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Education and Postgraduate Education of Psychiatrists in the Soviet Union and their Integration into a New Milieu. A View from the Present to the Past of Former Soviet Psychiatrists

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Abstract: The article presents the problems and difficulties that psychiatrists from the former Soviet Union (FSU) have to cope with in Israel. Immigration and acculturation in a new milieu is a complex process and even more complicated for those whose specialty is medicine and particularly psychiatry. There is a wide gap between the skills and knowledge that new immigrants brought with them from the FSU and the professional demands in the new country. Psychiatry and psychiatric education in the FSU were determined by the cultural practices and traditions of the region and the organizational principles of the USSR which were very different than those of western society and the State of Israel. In comparison to the West, postgraduate psychiatric training in the USSR was shorter and less rigorous with an emphasis on biological therapy. Soviet "psychotherapy" was more reality oriented and more authoritarian than in the West, stressing "collective" group therapy. We describe the basic principles of Soviet medical education and the radically different social, intellectual and political history of the former Soviet Union. We relate the experiences of psychiatrists in the FSU in learning dynamic psychotherapy and the difficulties connected with this education. Moreover, the process of educating psychiatric residents is described from a supervisor's point of view. This complex process led to some major difficulties. In order to cope with the difficulties the supervisor employed a broad variety of means and techniques: an introductory course and a basic seminar about fundamental cornerstones of psychotherapy were offered.

Immigration is a process involving significant cultural and psychological changes and, in some cases, may even lead to psychopathological reactions (1). Several waves of immigration from the countries of the former Soviet Union brought to Israel more than 1,000,000 people. Though the immigrants came from different ethnic communities, the difficulties they face are the same. The problems are substantial and largely interrelated; they pertain to the integration into a new, unfamiliar culture, the acquisition of a new language, the creation of new relationships in new surroundings, the reorganization of relationships within the family structure, the struggle for social and professional recognition, the search for suitable employment and housing, and the attainment of an appropriate lifestyle, to name just a few (2–4).

Medicine was a preferred career choice among Soviet Jews. Since the last wave of immigration over 10,000 physicians immigrated to Israel from the FSU. The transition from the FSU to Israel was a highly stressful and complicated process (5, 6). During their absorption the physicians underwent the painful process of professional adjustment that was connected with differences in specific medical professions, and psychiatry was one of them. Soviet psychiatrists were educated differently, e.g., they were not trained in the psychodynamic approach to psychotherapy.

In order to better understand Soviet psychiatry and psychology we will describe and compare it with other traditions in Western Europe, Britain and North America. The essential nature of Soviet psychiatry and psychology cannot be understood without some basic knowledge of the Soviet system of medical education.

Medical Education: How it Was

The medical education system was built on the organizational principles of the USSR. Medical schools (medical institutes) were under the jurisdiction of

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the Ministry of Health and were separated from the universities (that were under the jurisdiction of the Ministry of Education). Soviet medical education could be divided into two stages: the first is general medical education, in medical institutes (six years + a year of a clinical specialization), and the second is postgraduate medical education (7).

In medical institutes there was a unique feature of Soviet medical education: student scientific societies under the tutorship of a professor in the form of a professional seminar. Each clinical specialty had a student scientific society, which provided students the beginning of their specialization. There, every student who was interested in a particular discipline had the opportunity for more in-depth work in a specialty (7). Psychiatry was taught for a month in the fifth year, with one-half of each day devoted to lectures and the other half to patients. The goal was for students to gain a theoretical understanding of mental illness and the ability to recognize psychiatric disorders and indications for psychotropic medications and psychotherapy in accordance with Soviet interpretation.

After graduation from the medical institute, young physicians had four options to continue their postgraduate education (independent of a specialty). A usual way for most physicians was practical work in an outpatient clinic or in a hospital with subsequent postgraduate courses (lasting from one to six months) in postgraduate training institutes. The second option was two years in a postgraduate institute for physicians with simultaneous clinical work in some specialty (*Ordinatura*). The third option was three years of education in a research institute — with clinical and scientific work with an obligatory PhD thesis (*Aspirantura*) at the end of that period, and the fourth option was work in a research institute as a clinician and as a scientist.

Postgraduate Education

There were 16 special postgraduate institutes for physicians in the USSR, with 14 chairs of psychiatry. For special branches of psychiatry postgraduate training was done in the Psychiatric Research Institute. The training of professionals in institutes for postgraduate training was implemented through training courses oriented in line with the level of professional skills of the trainees (courses for beginners, for psychiatrists with experience, and for professors). One of the forms of postgraduate training was visiting courses of the Central Institute for Advanced Medical Training (Moscow) to various regions of the country. Teaching was conducted according to detailed, elaborate programs (8).

