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FEATURE: PERSPECTIVE

From Doctor to Therapist

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There has been much debate historically about the role of psychiatry in medicine (for a review, see [1]). But, no less fascinating is the debate often observed within our residency program as to the role of the medical oriented psychiatrist versus the psychiatric psychotherapist. Although the leading founder and many influential thinkers of psychology were doctors and although many residents will identify themselves as psychotherapists [2], it is often a challenge for a resident to integrate the role of being a doctor with the roles and practices of becoming a psychotherapist. While much has been written about interdisciplinary conflicts between psychologists and psychiatrists (e.g., [3–5]), there is not as much emphasis on the intrapersonal tension of the psychiatrist taking his or her first steps from doctor to therapist.

For many residents, the third year of residency is the first time where the majority of their practice is comprised of an outpatient caseload where they follow up patients longitudinally, not only for medication management, but also for therapy services. It is during this year that both residents and their supervisors note a fascinating transition. They move from psychiatric doctors, to psychiatric psychotherapist. As one resident stated: "the first 2 years of residency I learned how to be a doctor. The last 2 years of residency I learned how to become a psychotherapist." At the beginning of this journey, we see some common difficulties that the residents face as they try on both "hats"—of psychiatric doctor and psychiatric psychotherapist.

Diagnosis Versus Formulation

Psychiatric diagnoses, like all other medical diagnoses, are based on symptoms and understanding the natural course of a psychiatric illness. In this model, symptoms lead to a diagnosis which is best understood with a biomedical explanation which most often results in medication trials as the core treatment. Usually, within several sessions, it is fairly feasible to monitor symptoms and whether the medication and/or particular dose is helping to reduce symptoms (of anxiety/depression/psychosis, etc.) or not, and at what cost (i.e., possible side effects). If a medication trial fails, the doctor may revisit the symptoms and diagnosis. This is largely a linear process which enables most psychiatrists, for most diagnoses and many symptoms, to derive a list of qualifying medications.

Residents quickly learn that many symptoms and some major psychiatric diagnoses do not always have a known biomedical cause and they are now faced with developing and utilizing a psycho-social-cultural formulation to explain the symptoms or diagnosis of their patients from which they can develop a psychological treatment plan. Developing the psychological understanding that explains symptoms and diagnosis and informs treatment is clearly the most challenging part for many residents, and it is this process that becomes the bridge that enables the transition from thinking as a psychiatric doctor to developing as a psychiatric psychotherapist.

When thinking of a patient intrapsychically, the underlying reasons that lead someone to a certain diagnosis become just as important as the diagnosis itself (if not more). Essentially, in order to know how to treat a patient psychotherapeutically, a biomedical diagnosis is not enough. We also need a psycho-social-cultural formulation. A biomedical diagnosis is like a funnel—the doctor attempts to extract a categorical biomedical diagnosis from the various symptoms. However, a psycho-social-cultural formulation can expand and often requires more than one way of thinking about a patient. Aveline [6] notes that in the assessment of psychiatric disorders, two objectives are in opposition. On the one hand, the complexity of the disorder needs to be reduced to simple, significant terms, and on the other, the rich uniqueness of that person's

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problems must not be lost. The first objective is met by biomedical diagnosis, commonly of the single-label categorical variety often exemplified by the DSM-5. Psychological formulation is tailor made for the second.

For residents coming from a biomedical model, learning how to formulate in terms of underlying psychodynamics rather than observable symptoms takes time. According to McWilliams "this shift from getting a general sense of a person to conceptualizing that individual's central dynamics is not always easily made. Case formulation goes way beyond nosology… Formulating a case is a subjective, speculative, individualized, and comprehensive process…One needs to tolerate some disorganization and ambiguity in the process of letting the patient's psychology make an impact on one's own" [7]. Hunt [8] notes that psychologists rarely discriminate between means and ends; therefore, psychology does not label certain behaviors as good or bad, whereas in medicine, there are clearly defined ends—the health of the patient—and a number of well-defined means for achieving them. Thus, in the biomedical model, a diagnosis is derived from the signs or symptoms. In a psychodynamic model, symptoms are derived from an underlying dynamic which can be, depending on the theory, a compromise formation of an unconscious conflict, developmental deficits, dissociation between different parts of the self, etc.

Given these contrasts, we see how difficult it is to make a shift from learning an objective, observable, organized biomedical model of diagnosing, to one that is more subjective, addresses the implicit and unconscious, and requires the doctor/therapist to sit in ambiguity for a while, while adjusting and fine-tuning a formulation. It also requires a shift in the state of mind of paying attention to the content (i.e., symptom report) to paying attention to the process—what is the patient saying between the lines, non-verbally; what is the patient's underlying motivation; and what drama is played in the patient's inner dynamics as well as socio-cultural elements.

