioner.<sup>12</sup>

The medical identity, although not completely satisfactory for him, is nevertheless a cherished possession of the beginning resident. In other specialties, this identity will be strengthened and qualified. In psychiatry it proves insufficient to face the complexity of the field, and is threatened by opinions which consider medical attitudes a handicap, something to be unlearned in order to facilitate professional development," or by interpretations of the attempts to preserve the medical model as a defense against the anxieties associated with learning the art of psychotherapy.<sup>3</sup>

The potential insecurity of the beginning resident and the adverse conditions of psychiatric training may set the way for what has been described as the 'beginning psychiatry training syndrome', a psychological response of the resident to his first year of psychiatric training, characterized by temporary neurotic symptoms, psychosomatic disturbances and

symptomatic behaviour.<sup>10</sup> When this happens, the moratorium has proven an emotional trap, the loose ego-identity has not been strengthened, but on the contrary, it is being threatened by dissolution and hampered by gloomy prospects of 'ever knowing what it is all about'. Identity diffusion, the danger of late adolescence, is finally attacking this young, ambitious, promising procrastinator who is the psychiatric resident, and causing all the emotional upset observable in the beginning of his training.

Fortunately, most residents have enough resources to avoid the dangerous defense of negative identification. Although a few reject psychiatry altogether, the majority defend themselves against identity diffusion by over identification with the heroes of psychiatric cliques. The founding father of a given school of thought, or the resident's mentor, for that matter, becomes a savior who, by allowing identification with him, *will* rescue the lost resident and conduct him to solid ground again. Following the dynamics of this type of defense, other ideologic groups will be rejected and held in contempt, the doctrine of the own group becoming a pillar of the sense of ego-identity. This phenomenon has been exposed from a different angle by Stone, who showed, in a statistical study, that as training progresses<sup>14</sup> residents develop a major ideology similar to that of faculty members.

### PSYCHIATRY, SCIENCE OR BELIEF?

Thus, the adherence to a psychiatric ideology might not be based on the observation and interpretation of facts, which is scientific, but on over-identification with admired members of an ideologic group, which is not scientific.

Identification with a master may play a role in the learning of the more artistic aspects of psychotherapy,<sup>8</sup> but may also be a defense against feelings of identity diffusion, brought by the vagueness of the field and the nature of psychiatric training.

Freud<sup>7</sup> considered knowledge based on belief to be an illusion, and affirmed that true knowledge can only be acquired through a scientific view of the world.

Progress requires knowledge, and it cannot be achieved by projection of infantile omnipotence to god-like authority figures, but by recognition and use of the limited human ability to deal with internal and external reality.

The intense emotional factors in psychiatric training are not favorable to the formation of a "scientific view of the world" in the psychiatric resident, and thus psychiatry runs the risk of becoming a constellation of beliefs rather than a unitary scientific discipline.

## CONCLUSION

If the progress of psychiatry depends on the preservation of the scientific method, more attention has to be paid to the emotional factors influencing the formation and acceptance of psychiatric ideologies.

Identification with admired teachers, a method of learning accepted and even encouraged in many training centers, may in fact be a defense against deep anxieties, and preclude the inquisitive spirit necessary for real knowledge and understanding.

More research is required on the emotional effect of psychiatric training, and on the way residents and faculty members adapt to it. Conventional training programs may be in need of revision in order to facilitate emotional growth and the development of a scientific view of the world.

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