Psychotherapy and Psychoanalysts in Psychiatric Residency Training

NORMAN A. CLEMENS, MD
MALKAH T. NOTMAN, MD

There is a renewed interest in teaching psychotherapy in psychiatry training programs in the context of the current accreditation standards for developing competency in psychotherapy. However, meeting the standards requires adequate faculty, expertise, motivation, and patient population to support a substantive didactic and experiential base for residents to develop phase-appropriate competence. Psychoanalysts are in a position to provide capable instruction and supervision in psychodynamic as well as supportive psychotherapy, but they are not evenly distributed in the United States. The psychoanalyst authors investigated the experience of psychiatry residency training programs in eastern Massachusetts and northeast Ohio with regard to their current practice in psychotherapy training in general and psychodynamic psychotherapy in particular. They asked about the time given to formal teaching, therapy experience and supervision, the composition of the faculty, and the presence of psychoanalysts as teachers or supervisors. Personal interviews to clarify aims, attitudes, and needs supplemented responses to the questionnaire. This article describes these findings and the opportunities and challenges that are evident in the current environment of psychiatric training. We found that most programs made substantial efforts to teach psychodynamic and cognitive-behavioral therapies, but that supportive therapy received less focused attention. The involvement of psychoanalysts in teaching was generally welcomed in this sample, but was dependent on their availability in the community. (*Journal of Psychiatric Practice* **2012;18:438–443**)

KEY WORDS: psychotherapy, training, residency, psychodynamic psychotherapy, cognitive-behavioral therapy, supportive psychotherapy

The vital role of psychotherapy among best practices in psychiatry has been reaffirmed in the current standards of the Accreditation Council for Graduate Medical Education (ACGME)[1] for competencies that psychiatric residents must demonstrate in the course of their training. This has posed a challenge to residency programs to build the faculty expertise to provide this training. As representatives of the American College of Psychoanalysts, an organization of psychiatric psychoanalysts, the authors investigated the way in which 11 psychiatric residency programs are approaching this challenge, particularly with regard to teaching psychodynamic psychotherapy. Seven programs were in eastern Massachusetts, and 4 were in northern Ohio. The results were presented during a Presidential Symposium on Teaching Psychodynamic Psychiatry in an Era of Neuroscience, co-sponsored by the American College of Psychoanalysts, on May 14, 2011, at the Annual Meeting of the American Psychiatric Association in Honolulu, Hawaii.[2]

In a recently published article, Sudak and Goldberg reported a similar but much larger survey concerning psychotherapy training in psychiatric residencies.[3] They surveyed U.S. general psychiatry training directors concerning the amount of didactic training, supervised clinical experience, and numbers of patients treated in the three models of psychotherapy mandated for competency by the ACGME: psychodynamic, cognitive-behavioral, and supportive. They found "a wide range of experiences in psychotherapy education." Psychodynamic training was found to be "the most robust," but had the "greatest variability." Comparison with a previous study of training in cognitive-behavioral therapy (CBT) showed that training in this area had "advanced significantly over the past decade." Finally, Sudak and Golderg reported that residents

Norman A. Clemens, MD, is Emeritus Clinical Professor of Psychiatry in Case Western Reserve University and a Training and Supervising Analyst in the Cleveland Psychoanalytic Center. Malkah Tolpin Notman, MD, is Professor of Psychiatry in Harvard Medical School and a training and supervising analyst in the Boston Psychoanalytic Society and Institute. Both are members of the Board of Regents of the American College of Psychoanalysts.

DOI: 10.1097/01.pra.0000422742.72247.6c

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

provided significantly more hours of supportive psychotherapy than other types of therapy but received "the least amount of didactic time and supervision" in this area.

Method

Descriptive and numerical data about 11 programs were gathered electronically by means of a Survey Monkey survey in 2011. One additional program in northern Ohio did not respond to repeated requests. The authors inquired about the aims of the residency training directors with regard to psychotherapy. Numerical data included the number of hours during the entire 4-year span of the residency devoted to formal instruction, supervision, and patient care, along with the number of patients seen in psychotherapy of the three types specified by the 2007 ACGME standards: psychodynamic, cognitive-behavioral, and supportive. The survey also collected data on the number of faculty and the professional backgrounds of the teachers, as well as the involvement of psychoanalysts in the programs.