In comparison to the West, postgraduate psychiatric training in the USSR was shorter and less rigorous with an emphasis on biological therapy. Soviet "psychotherapy" was more reality oriented and more authoritarian than in the West, stressing "collective" group therapy, consistent with the general emphasis on society and the need to help the individual be more effective in society (7). Psychological (psychotherapy) education included some postgraduate courses in hypnosis, auto-suggestion therapy, relaxation or auto-relaxation, "culture-therapy" (using art, music, etc.), occupational therapy, and psychodrama. Soviet psychotherapy was conducted in individual or group sessions (9).

Some History about Psychoanalysis in Russia and USSR

Psychoanalysis or psychodynamic therapy is not mentioned in this list of psychotherapies for quite clear reasons. Russian psychiatrists were among the earliest followers of both Freud and Jung and were natural enthusiasts for psychoanalysis. The first translation of any of Freud's works into a foreign language was the Russian edition of "The Interpretation of Dreams" in 1904. The majority of Russian psychiatrists began to use psychoanalysis among other methods of psychotherapy (10). The activity of Russian analysts could not remain unnoticed and in 1912 Freud wrote in a letter to Jung: "In Russia (Odessa) there seems to be a local epidemic of psychoanalysis" (11). Russian analysts were active in the spread of psychoanalysis in the first decades of the 20th century. At one point one-eighth of the entire membership of the International Psychoanalytic Association was Russian (10). One of the first Russian origin stalwarts of Freud was Max Eitington (1881–1943) — a psychoanalyst and one of Freud's closest friends. He was head of the Berlin Institute and president of the training committee of the International Psychoanalytic Association in 1926. After his immi-

gration to Palestine he established the Psychoanalytical Association (12, 13).

In 1921 under Trotsky's protection in Moscow others of Freud's Russian followers — Moshe Wulff (later emigrated to Palestine) and Ivan Dmitrievich Ermakov — founded the Russian Psychoanalytical Society (10). Freud's works were translated into Russian in a series called the "Psychoanalytic Library," edited by I.D. Ermakov. Among Russian psychoanalysts were also women such as Lou Andreas-Salome (1861–1937), Tatiana Rosenthal (1885–1921) and Sabina Spielrein (1885–1942). In 1923, Spielrein, encouraged by Sigmund Freud among others, returned to Russia, and joined the Russian Psychoanalytical Society. In 1942 she and her two daughters were executed by German soldiers together with many other Jews.

With time, in the Soviet Union, "psychotherapeutic individualism" came to be criticized for its supposed contradiction of collectivist ideology, and psychotherapy was transformed into "sanitary education in small collectives of neurotics" (14). If in the early 1920s psychoanalysts hoped that they could achieve a synthesis of Freudian thinking with Marxism, by the middle of the decade these attempts ceased and psychoanalytic thinking (with its focus on the individual rather than the collective) was deemed antagonistic to the totalitarian regime and was ultimately suppressed. Freudian theory was also rejected, according to the official view, because it exaggerated the role of sexuality, underestimated the social problems of the "working class," and had a non-materialist theoretical framework. Analysis was accused of "idealism" and "subjectivism" as opposed to materialism, realism and scientific socialism.

In 1925, the Moscow State Psychoanalytic Institute was abolished, the publication of its journal was stopped, and the Head of Institute, Ermakov, and some coworkers were arrested on political charges and they perished in the GULAG (15). The word "psychoanalysis" was banned and was deleted from psychiatric textbooks, and its positive mention could lead to arrest. During this time, despite being outlawed, the spirit of psychoanalysis somehow was kept alive underground. The literature was not obtainable. However, there were groups of individuals who quietly but illegally practiced and published psychoanalytic literature up to the advent of *perestroika* in the late 1980s (16), and only President Boris Yeltsin's Decree No.1044 in July 1996 reestablished psychoanalysis as a legitimate activity (17).

In different periods of Soviet history, along with psychoanalysis many other disciplines of Russian thought suffered a similar fate of suppression. (For example, industrial psychology was liquidated in 1931, pedology [intelligence testing] and genetics were abolished in 1936, and cybernetics was forbidden at the end of 1940s.)

