Some years ago, during a workshop that focused on the integration of psychotherapeutic and psychopharmacologic treatment, a young woman patient was presented who had problems with both severe manic-depressive illness and borderline personality disorder. She was extremely sensitive to medications, but even during times of stability of her manic-depressive illness, management was difficult. Following a presentation of a videotaped psychotherapy hour of a resident and the patient, a residency director in the audience raised his hand and said, “I don’t know why you showed this videotape. This woman has manic-depressive illness and needs medication, and that’s that.” Although this may seem a caricature of the emphasis on biological psychiatry in the last several decades, the question was asked by an experienced residency director who had been in his position for many years. Too many clinicians believe that good psychopharmacology practice requires only knowledge of dosages, side effects, drug interactions, and indications for the medication. To me, however, the essence of good psychopharmacologic management is how one responds when a patient comes into the office and says, “Dr. Tasman, you know that medication you prescribed. Well, I’m not going to take it any more.” Dealing with issues of resistance and treatment compliance, even in a busy medication clinic, an emergency room, or an inpatient unit, requires psychotherapeutic skill and knowledge.

THE PRESENT NEED

The economic forces transforming the clinical practice of psychiatry over the past several decades have seriously affected academic medical centers as well.\(^1\) Shifts in delivery systems, decreases in public funds available to support academic medical centers, and a disproportionately severe effect within psychiatry of the wave of managed care have all put increasing pressure on psychiatry faculty to generate funds necessary to support their positions. This has meant less time available for teaching, even from committed clinician educators. Further, the explosion in neuroscience research and available grant funds to support such work have led to an emphasis on faculty who have the potential for garnering research funds and a relative deemphasis on those who rely primarily on clinical service to provide salary support. These forces led to a mass exodus of psychoanalysts from departments of psychiatry in the 1970s and the 1980s. Feeling devalued and underappreciated, psychoanalysts reacted with anger and hurt, leading to a situation in which many departments of psychiatry today have little access to those psychiatrists most expert in teaching psychodynamic principles and techniques. Further, the explosion in the knowledge base in psychiatry in the last several decades has led to intense competition for curriculum time, producing a situation in which there is decreasing curriculum and supervisory time devoted to psychotherapy training at the same time that there are few faculty available to teach it. Moreover, the competition for what psychotherapy training time is available is
now intensified with the growth of newer and more research-tested psychotherapy techniques such as cognitive-behavioral and interpersonal psychotherapy.

Even with delivery system changes, the clinical vignette at the start of this paper illustrates that it is still essential for psychiatrists to have the knowledge and skills base necessary for psychological understanding and intervention. This is true even when the primary treatment modality is psychopharmacologic. These needs are present not only in the outpatient clinic, where research is beginning to show the superiority of combined medication and psychotherapy treatment (especially in seriously ill patients), but in every clinical setting.

Twenty-five years ago it was still not uncommon for psychoanalysts to be directors of every clinical service and of both medical student and residency education programs. There was no question, in that environment, that residents would be exposed to a psychodynamic way of understanding no matter what patient they were seeing or in what setting. However, at present, teaching the knowledge and skills necessary to conduct psychodynamic psychotherapy occupies little curriculum time. Further, few data exist regarding adequacy of psychotherapy training, which is necessary to plan appropriate training experiences. It is known, however, that residents feel increasingly unskilled when it comes to psychoanalytic psychotherapy. In discussions with residents around the country, the one issue heard more than any other is a wish for a more adequate psychodynamic psychotherapy training program.

Most residency programs at present still claim to focus most of their psychotherapy training on a psychodynamic model of understanding and intervention, although this focus has significantly decreased in medical student education. However, what is defined as psychodynamic psychotherapy differs widely. A study conducted 12 years ago revealed that approximately 80 percent of residency programs reported that psychodynamic psychotherapy was the primary model of psychotherapy training used; however, there was very little experience offered in treating patients for any length of time. The total percentage of cases that were carried for longer than a year was less than 10 percent in that study. Is this adequate or not? We have insufficient data on which to base a conclusion. Further, with the growth of cognitive-behavioral therapy and interpersonal psychotherapy (IPT) in the last decade, it is clear that a repeat survey would no longer reveal the same emphasis on psychodynamic psychotherapy.

The issue of psychotherapy training, though, also raises other questions. Many would argue that benefits well beyond learning the specifics of psychotherapeutic treatment come from learning about psychodynamic concepts and psychodynamic psychotherapy.

**THE BENEFITS**

A paper published in the *American Journal of Psychiatry* in 1990 argued that there were at least 10 major reasons for continuing to teach psychodynamic psychotherapy. Three of these related directly to the acquisition of skills necessary to deliver psychodynamic psychotherapy to patients, but seven others were related to the acquisition of skills, knowledge, and experiences important to other aspects of psychiatric and medical practice.