The investigators followed up with in-person or telephone interviews to verify and clarify the survey data and to explore in greater depth how the residency training directors approached the task of providing psychotherapy training. Based on an assessment of the limitations of the numerical data, we gathered qualitative information that highlighted more subtle aspects of the challenges residency training programs face and the ways in which they and their faculties respond to them.

Finally, we compared our survey results with those reported by Sudak and Goldberg.[3]

Results

We found that numerical responses could only provide crude estimates because the training experiences are scattered over a wide range of settings and activities. The experiences of individual residents vary widely and are not always meticulously documented or available to training directors, so that generalizations could only represent a presumed average. No quantification of informal clinical teaching outside of formal instruction or supervision was available. Differentiation of the three psychotherapy modalities was not clinically clear-cut, especially with regard to supportive therapy, which may be a basic element in the other two modalities.[4] Training directors had to arbitrarily categorize the kinds of psychotherapy offered in order to provide numbers, even when insufficient clinical data were available at their administrative level to make a clear distinction. The data also varied widely from program to program, reflecting differences in case loads and record-keeping, as well as in attitudes towards psychotherapy. Thus the numerical results presented here must be taken as only very broad indications of what actually happens in these programs.

All of the programs we surveyed teach psychotherapy (unspecified), with the stated aim of achieving a phase-appropriate level of competence in providing this treatment modality. All except one program teach psychodynamic psychotherapy with the aim of achieving a phase-appropriate level of competence in that area.

With regard to psychodynamic psychotherapy, formal education (lectures, seminars, case conferences) was offered for an average of 105 hours (range 2–200 hours) over the 4-year span of a resident's training. An average of 133 hours of supervision was offered (range 2–200 hours). An average of 234 hours of therapy was provided to patients (range 8–500 hours). The number of patients seen for more than initial evaluations averaged 62 (range 2–500 patients). The length of psychodynamic therapy sessions was consistently 45–60 minutes. Nine programs provided psychodynamic therapy in weekly sessions, and 2 offered it at intervals of 2–4 weeks (which may be supportive but of questionable value for effective psychodynamic work). The outliers at both ends of these large ranges reflect the difficulty the directors may have in actually quantifying what goes on in their programs, but the low-end figures are consistent with a single training program's admitted lack of intent to train residents to competence in psychodynamic therapy. With regard to CBT, the training directors reported an average of 45 hours of formal education over the 4 residency years, with 59 hours of supervision for 32 patients. With regard to supportive therapy, they reported averages of 20 hours of formal education, 62 hours of supervision, and 153 patients seen. Again, wide ranges were reported.

Categorizing our raw numerical data in the same way as Sudak and Goldberg,[3] we found that our results were consistent with theirs in demonstrating "a wide range of experiences in psychotherapy education," with a number of similarities in the pattern of

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

Table 1. Comparison with findings of Sudak and Goldberg[3]

Hours	CBT		Psychodynamic		Supportive	
	This study[a]	*Sudak*[b]	*This study*[a]	*Sudak*[b]	*This study*[a]	*Sudak*[b]
Didactic	*N* = 11	*N* = 76	*N* = 11	*N* = 74	*N* = 11	*N* = 75
< 30	36.4%	67.1%	9.1%	29.7%	81.8%	85.3%
30–69	45.5%	32.9%	18.2%	46.0%[c]	18.2%	14.7%
⩾ 70	18.2%	1.3%	72.7%	24.3%	0%	1.3%
Supervision	*N* = 11	*N* = 77	*N* = 11	*N* = 75	*N* = 11	*N* = 73
0	9.1%	6.5%	0%	1.3%	9.1%	11.0%
< 30 (including 0)	36.4%	53.2%	18.2%	26.7%	36.4%	49.3%
30–69	36.4%	39.0%	9.1%	34.7%	36.4%	32.9%
⩾ 70	27.3%	7.8%	72.7%	38.7%	27.3%	17.8%

[a] *Data gathered in 2011*
[b] *Data gathered in 2010*
[c] *Corrected from erratum in published paper with permission of the author*

results (Table 1). Differences in the results of the two surveys could be attributed to our relatively small sample and possible variation in data collection by the training directors, as well as the possibility that eastern Massachusetts and, to a lesser extent, northern Ohio have a degree of psychoanalytic presence that is greater than in the rest of the country.