There is the widest theoretical gap between Soviet and non-Soviet psychology in the area of emotions, feelings and affect. According to Soviet textbooks, consciousness is a reflection of external reality and neurosis is a product of bourgeois societal conditions (10, 18). Man was not only an object, but a subject, whose consciousness reflects reality and at the same time transforms it (9).

In spite of this fact, Soviet psychologists made a significant contribution to world science, and some became world-famous. For example, Pavlov's name and his works regarding the physiological foundation of emotions and feelings were widely appreciated and for research pertaining to the digestive system. I.P. Pavlov (1849–1936) was awarded the Nobel Prize in physiology (19). Social psychology was associated with the name of V.M. Bekhterev (1857–1927) and his theory regarding "collective reflexology" was presented in "General Principles of Human Reflexology" (20). L.S. Vygotsky (1896–1934) was a great psychologist, founder of the historical-cultural school, and his theoretical point of view was stated in "History of the Development of the Higher Psychological Functions." Neuropsychologist A.R. Luria (1902–1977) developed the "theory of brain functions" (19).

We (VL, KF) represent examples of new immigrants who arrived in Israel at a relatively young age, who had worked as specialists in the USSR and continued to work in Israel as psychiatrists. With our graduation from the Medical Institutes in 1970 through the 1980s we reached the peak of Soviet psychiatry. As many of our colleagues-psychiatrists, we had vague ideas regarding psychoanalysis and psychodynamic therapy. In the USSR there were some psychiatric "schools," such as the "Moscow school of psychiatry," that involved an elaboration of a unified hypothesis of psychopathology, mainly of

schizophrenia. This approach has been criticized by the "Leningrad school" in particular for overdiagnosing and misdiagnosing schizophrenia. A completely different approach was that of Georgian psychiatry (Tbilisi), with an enormous interest in the unconscious as a major factor in explaining psychiatric disorders. In 1979 the 1st International Conference on the Unconscious was held in Tbilisi and a large four-volume proceedings based on the papers presented there quickly became a bibliographic rarity. Naturally, those psychiatrists who graduated from various medical institutes and worked in different cities had dissimilar approaches to the diagnosis and treatment of mental disorders.

During our education in the Medical Institute and in the postgraduate institute, some teachers who tried to lay the foundation and to throw light upon Freudian theory used the cover of criticism of analysis as a means for its dissemination. Sometimes they helped to provide the necessary support and access to this knowledge, around the limits imposed. There were some students who took the hints and independently continued to study psychoanalytic literature. Moreover, some psychiatrists had Freud's works that were published in the beginning of the 20th Century that had been passed around or had been passed on from generation to generation as copies printed on a typewriter. Attempts to obtain his works in state libraries were met with difficulty since the works were sequestered in special rooms, where difficult-to-acquire authorization was needed in order to gain access to them. For example, my (VL) request to the State's Lenin Library (a first-rate library in the USSR) to borrow one of Freud's works entailed the question: "For what do you need this book?" and only a day later my request for a photocopy was approved with access only in the reading room.

Difficulties in Learning

One of the most important aspects of immigration is professional adjustment, in particular restoring one's professional position. A loss of professional status often results in distress reactions (5, 6).

In the light of the above, learning, or more precisely, re-learning of psychotherapy and especially psychodynamic psychotherapy after immigration to Israel was not a simple task. It concerned not only understanding of principles or terms of psychodynamic theory, but also of different life experiences than those of our West-origin colleagues. Psychological approaches to explanation of psychotic disorders was unusual for physicians from the USSR and were unacceptable for us (VL, KF). Biological trends were mainstream in psychiatry and this made psychiatry a science and not an art.

There was a lack of experience with talking therapy, especially the open-ended variety. Psychotherapeutic methods of treatment in Russia were directive, aimed at shaping behavior rather than focusing on the internal world, and were conditioned upon conventions that were allied with political ideology. This lack of familiarity with talking therapy led to expectations of an immediate cure, insistent requests for direction and concrete advice, impatience with the developing psychotherapeutic process, and perhaps most significantly, a lack of a sense on the former USSR patient's part that he or she was to be an active participant in the exploratory task.

Moreover, people in the USSR, more frequently than their counterparts in the West, express doubts about trust in the therapist, and concerns about confidentiality. Very often the patient was the only person not allowed to know the truth about his/her health. The government had a right of access to medical records and the existence of medical secrecy was an abstract concept. Many of us were familiar with or had heard from parents or well-known friends of parents that the loyalty of the practitioner could not always be relied upon to be on the side of the patient. It was a bad habit to talk with a stranger in the Soviet Union, as one could never be sure that the one you are talking with was not a KGB agent or a "supergrass." That's why we preferred to open our inner world only to close friends, in the kitchen.

