THE PERSONALITIES OF PSYCHOTHERAPISTS

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Psychiatry and psychopathology tell us that there are regular and repeatable ways in which severe impairment occurs. These forms of impairment may be due to chromosomal differences. The regular behaviours and interpersonal relationships of the three per cent of the population who are psychiatrically diagnosable sometimes do not respond to psychotherapy or medication. Below, I give some thoughts on the shortcomings of some types of learned therapist behaviour. My aim is not to instigate a witch hunt, but to bring to awareness the impact of ourselves on clients. Through my own personal therapy, supervision and self-observation, I can see aspects of myself in the categories I describe. The format this paper follows is to briefly recap the psychiatric criteria. Next, I describe some criteria for the description of therapist behaviour.

Given that many therapists are attracted to the profession are in their own pain, have suffered and partially overcome their own misfortunes. Therapists frequently come from similar, or almost the same family background and personality pool as clients. When stress gets very high, therapists may share the same difficulties as the people they are trying to help. If this is so, it means that it is only the overlay of training and positive coping skills that makes any difference between them. The therapeutic situation becomes one of therapists working within the confines of the professional role, and clients electing to enter into this contact.

There is a need to distinguish between, for instance, schizoid-appearing behaviour which a person adopts at will, and schizoid personality characteristics which are unchangeable, and over which the person has little or no conscious choice. I am sure there is a close similarity between immature personalities and those with personality disorders. Perhaps the distinguishing mark is that those with the most severe personality disorders are totally unamenable to change, and therapy is not indicated for them. Less severe personality disorders may change over a period of years, but only through long-term therapy with a skilled individual. Those with less an amount of personality disorder and immaturity should receive much benefit from therapy, and be

able to use it as a chance to make the necessary adjustments for fitting into society. This is, I suspect, part of the reasoning for mandatory personal therapy for therapists. It becomes mandatory because it gives a chance for those who are stuck in their development to be facilitated by either their own brand, or another form of therapy.

Some of the themes that I wish to introduce in this paper have been mentioned by other authors. McConnaughy (1987) made two points which I feel are particularly relevant: "While we can learn the techniques of others, and these techniques can enhance our work, we cannot precisely duplicate our teachers. Any techniques we select will become distilled into our own special style of interacting with clients", (p 303). McConnaughy also quotes Beutler, Crago and Arizmendi (1986) whose research showed that the state of therapists functioning does effect psychotherapy. Those practitioners lowest in emotional disturbance were more consistent in producing results with clients. McConnaughy surveys some of the research literature in his paper and a truism which is noted that therapists should be well developed and comfortable with themselves and able to relate effectively with others. The concomitant is that practitioners who are insufficiently mature will have much difficulty in attending to clients needs. The dynamics of the therapy relationship lies in the space in between each practitioner and client.

Before moving onto discuss client pathology, it is worthwhile just to note what goes under the heading of personality. Personality is the innate capabilities of a person, something which they have had little difficulty in developing within themselves. Skills on the other hand are learnable and can be taught to others once they have been identified. The dividing line between skills and personality is not a strict one as a person's most innate qualities can change through the decades, but somehow personality is that which is slow to change. Skills are items of behaviour which can be produced at will and are adapted to current circumstances. Personality does not change so readily.

Brief psychiatric overview

Antisocial and psychopathic people can be noted by their amorality and irresponsibility which gives them a tendency towards becoming confidence tricksters and grossly criminal. The way to work with them is to hold them to strict boundaries and be directly confrontational.

Narcissistic people characterise themselves by their grandiose sense of self-importance, which hides their fragile identity and low self-esteem. These persons respond well to supportive treatment in which their self-worth is affirmed.

Borderline personalities have rapid changes in mood and suffer from impulses to self-harm. In periods of crisis they may only benefit from sectioning under the Mental Health Act 1983. After discharge they can be followed up by low doses of phenothiazines. A mixture of confrontative and supportive styles of relating may help them.

Schizoid personalities are extremely aloof and isolated. They stay away from friendship which, when occasionally entered into, is often found to be brief and painful, as it brings up possible feelings of a loss of self, and strong feelings of longing, love and loneliness, so the relationship is broken off with much guilt. They may respond best with insight-oriented therapy and the building of a trusting relationship.