We also examined which disciplines taught the various forms of psychotherapy. Psychiatrists taught or supervised psychodynamic psychotherapy and supportive psychotherapy in all 11 programs, and CBT in 8 programs. Psychologists provided instruction in psychodynamic psychotherapy in 8 programs, in CBT in 10 programs, and in supportive therapy in 6 programs. Social workers taught psychodynamic therapy in 5 programs, CBT in 1 program, and supportive therapy in 5 programs. Teachers from nursing, counseling, and other disciplines provided training in psychotherapy (specific type not specified) in 3 programs.

Psychoanalysts taught and/or supervised in 9 programs, some of them quite extensively as part of the full- or part-time staff. The training directors in the 2 programs that lacked psychoanalyst involvement were asked whether such involvement would have been welcome. One said psychoanalysts would be welcome in augmenting the didactic curriculum. The other said that the attitude of the psychiatric department would not be receptive to psychoanalyst participation.

Psychoanalyst engagement in residency training is directly related to the size of the psychoanalytic community in which the training program is located. Eastern Massachusetts has three psychoanalytic institutes, two of which are approved institutes of the American Psychoanalytic Association and one of which is independent. There are approximately 300 trained psychoanalysts in the region. By contrast, northern Ohio has one approved institute in Cleveland and approximately 50 trained analysts. It is not surprising, then, that psychoanalysts teach in every psychiatric residency program in eastern Massachusetts but only 2 of the 4 programs surveyed in northern Ohio. Northern Ohio's experience is probably more typical of most of the United States. However, three of the training directors in Ohio had served on the board of trustees of the Cleveland Psychoanalytic Center.

Training directors were asked about their needs in designing psychotherapy training for their residents. They indicated a need for access to more patients who are suitable for treatment with psychotherapy as well as more money to pay teachers and supervisors; currently, most psychoanalysts teach in residencies on a volunteer basis under a part-time staff appointment. Most programs insist that psychoanalytic supervision be done on the training site, not in the analyst's private office, which may be a limiting factor in the availability of psychoanalysts because of

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

the travel time that the supervisor would have to take away from practice. One training director also expressed the need for more cognitive-behavioral supervisors.

We posed the following question: "What does your program see as the role of psychodynamic understanding of individuals in deciding which treatment would be appropriate for a given patient?" Most training directors felt that this was important, but some identified attitudinal and manpower factors that limit the extent to which this can be taught. One sample response was "They have to let go of DSM[5] and look beyond it to the person and the suffering… and the relationships." The training director of the program with the least formal training in psychotherapy stated a major goal of educating residents on "how to administer medicine in the most psychotherapeutic manner possible. The frame isn't the same, but psychotherapy experience is essential to managing medication." He implied that a significant amount of psychotherapy training in that program was integrated with teaching overall clinical management.

Many training directors discussed conflicting perspectives and attitudes that seem to pit "medicine" against psychotherapy, which can be summarized as follows. A one-sided "DSM" approach to diagnosis can turn residents away from getting to know the patient as a person. Seeking rapid symptom relief with medication can distract residents from exploring deeply troubling psychic difficulties. This is compounded by a mind-brain dualism that focuses exclusively on the complex processes of the brain and ignores the person. Patients themselves may defensively try to reduce all their problems to a "chemical imbalance" and demand "medicine" rather than "talk." In addition, the bias of managed care against all but the shortest-term psychotherapy under third-party payment and high productivity demands that greatly impede residents developing in-depth treatment relationships may form major barriers to offering best practices. Residents themselves may be very anxious about meaningful engagement with patients. Throughout the survey, the attitudes of department leaders appeared to have a profound impact on residents: if the leaders were overtly or subtly disparaging toward psychotherapy, they seriously undermined efforts to help the residents develop psychotherapy awareness and skills.