Biomedical Treatment Versus Psychological Treatment

Doctors have a great sense of agency, of being able to do something when things go wrong (medically). It is often difficult for residents immersed in a doing and fixing culture to sit back and listen which initially makes many residents feel useless or helpless (i.e., if they can't follow a linear or algorithmic trajectory of prescribing, offering more tests, or doing surgery). Beginning residents often feel as if they need more tools when they can't do much to change a person's suffering. On the other hand, when doing psychotherapy, many interventions are not aimed at creating an immediate observable improvement or change. Sometimes in therapy, the patient needs to regress a few steps backwards to be able to continue forward. Sometimes, an emotionally painful intervention during a session is needed to allow greater change in the long run. Sometimes, all patients need from the therapist is to actually do nothing, except listen, hold their patient's pain with them, and bear witness.

The pace of change using verbal psychotherapeutic interventions is also quite different from the pace of change with many biomedical interventions. It is much harder to predict how quickly psychological change may occur at an individual subjective pace compared to biomedical interventions. It is also more difficult to assess psychological processes and change as opposed to symptom reduction. It is easier to relieve a symptom such as anxiety than to help someone be able to fall in love. Coming from a hard science-based schooling, residents often have difficulty appreciating the inward effect they may have on their patients. Aspects such as alliance, transference, and containment are all part of the mix of psychotherapy that can be easily overlooked through the lens of biomedical interventions. We also find that most beginning psychotherapists (whether psychiatrists or other professional therapists) often dismiss or feel embarrassed about their countertransference, especially if it has negative aspects. For example, feeling that a patient is taxing, dreading the time and day a certain patient comes in may cause shame for the beginning therapist. It is often with relief that they realize they are not alone in having these emotions towards certain patients. They are even more relieved to learn that countertransference is not merely a nuisance that they need to get rid of, but instead rather informative. Every patient elicits different reactions from the therapist, and it often helps residents to get "unstuck" in therapy to be able to acknowledge, understand, and explore their countertransference, which as doctors, providing medical treatments is much more peripheral. Fennig et al. [9] note one of the problems of identity of the psychiatrist as psychotherapist is that in the psychotherapeutic model, residents feel more vulnerable, since they are themselves the instruments of the treatment and therefore failure feels more personal.

Finally, for a patient seeing a psychiatrist for both medication management and psychotherapy, medication has multiple meanings. Apart from its biomedical effects, medication is also part of the therapeutic relationship and the process of prescribing with all the accoutrements influencing the treatment as a whole. Medications can bear different meanings for different patients—it can be used as a source for a power struggle (will my doctor prescribe what I want him to prescribe?); represent hidden meaning for the patient (does my doctor think I'm nuts because he prescribed the same medication aunt Rose got when she was psychotic?); it can be used as a distraction from dealing with more difficult issues (the patient may consume the whole session by talking about minute side effects, etc.); it can be a transitional object (that pill box makes me feel safe because it is part of my doctor that I carry with me); and more. In addition, non-adherence with

medication can be understood with the aid of dynamic principles such as transference, countertransference, and resistance [10]. For example, once a psychiatrist gains an understanding that a patient may resist improvement of a mental health condition due to secondary gain (e.g., the patient has less responsibilities and expectations when depressed; the patient gets more attention due to panic attacks), the therapist can gain a better understanding of the non-adherence (or resistance) and may target and address it in a more dynamically informed manner. It is also important for psychiatrists to learn when it is not advisable for the same person to prescribe medication and offer therapy. Sometimes, it is better to have two different people do this. The advantages and disadvantages of the decision one makes about this are beyond the scope of this paper.

Overcoming the Tension

Two different clinical efforts at diagnosis, case formulation, and treatment planning may utilize either a nomothetic or idiographic approach. A nomothetic approach attempts to generalize and derive laws that explain objective phenomena. The biomedical approach of DSM-5 or other categorical approaches attempt to draw the general principles of diagnosis, case formulation, and treatment for a population of patients. For example, what can we generally expect to encounter when seeing a patient with major depression. The idiographic effort is more often the approach used when doing psychotherapy. It is our attempt to specify and understand the meaning of idiosyncratic, unique, and subjective phenomena in each patient. For example, it is our effort to find out what is truly unique and idiosyncratic in each patient suffering from major depression. According to Schafer [11] in the practice of psychiatry, we need not view these two approaches as competing, but rather complimentary: Millon [12] describes the process of integrating these two approaches as a synthesis in which from a rich and unique individuality (all that the person is), we can generalize certain commonalities, which in turn inform our knowledge of what makes every person uniquely different from everyone else.