Histrionic persons are prone to dramatics and self-centredness. Appropriate ways of relating to them include insight-oriented therapy, setting clear boundaries for the definition of client and therapist roles, and accompanying them as their peaks turn to troughs, and troughs to peaks.

Compulsive personalities are rigid and dogmatic, and may respond to insight-oriented therapy, along with the building of a trusting and caring relationship. Therapy and medication may help in extreme cases.

People who suffer panic attacks and extreme anxiety may benefit from a range of treatments including: insight therapy for resolving underlying conflicts, cognitive-behavioural therapy, medication, hypnotherapy and relaxation skills.

Delusions and psychosis are best treated by sectioning and medication. The belief systems must be accepted tacitly, and not reinforced or attacked. On the whole, therapy is not indicated, but some who have the vestiges of insight may benefit from it.

Therapist behaviours

Tremblay, Herron and Schultz found some evidence of a core personality among psychotherapists, but also noted differences within the various areas of the profession. Humanistic therapists were comparatively more interpersonally flexible, sensitive to their

feelings, prone toward intimate personal relationships, inner-directed, affirming of self-actualizing values, and likely to express feelings in action. Behavioural therapists were found to be more rigid, externally-directed and emotionally over-controlled. Analytical therapists were found to be outer-directed, emotionally restrained, flexible and goal oriented (Tremblay, Herron & Schultz 1986).

In this section I describe some types of therapist personality. This is done in a similar manner to Lapworth (Lapworth, 1992). In addition to the previous section I would like to present the following descriptions of therapist behaviours which I have seen at professional meetings. When I took the hesitant first steps of finding a training, I did not know which to choose, so I looked around over a wide range of training centres in London. I was surprised to find the existence of what I can only call clones. They exist despite the diversity of training courses, and their avowed emphasis on self-realization, and the promotion of the individual from the knots and ties of the family of origin. Clone behaviour is the adoptions of false selves which are acted out in all circumstances. False selves are caricatures of who therapists should be.

The trainers of any school must know each other, and obviously they share the same therapeutic stance. But this is not all they share. They frequently dress similarly, use the same key vocabulary, and sometimes speak with the same voice intonation and accent. They may also gesture and move similarly. In some institutes, each belongs to the same race, class, socio-economic background, and in some cases have identical educational experiences also. I noticed how each "cultural group" made reference to what could be called "right ways of living", as well as making comments on the indicators of psychopathology.

One way to judge pathology I was once told about is to look at the state of the person's shoes. For instance, if they were scrubbed, dirty and down at heel, it may suggest how the client looks after his or her self in other ways. Although it is an interesting observation to study the state, type and quality of clients' shoes, I do not think that a belief in "shoe analysis" or similar practices are compatible with professional therapy. I suggest that there are stereotypical behaviours of therapists are:

Firstly, it is not appropriate to play therapist at home with one's partner, family and friends (Farber 1983). Over interpretation and inappropriate interpretations about colleagues and administrative staff are out of place. Sometimes mirroring back their concerns can become a way of avoiding them altogether.

Therapy bores are obsessive-compulsive types of who successfully avoid normal living to concentrate on a state of perpetual training. Every spare moment is spent in weekend workshops, evening groups and visits to therapeutic communities during the holidays. Another form of obsessive-compulsive behaviour can be constant head nodding, the relentless expression of concern and caring, with the ever present murmur of encouragement at all times, no matter what is being expressed. The frequent repetition of certain words and phrases also indicates a fixation on certain factors which are deemed healing.

Those who are overly aloof can be seen when creative silence and neutrality are taken to an extreme. They appear abstinent in their personal relations and not just with clients. In extreme cases, they do not say even hello, or acknowledge colleagues with a nod of the head. They give little, and omit the small pleasantries of everyday life. Their blankness can cause anxiety as they blatantly show that they are not interested in small talk and social niceties. The consequences of over aloofness, the silent presence of an unknowable person, are that they can create an impression that they dislike or perhaps are afraid of colleagues.