We observed that the training environment is burdened by the pressure of limited time and competing responsibilities. There are many subject areas to cover, all with burgeoning new knowledge to impart. Heavy service demands in both public and private settings tend to push towards "med checks," computer check-lists that detract from eye contact with the patient, and the "10-minute visit," with any talking at all being devoted to superficial "psychoeducation." Some programs have multiple short rotations in geographically distant locations requiring much nonproductive travel time from the residents. In addition, legally required time off, such as post-call days, often causes residents to miss seminars or supervision visits.

The economic environment is also not conducive to promoting resident interest in psychotherapy. Pressure from insurance companies to shorten hospital stays and minimize outpatient visits makes it very difficult for residents to invest in understanding patients. The residents are also aware that low insurance payments for psychotherapy will make it more lucrative to conduct a high-volume, "med-check" practice after graduation. This is likely to have a significant impact on residents with high educational debts, who may be reluctant to take the initial risk of entering private practice and instead will seek salaried positions that emphasize higher volume and more visits per hour.

The training directors were asked what they saw as the mission of the residency—whether it was 1) to prepare the resident to function in the prevailing practice environment as third party payers and service needs mold it or 2) to be competent in all the dimensions of psychiatry and what it can offer for patients. They struggle conscientiously with the dilemma of these conflicting realistic pressures, addressing the first of the two while not losing sight of the second. One director was particularly articulate in saying unequivocally, "We have to convey the perspective and skills of psychotherapy. Otherwise they will be dangerous. I don't want to send people out there who don't know any better and think that is psychiatry… They need to see the flaws in that practice model."

Discussion

This study was necessarily impressionistic, with many limitations that were described above.

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

Objectivity is also an issue, as the residency training directors have a vested interest in the reputation of their programs and in being seen as meeting ACGME standards—and the investigators are known to represent a psychoanalytic organization and have a vested interest in the quality of training in psychodynamic psychotherapy.

Nonetheless, some conclusions can be drawn. The authors are grateful to the residency training directors who took the time to collect data and respond to the questionnaire and to engage in more in-depth discussion about their thinking and challenges. For the most part, the training directors seemed deeply committed to providing a meaningful experience in psychotherapy for their residents that went beyond just meeting the requirements of the ACGME. The contrast between the eastern Massachusetts and some of the northern Ohio experiences demonstrates the importance of engaging the psychoanalytic community in providing psychodynamic training. However, one program in Ohio that does not involve analysts nonetheless appeared to provide quality training through the work of psychodynamically trained psychiatrists and psychologists who are not analysts, who also contribute significantly in most programs.

What seems to work well for teaching psychodynamic psychotherapy? In the same symposium at which this study was presented, Gabbard outlined very cogent recommendations for such training.[6] Many of our own views of optimal conditions, outlined below, are consistent with Gabbard's recommendations, although they are presented differently:

- Psychoanalysts and dynamically skilled psychiatrists, whether full time or part time, are present and engaged as role models.
- The residency training director places a high priority on psychotherapy and understanding patients as people.
- We agree with Gabbard's recommendations to have "one person responsible for coordinating the psychotherapy training." Two programs that we surveyed have established the position of a Director of Psychotherapy Training, which appears to be a major advantage.[7] A description of one of these innovative programs was also presented at the 2011 APA Presidential Symposium.[8]
- The formal curriculum goes beyond presenting basic concepts and is current with contemporary psychoanalytic theory and technique. It is lively and interactive and includes an evidence base for efficacy, cost-effectiveness, and neurobiological correlates of psychotherapy. Above all, instruction must be clinically relevant with case material or live interviews as a base, rather than theory-driven.
- Psychodynamic teaching does not disparage other therapies; rather it looks at the commonalities and interaction between the approaches. Psychotherapeutic principles are operative in "med checks" as in all psychiatric care.
- The residents have clinical experience conducting therapy with one-to-one supervision, perhaps augmented by observing others conduct interviews, live or recorded.
- From the psychodynamic perspective there must be long-term therapy with patients once or twice a week.

Most of the focus on psychotherapy appears to occur in the PGY 3 year, which in many programs is devoted to outpatient experiences. Attentive supervision in all modalities is characteristic, although more attention needs to be paid to recognizing the supportive elements of all psychotherapies and distinguishing the specific techniques of psychodynamic therapy and CBT from the basics of support. PGY 4 is often devoted to electives and sub-specialty exposures, with some continued long-term work with patients. There can be an elective psychotherapy concentration. This is a good time, now that the residents have an experience base, for residents to have advanced seminars that discuss their internal experience of being a therapist. While therapy for the resident was not addressed in this study, the authors recommend released time and funding for residents to have personal psychoanalysis or intensive psychotherapy.