How does this translate to a curriculum in which we can help residents overcome the difficulty of negotiating seemingly conflicting states of mind between psychiatric doctor and psychiatric psychotherapist? In our psychotherapy scholar track [13] and residency, we encourage exposure to nomothetic and idiographic ways of formulating resulting in residents exploring and understanding the generalizations provided by multiple theories and simultaneously experiencing what is truly unique about every individual. Residents are encouraged to "play" with diverse hypotheses rather than strive for a single "truth." This encourages a mindset in which residents realize there is never just one way to think about a patient and that diagnosis and formulations are hypotheses in action based on categorical diagnosis and general psychological theories (nomothetic approach) applied to the unique patient characteristics and working alliance established by a unique patient and distinct therapist (idiographic approach). In his classic paper, Walder [14] presented the principle of multiple functions, in which any attempt the ego makes at solving a problem is also a simultaneous attempted solution of other problems. In the same respect, residents learn that one symptom may serve multiple functions, which broadens how physicians can view medical symptoms and opens the world of psychotherapeutic explanations. As Walder states: "… Psychoanalysis is a kind of polyphonic theory of the psychic life in which each act is a chord, and in which there is consonance and dissonance" [14]. For example, a patient with depression may be seen through the biomedical model as having a chemical imbalance or a genetic predisposition requiring a psychopharmacological intervention. Adding another perspective, psychodynamic ego psychology may describe the patient as having a harsh super-ego that leads to self-disparaging beliefs and low-self-esteem causing depression. Alternatively, an attachment theory viewpoint does not preclude a biomedical explanation. For example, we may conceptualize the depressed patient as historically having had an avoidant attachment to his mother, leaving him with an insecure attachment, which predisposes his brain circuitry/neurotransmitter systems to a biomedical depression.

Throughout the third year of our program, residents also participate in a yearlong Balint or countertransference focused group conference in which they freely discuss their reactions to their cases. As our Balint group leaders come from a psychodynamic school of thought, we use a dynamic approach in this section of our residency curriculum. It has been our experience that teaching residents psychodynamic formulation skills using multiple psychodynamic theories can provide residents with in depth tools for understanding the idiographic approach to patients. We recognize that others may choose alternative approaches of teaching formulation from a different set of theoretical orientation, e.g., compare cognitive behavioral therapy formulation versus family therapy, versus psychodynamic formulation. This is also done in other sections of our program as well. However, for the purposes of this paper, we are presenting just one curriculum element which focuses on psychodynamic theory. As part of this psychodynamic exercise, every few weeks, we present a new angle of *applied* psychodynamic theory at an introductory level. We spend the next few weeks exercising, applying, and thinking about patients from that particular angle. This is mainly an exercise in psychodynamic case formulation, regardless of whether we conclude that psychodynamic psychotherapy is the treatment of choice or not. As the year progresses, more

and more angles are built one on top of the other. The curriculum is presented in this manner:

1. Ego psychology: We emphasize the patient's intrapsychic conflicts. What wish, defense, or compromise solutions are active in a session? What is the patient defending against? What are the predominant patient's ego functions utilized and ego strengths? What moral code or idealized ambitions is the patient pursuing?

2. Object relations: We examine the internal representations of self, others, and relationship roles. What are the observable patient's interactions with their therapist? Are the patient's internal representations whole or part objects? Are they split or rapidly alternating? Textured and multidimensional or stereotypical? Flexible or rigid? Generally trusting or suspicious? Merged or individuated? A practical exercise we use to exemplify what object relations is, is showing residents responses to Rorschach cards. For example, they are struck by vast differences in responses to just the first card such as "dark evil bat wanting to attack me" (paranoid object relations), "ripped out guts" (psychotic morbid part object relations), or "bat" (popular whole object relations).

3. Self-psychology: We introduce an emphasis on development of self-esteem/ narcissism. Does the patient require excessive mirroring (recognition and admiration) exhibiting a historical deficit? Has mirroring been sufficient to give rise to self-confidence, self-esteem, and ambition? Does the patient tend to idealize or devalue the therapist and others? How does the patient react to an empathic failure of the therapist? Are there expressions of twinship with the therapist or others? Does the patient have a fragile self? Is the patient vulnerable to feelings of emptiness, meaninglessness, or incoherence (fragmentation) that is excessively dependent on external events and gratification to bolster a stable sense of self?

