June 1989

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Homer C. Curtis, M.D.

President, American Psychoanalytic Association

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Recommended Citation

Curtis, M.D., Homer C. (1989) "In Response: The Place of Psychotherapy Training in Residency Programs," *Jefferson Journal of Psychiatry*. Vol. 7 : Iss. 2 , Article 14.

DOI: <https://doi.org/10.29046/JJP.007.2.013>

Available at: <https://jdc.jefferson.edu/jeffjpsychiatry/vol7/iss2/14>

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In Response

The Place of Psychotherapy Training in Residency Programs

Homer C. Curtis, M.D.

As a belated response to the debate about the value of teaching psychotherapy in psychiatric residency training, (Jefferson Journal of Psychiatry, Vol. 5(1):54-66, 1987) I would like to add my voice to the affirmative side. That there is such a debate seems symptomatic of an unfortunate and unnecessary misuse of important advances in neurobiology to justify the sidelining of psychodynamic psychotherapy. A search of the psychiatric literature of recent years reveals an emphasis on biological psychiatry and a relative neglect of psychotherapy. A similar trend has been noted in some residency programs and in the annual meetings of the American Psychiatric Association. However, the pendulum appears to be swinging back, as was demonstrated at a recent meeting of the APA, where panels and lectures on psychotherapy attracted overflow audiences. A symposium on psychotherapy sponsored by the American Psychoanalytic Association could not be contained in the 200 seat room and several hundred other people had to be shunted into adjacent rooms where the discussion could be heard over loudspeakers. The audience, composed mainly of young people, was obviously hungry for more information on the psychological aspect of psychiatry, a fact noted by officers of the APA who recognized the relative imbalance of the recent programs.

As an example of the kind of interest that brought so many young psychiatrists to that symposium, questions were raised by several in the audience about dealing with unruly emotions and irrationality in their patients, while others extended that to include similar reactions in themselves. They were clearly not satisfied with a medication-only approach that would assume that such reactions were simply epiphenomena of a biological disorder, for which drugs could be given to eradicate undesirable emotions. A preference for this way of avoiding or controlling unreason and distressing affects may often stem from a need to control feelings aroused in resonance with the patient's stormy emotions. It is also frequently coupled with claims that the efficacy of psychotherapy is unproven, or that it is not cost-effective, or that other health professionals can supply it.

The other way is to recognize that both we and our patients are capable of a wide range of feelings and thoughts, sometimes reasonable and sometimes

unreasonable, and that the welfare and growth of not only our patients but also of ourselves are best tended to by accepting that fact of life and finding ways of understanding and working with it. As Freud wrote to Stefan Zweig, "the task of psychoanalysis is to wrestle with the demon of irrationality in a sober way."

I believe that many of us went into psychiatry because of a combination of factors related to our awareness of the inner life of the emotions. Perhaps we hoped to understand ourselves and our conflicts better, and saw working with psychiatric patients as a means to that end. Perhaps this was experienced as an interest in and curiosity about how the relationship between physician and the patient can be a major force in healing. This age-old idea has recently been threatened in an unfortunate and unnecessary side-effect of the scientific and technological explosion in our field. The value of these advances is without question, but has led some to proclaim that the practice of psychotherapy must yield its place in psychiatry to those modalities of patient care that are more "scientific," and promise a more rapid and less painful "cure." With such a point of view it is no surprise that some have even advocated that the teaching of psychotherapy in residency be abolished. Various arguments are advanced for this suggestion: training for psychotherapy doesn't prepare the resident to deal with large segments of the mental patient population. It is also said that psychotherapy can be provided by other professional groups, and therefore isn't uniquely a psychiatric therapeutic modality. Since other mental health professionals provide therapy at lower cost, psychiatrists should concentrate on developing their unique skills and leave psychotherapy to others. Thus, in residency training the time usually taken in teaching and learning psychotherapy can be more efficiently devoted to learning those unique skills. This would involve more attention to neurobiology, somatic interventions and drug therapy.