While our study focused primarily on formal psychotherapy instruction and experience that usually occurs in the later part of the residency, the authors believe that psychotherapy training should begin at the start of residency and be integrated with other modalities in a model of care that addresses mind and brain as a unity. Some training directors also express and/or implement this view. Psychiatrists and other professionals teaching in PGY 1 and 2 have much to convey about the psychiatrist-patient relationship, awareness of the patient's emotional and subjective life, the therapeutic alliance, transference and countertransference, the psychological issues in hospitalization and medication manage-

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.

ment, and the ethics of patient care. Diagnostic interviewing and treatment planning at any level are inadequate if they fail to include a psychodynamic understanding of the individual. This is all the more important because the residents tend to start off treating patients with the most severe mental illnesses, in which attention to intrapsychic processes and the doctor-patient relationship is crucial. Optimally, they can spend a few hours a week providing long-term care to some of the patients they have discharged from the hospital, which is important in learning the natural history of illness as well as the role of psychological issues.

Educating faculty is also important, particularly to bring them up to date on empirical studies concerning the effectiveness[9–11] and cost-effectiveness[12] of psychotherapy and neurobiological correlations, as well as new methods of teaching and supervision. Where psychoanalysts are available, greater engagement in the curriculum and supervision may be attainable by partnering with psychoanalytic institutes, making flexible arrangements for psychoanalyst supervisors to optimize their use of time away from their patients, and offering reasonable payment for time contributed over and above basic faculty obligations.

Conclusion

In this study, we found that most programs were making substantial efforts to teach psychodynamic and cognitive-behavioral therapies, while supportive therapy received less focused attention. The involvement of psychoanalysts in teaching was generally welcomed in this sample but was dependent on their availability in the community.

References

1. Accreditation Council for Graduate Medical Education. Program requirements for graduate medical education in psychiatry, 2007 (available at www.acgme.org, accessed October 7, 2012).
2. Moran M. Psychodynamic psychotherapy training: What it needs to survive. Psychiatric News July 15, 2011, Vol. 46, No. 14 (available at psychnews.psychiatryonline.org/newsArticle .aspx?articleid=115856, accessed October 7, 2012).
3. Sudak DM, Goldberg D. Trends in psychotherapy training: A national survey of psychiatry residency training. Acad Psychiatry 2012;36:369–73.
4. Plakun EM, Sudak DM, Goldberg D. The Y model: An integrated, evidence-based approach to teaching psychotherapy competencies. J Psychiatr Pract 2009;15:5–11.
5. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, edition unspecified.
6. What works and what doesn't in teaching psychotherapy to residents. Psychiatric News July 15, 2011, Vol 46, No.14 (available at psychnews.psychiatryonline.org/newsArticle .aspx?articleid=115855, accessed October 7, 2012).
7. Ferri M, Stovall J, Bartek A, et al. The chief resident for psychotherapy: A novel teaching role for senior residents. Acad Psychiatry 2010;34:302–4.
8. Moran M. Chief resident for psychotherapy tries to allay anxiety. Psychiatric News July 15, 2011, Vol. 46, No. 14 (available at psychnews.psychiatryonline.org/newsArticle .aspx?articleid=115854, accessed October 7, 2012).
9. Leichsenring F, Rabung S. Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. JAMA 2008;300:1551–65.
10. Leichsenring F, Rabung S. Long-term psychodynamic psychotherapy in complex mental disorders: Update of a meta-analysis. Br J Psychiatry 2011;199:15–22.
11. Roth A, Fonagy P. What works for whom? A critical review of psychotherapy research. New York and London: Guilford; 2005.
12. Lazar S, ed., for the Committee on Psychotherapy of the Group for the Advancement of Psychiatry. Psychotherapy is worth it: A comprehensive review of its cost-effectiveness. Washington, DC: American Psychiatric Publishing; 2010.

Copyright © Lippincott Williams & Wilkins. Unauthorized reproduction of this article is prohibited.