4. Relational psychology: We introduce emphasis on process rather than content. How do two minds, or two subjectivities, in interaction, mutually and reciprocally influence one another? How are thoughts, feelings, and behavior co-created or co-constructed in a relational context? How do the therapist's behavior, personal characteristics, and mere presence influence what we can observe about the patient and vice versa? How does the therapist participate in co-constructing experience and behavior that might otherwise be viewed as symptomatic or pathological? Can the therapist notice shifts in the self-states or affects in their patient during sessions? Can they distinguish between the patient's multiple selves? Can they describe the patient's implicit relational knowing? How does the therapist influence the patient?

5. Attachment theory: What type of attachment does the patient have? How would a hypothetical Adult Attachment Interview [15] look like for a particular patient? We describe the importance of mentalization as the ability to conceive of one's own and other's intentions and our own minds and those of others as sources of motivation that underlie behavior in the social world.

This is by no means intended as an exhaustive list of psychodynamic theory and formulation. We describe this exercise in giving residents a view of patients sometimes from nomothetic and/or idiographic angels in a *simplified* and *applied* manner. It is also an exercise in getting them to think in divergent idiographic/polyphonic ways, as opposed to the biomedical line of convergent thinking. The exercise corresponds to the synthesis process described by Millon, in which a patient is deconstructed into idiographic components that teach about the patient's nomothetic qualities, which eventually leads to a nomothetic individuality formulation.

Discussion of transference, countertransference, and resistance is woven into each module and discussed through the particular lens of each theory as well as a discussion of how we view change occurring in the patient given our theoretical formulation. This exercise emphasizes psychodynamic formulation, whereas the interventions may be from other modalities. For example, psychodynamic formulation may lead to a conclusion that CBT is best for a patient due to poor insight and reality testing. In addition, though some theories offer beautiful and creative insights into the inner dynamics of the human psyche, the interventions derived from the theory do not always seem compatible when taken as a whole. For example, while Winnicott offered many significant and beautiful ideas as to how to think about patients, his way of intervening—providing a holding environment with no expectations (e.g., [16])—is rarely appropriate in its entirety for the setting or population seen by the residents.

By the end of the year, these classes allow the residents to describe their patients through nomothetic or idiographic approaches using multiple lenses and to formulate a case in a multidimensional or multi-theoretical way as different issues arise. Different schools of thought become complementary and intertwined rather than compartmentalized. Residents describe feeling empowered at being both doctors, who can treat and prescribe medication, while also being therapists who can think deeply and thoughtfully about their patients. Our residents have described they feel they have more to offer and a better understanding of their patients, whether they see them for medication management, psychodynamic psychotherapy,

or behavioral therapy. As one resident noted, "this (curriculum) gave us a language to be able to describe our patients." The curriculum is intended to help residents develop a therapeutic strategy and to be able to explain why a certain approach is preferred (e.g., supportive therapy, medication management, long-term psychodynamic therapy, behavioral therapy, etc). We believe that any learning exercise that allows residents the opportunity to think of patients through different lenses can achieve a similar learning experience and process. In other parts of our psychotherapy scholars track [13], we also encourage a similar process having residents think of patients from behavioral, cognitive-behavioral (CBT), systemic models, etc. In addition, we provide ongoing instruction of how psychotherapy impacts neuroscience and vice versa facilitating the conceptual integrations to think both biomedically and psychologically

Kay Jamison writes about both ends of psychiatric care: the providing end (as a psychiatry professor) and the receiving end as patient. Dr. Jamison's own struggles with bipolar disorder are portrayed in her memoir "An Unquiet Mind." She eloquently writes: "… I cannot imagine leading a normal life without both taking lithium and having had the benefits of psychotherapy. Lithium prevents my seductive but disastrous highs, diminishes my depressions, clears out the wool and webbing from my disordered thinking, slows me down, gentles me out, keeps me from ruining my career and relationships, keeps me out of the hospital, alive, and makes psychotherapy possible. But, ineffably, psychotherapy heals. It makes some sense of the confusion, reins in the terrifying thoughts and feelings, returns some control and hope and possibility of learning from it all. Pills cannot, do not, ease one back into reality; they only bring one back headlong, careening, and faster than can be endured at times. Psychotherapy is a sanctuary; it is a battleground; it is a place I have been psychotic, neurotic, elated, confused, and despairing beyond belief. But, always, it is where I have believed—or have learned to believe—that I might someday be able to contend with all of this. No pill can help me deal with the problem of not wanting to take pills; likewise, no amount of psychotherapy alone can prevent my manias and depressions. I need both…" [17].

So too, residents in psychiatry learn that they can *offer* both…

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