Those who really want to appear warm and accepting can be prone to hugging at every given opportunity during a weekend workshop, which is in contrast to the normal bodiliness of British life, possibly one of the least physical cultures in the world. In distinction, physical touching and over genuineness are frequent and inappropriate, and may be rejected by those who find it false camaraderie, or to whom this behaviour may appear presumptuous or invasive.

In some groups there can be an unspoken agenda which is "right on" and discriminatory in its passion to be politically correct. A reversed set of values occurs which accuses all who do not criticize conservative white middle-class, "male" values. In this replication of discrimination, the inverted value system favours female, non-white working-class people, left wing politics and minority rights. Right on behaviour discriminates against those who do not fit in with the majority and prevents any discussion of the strong feelings which motivate the accusations.

When peoples' beliefs are extreme and seemingly irrational, or they see feel and hear what we do not, the processes of delusion and psychosis may be at play. Some people hold their belief system to be all seeing and utterly correct. When they feel they have the best way of interpreting the world, it closes off other possibilities which may have an equal probability of being applicable. When theoretically described processes are believed to be at play, with little evidence to support their presence, in the case at hand, it seems like the professional is seeing

something that colleagues do not. What irks me a great deal are those who in supervision or a case discussion, after hearing a minute of a client's presenting difficulty, dive straight into some assumptions about unconscious processes or some pet theory. What I find particularly irksome is that they have not heard out the full problem, nor met the client, nor appreciate the uniqueness of the interaction between the two parties. Whatever happened in the session in question was *there* and *then*, in the past, and cannot be repeated again precisely as it was before, nor known in its entirety.

Some writers are quite indecipherable to those who have not taken the large amount of effort required to search for the meanings the authors suggest. It is an elitist style full of jargon in the pursuit of exclusion of those who hide their intentions, and force those who want to learn into a state of frustration and apprenticeship which may last several years. This occurs across the board of all theoretical disciplines. The rationalistic and scientific psychologists are a lesser variety of this process of abstraction. They are busy trying to keep themselves out of the frame of their papers. When the process of rationalization and abstraction becomes excessive, it could be called "clever-ing". This happens when therapists take a perennially over-rational approach to all matters in life.

Over extending oneself past one's capabilities takes place when professionals take on too many clients, meetings and other responsibilities, and do nothing to reduce the number of hours worked. This leads to exhaustion and depletion. The amount of denial can become ludicrous even in those who have had many years of reflecting on their motivations and impulses in personal therapy. In the worst cases desperation at the lack of coping can become a motivating factor for therapists as Fine's research shows (Fine 1980).

Good enough therapy

Good enough therapy can be still achieved by "walking wounded" therapists who have some moderate to severe incapacitation, due to aspects of themselves which they cannot change, which effect how relationships are entered into, and how they misperceive themselves and others. They can convince themselves that "I'm OK", and tell others that all is well.

Good enough therapy also takes place by the perception of interpersonal charisma in the person of the therapist. As Burton has noted, therapists are idealized and deemed to be perfect,

trustworthy and eminent in all ways (Burton 1970). Good enough therapy takes place when therapists who neither teach, research, publish, or shine in group supervision, still provide client amelioration on a consistent basis with a very wide range of clients and presenting problems. This is the quality of the unsung heroes and heroines of therapy. These people are deeply committed to their work and may not seek out forums where they could pass on their approaches and attitudes.

Conclusion

One of the points I have been trying to make is that the interpersonal behaviours of therapists in the consulting room are stylized to produce certain ways of relating, in order to create a certain set of reactions and forces within clients, which it is hoped will reorient them along the desired lines. It is also the case that therapists must also live in the atmosphere they co-create with their clientele.

I have no great insight as an ending to this piece. I realize that I have broken the taboo and silence about discussing the personalities of psychotherapists and mental health professionals. I am unrepentant about this. Psychotherapists require a self confidence and resilience built on neither an arrogant nor a negative self image. Positive coping and no recourse to false selves are required as a gesture in the direction of positive mental health. If we embody and live out what we believe in with clients, it had better be non-pathological.

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