Are we then to exchange a "brainless psychiatry for a mindless one?" When I went through residency training, the drug revolution was barely getting started; ECT and insulin treatment were widely used for sicker patients. Thus psychotherapy, partly by default, was the "only game in town" for treatment of most patients. But now the therapeutic armamentarium has broadened greatly and a true eclecticism is now possible. Regrettably, human nature being what it is, there is the ever-present temptation to follow the newest therapeutic trend to a faddish degree; thus losing the balanced approach that provides a base for discrimination and specificity or a synthesis that fits the clinical needs. Thus, even when careful diagnosis indicates the need for psychotropic medication, can we afford to forget the person taking the medication? In its simplest form, such awareness may be necessary for patient compliance; in more subtle ways, we must recognize the transference—countertransference interaction, and the healing effect of a compassionate, understanding relationship within which almost all psychiatric patients can be helped to expand their self-knowledge and mastery of themselves and their reality. Thus it seems to me that the argument that learning and practicing psychotherapy is not an efficient use of a psychia-

trist's time and skills is confounded by the fact that every encounter with a patient is significantly psychotherapeutic whether formalized or not.

The search for new knowledge and ways of helping psychiatric patients can be perverted if, in the search for certainty, we turn *away* from the discomforts of painful affects and uncertainty of the interpersonal experience, which might better be confronted and dealt with. Of course, the effort to abolish psychotherapy from psychiatry may not be so easy. Perhaps one could not speak its name nor explore its nature, but how could one exclude its power from our work? Ignoring transference and countertransference will hardly abolish them from every encounter with our patients.

Viewed in this manner, learning psychotherapy is more than the gaining of a therapeutic technique. It is the means of developing mental capacities, powers of observation of the self and other, of learning to tolerate ambiguity and uncertainty. It is perhaps the most significant force in the maturation of the resident who wants not just to *learn* about psychiatry, but to *become* a psychiatrist, that is a physician who understands his patient's psyche and how that psyche resonates with his patient's physical and social being. This obviously transcends indoctrination in the various clinical skills, whether the use of drugs or psychotherapeutic techniques of individual, family, group or behavior therapy. Such a *becoming* is of course never ending; it is a continuously evolving, life-long effort to overcome the limits of awareness of one's own and the patient's inner life, thus making possible the process of cognitive and emotional maturation.

A major contribution to this process is the opportunity to work intensively as a participant observer with patients over a significant period of time, sharing with the patient the vicissitudes of his illness. This sustained and intimate experience with the patient and his struggles can be a vital factor in the evolution toward clinical maturity. I say "can be" because such intensive work with patients can be painful, with reactivation of unresolved personal problems. It is hardly a mystery why most residents go through periods of anxiety and discouragement that may lead them to want to withdraw, temporarily or permanently, from intensive psychotherapeutic work with patients. The importance of a supportive residency program with advisors, supervisors and the possibility of personal psychotherapy in such times of stress is obvious. Such support can tide the resident over this difficult and challenging period, and help transform what might otherwise lead to a defensive retreat or blunting of empathic capacities into an important catalyst toward compassion and wisdom.

Such personal experience with emotional travail parallels what the psychiatrist in training sees in his patients. Close study of the course of a patient's illness demonstrates the often discouragingly slow rate of change. Yet it is likely that rapid shifts will disappoint us. Working with the patient's progress and regress forces us to question our assumptions and omnipotent fantasies, moving us at once toward humility and wisdom. Where changes occur slowly wisdom can only ripen slowly. And in our impatience, we may be tempted to substitute generalizations and theories. Even if such generalizations are basically correct they must be

recognized as temporary glosses. If they supply unwarranted confidence and false security they may impede a more gradual and solid acquisition of clinical competence based on personal experience and work. This can be conceived of as a kind of inexact interpretation, to use Glover's term, in which the resident, much like his patient, finds a displacement that provides a sense of relief and comfort while avoiding the difficult search for the more slowly acquired, personally achieved wisdom. This will usually mean keeping an open and questioning attitude toward not only the received general wisdom, but also toward our presumptions. This will almost surely lead us to recognize how our biases and idiosyncrasies can blur our observations and limit our efforts to understand and help.

This aspect of becoming a psychiatrist can't be hastened if it is to lead to clinical and personal wisdom. No amount of intelligence, talent and mastery of psychiatric knowledge can, by themselves, lead to a maturity of clinical judgment. This comes primarily through the integrating influence of the gradual acquisition of self-knowledge and sharing in the struggles of our patients. This in turn points to the obvious necessity of continuing this maturational process for the rest of one's professional life, broadening and deepening the foundation laid down in the formative experiences of residency training.