The 1990 publication described these seven issues:

1. **The concepts of psychodynamic psychotherapy are intimately related to the psychological and social concepts of all doctor-patient relationships.** The psychotherapeutically competent psychiatrist should be able to provide more effective consultation to medical colleagues and be able to manage his or her own non-psychotherapy doctor-patient relationships more effectively.

2. **Psychotherapy training also provides the resident with experiences that enhance learning about and management of other dyadic relationships within psychiatry, such as in supervision, consultation, and mental health administration.**

3. **Psychotherapy training enhances basic interviewing expertise by providing the resident with an opportunity to observe longitudinally the course of psychopathological and normal mental phenomena present in an initial interview.** This experience makes it possible for the resident to recognize emerging mental phenomena earlier, more accurately, and more confidently.

4. **Psychotherapy training provides the resident with an in-depth and longitudinal view of both conscious and unconscious mental functioning, which may be normal or pathological and which are related to the effort to change thinking, feeling, and behavior.** Such an effort requires an ongoing relationship between therapist and patient and involves the inevitable obstacles, resistances, strengths, and opportunities related to such an effort. Understanding these phenomena is essential to treatment planning and management of virtually all psychiatric disorders.
5. Psychotherapy allows the observation of complex pathological and normal mental functioning over time. In so doing, it complements the observation of similar mechanisms in inpatient, consultation, and emergency room settings. Furthermore, it provides access to the primary materials that form a basis of general psychodynamic theory. As such, psychotherapy training enhances the learning of psychodynamics as a basic science within psychiatry.

6. Many ethical difficulties result from psychiatrists’ problems in managing their feelings and reactions to patients. With its emphasis on the complex dyadic emotional interplay between psychiatrist and patient, psychodynamic psychotherapy training enhances psychiatrists’ ability to anticipate, analyze, and avoid ethical dilemmas and transgressions.

7. Finally, practicing psychotherapy forces the psychiatrist-in-training to observe, analyze, and attempt to understand an extremely complex interactive phenomenon. This enforces intellectual rigor and discipline in observing behavior, developing hypotheses, and analyzing theories and data.

Even if we are uncertain about the role that conducting psychotherapy will play in psychiatrists’ activities in the future, the above issue highlights the importance of psychodynamically informed residency education. There is little evidence that all this other learning that occurs during psychotherapy training can as easily be learned in other ways, especially in undergraduate medical student education.

Many fear that we are in danger of training a generation of psychiatrists and physicians who lack basic psychotherapeutic skills or a framework for understanding mental functioning from a psychodynamic perspective. With the neuroscience knowledge explosion continuing, and with the financial pressures on academic departments of psychiatry unlikely to diminish, there is little likelihood of a major influx of full-time psychoanalysts into academic departments of psychiatry any time in the near future. However, this state of affairs intersects with pressures from residents for more psychotherapy training and with the medical education emphasis on primary care training, especially psychoanalytic or psychodynamic psychotherapy training. This conjunction of limited faculty resources with new pressures for training provides an opportunity unparalleled in recent years for psychoanalysts, and others able to teach psychodynamic knowledge and practice, to reengage in psychiatry teaching programs from the first-year medical student level on up.

Even in the heyday of academic psychoanalysis, much of the teaching and clinical supervision provided to residents was made available by volunteer faculty in private practice. The severe financial pressures under which most analysts practice today are well known, but it is clear that this is a time that there must be a recommitment to reengagement in psychiatry residency training lest the entire body of psychoanalytic knowledge and skills be lost to the discipline of psychiatry. Historically, analysts provided clinical supervision of outpatient work, often in their own offices. At present, though, there are opportunities to teach within the academic medical center on any clinical service and at every level. This is especially true with the rise of preclinical introduction to clinical medicine courses, which are often co-coordinated by psychiatry and which have a major emphasis on teaching students about the doctor-patient relationship. Even an hour or two a week spent making rounds on a consultation service, an inpatient unit, or working in an emergency department supervising residents or teaching students can help provide early imprinting of a psychodynamic way of thinking in younger psychiatric colleagues. It is well known from educational research that early imprinting of frameworks for making sense of information often has the most dramatic effect on the way data are perceived, interpreted, and integrated over time.

Thus, it is important that psychoanalysts move beyond reactions to the perceived rejection by academic psychiatry over the last several decades and offer to reengage even at the earliest levels of training. Interestingly, the same financial pressures that drove analysts out of academia now make department chairs receptive to and welcoming of offers to teach or supervise from volunteer faculty in nearly every clinical setting. To ensure that the psychiatrists of the future have the requisite psychodynamic knowledge and skills base, psychoanalysts must take advantage of the unparalleled set of opportunities available within psychiatry teaching programs.

REFERENCES