This was a serious concern, since it led to an avoidance of issues of shame closely related to mistrust, to the problem of prejudice and the denial of opportunity. At the beginning of our time in Israel, it was difficult to discuss intimate relations or our feelings with a patient or with a supervisor, to understand and to accept psychodynamic aspects of mental and personality disorders. In addition to these difficulties there was another one — to yield the active role in psychotherapeutic treatment to the patient. In contrast to our expectations, the language

problem was not really a problem, because the new information regarding psychotherapy that we learned was in Hebrew and in English, and these terms and expressions we did not know in Russian. However, there was another problem, which was to be sensitive to the cultural differences and customs of the patients (21). Many of us could solve these problems and continue our way in psychiatry but others have left the profession.

In addition to problems with a psychotherapeutic approach, after immigration to Israel and starting to work as a resident in psychiatry, we found that the psychopharmacological approach to treatment was different. In the USSR medications for psychiatric patients were prescribed according to psychopathological symptoms (target-medicine) and in general it used combination therapy (two or more neuroleptics). In clinical discussions European terms and eponyms were used, including ICD classification modified accordingly to Soviet psychiatry, and we had never heard about the DSM classification.

Teacher and Supervisor's View

Over the last 12 years one of the authors (EW) served as a director of psychotherapy training for psychiatric residents in the Beersheba Mental Health Center (Israel). During that period more than 30 residents from the former Soviet Union were taught and supervised in preparation for the psychiatric board examination.

The process of education includes frontal lectures in courses, group and individual supervision, instructed reading and training for the examination.

This complex process has led to some major difficulties. Soviet psychiatrists function in the context of a collectivist society very different from the Western more individualistic society. They were responsive primarily to the collective ethos which forms such an important part of their patients' daily lives.

The "Homo Sovieticus" mentality (22) of immigrants from the FSU "induced being accustomed to collective activities": in addition "the Soviet citizen was conditioned from birth to conform to the system, and to obey the rules and the authorities and to have a sense of being constantly under surveillance" (23). Soviet citizens tend to be cautious and to have a passive conformist mode of thinking and predisposition, and to avoid challenging authority figures. A second area of problems emerged from the Russian scientific commitment to a materialistic approach to the world which was a long time Russian tradition, and served as fertile ground for dialectical materialism. An application of this concept to human sciences (like psychology and psychiatry) includes emphasizing organic-biological factors and ignoring intra-psychic and psychodynamic factors. Another problem area emerged from the emotional state of the residents in the process of their immigration to a new country. According to some publications during the first three years following immigration, the percentage of people suffering from a high demoralization level increased gradually from 8% to 33% (4). An additional difficulty that was revealed at the beginning of work as a therapist was the cultural gap between the new immigrant therapist and the client from Israeli culture.

In order to cope with the difficulties we employed a broad variety of means and techniques: an introductory course and a basic seminar about fundamental cornerstones of psychotherapy were offered. Personal supervision was provided emphasizing the intra-psychic aspect, as well as group supervision with a psychodynamic orientation and with case presentations by the participant residents. Our policy was to encourage the residents to express their opinions without fear of criticism. Concerning the cultural gap, we made efforts to acquaint them with Israeli culture through lectures, reading Israeli literature, and by visiting Israeli theater and cinema which present Israeli cultural patterns. By deepening the process of social acculturation we assisted them both in their personal assimilation into Israeli society and professionally in their becoming culturely sensitive therapists.

The combination of these means applied over several years led the resident to internalize the basic terms in dynamic psychotherapy, and to use them in a proper way. Residents succeeded in writing psychotherapeutic case reports, in presenting them orally and finally in the increasing rate of success in psychotherapy board examinations.

Concluding Remarks

Immigration is a complex process that brings chal-

lenges on a personal and professional level. Cultural assimilation requires the integration of previous knowledge. Integration necessitates the recognition, understanding and acceptance of the new society with all its differences. The personal and professional experience of immigration is an interconnected process that can interfere one with the other or provide the opportunity to develop new skills and professional assimilation. The latter is impossible without changing one's viewpoint from an "only biological" approach to a psychodynamic one too. This aspect is very important not only from a theoretical point of view, but also in everyday clinical work.

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