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Teaching Psychoanalysis to Residents in Psychiatry

**Windows of Friendship or Animosity?: Teaching Psychoanalytic Psychotherapy to Residents in Psychiatry**

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“If you know the enemy and know yourself, you need not fear the result of a hundred battles. If you know yourself but not the enemy, for every victory gained you will also suffer a defeat. If you know neither the enemy nor yourself, you will succumb in every battle.”

Sun Tzu, *The Art of War*

Psychoanalytic communities, international and domestic, are concerned about the colonization of psychiatry by biological subspecialties and the consequent marginalization of psychoanalysis and psychoanalytic psychotherapy (PAP). In dealing with the concern, it is imperative to teach PAP to residents in psychiatry well enough. It will not only produce competent psychiatrists but also maintain PAP as the powerful therapeutic tool for psychiatrists. Also, PAP training can supplement descriptively-designed DSM system with psychoanalytically-informed diagnoses in understanding patients.

Teaching PAP is complex. No consensus appears to exist for what and how much we should teach residents. We do not know much about the current situation and the obstacles. We need data. In this paper, I aimed to explore the issues by collecting basic data, studying them, and coming to suggestions.

**Method**

I interviewed eight graduating PGY-4 residents in the four-year program (29-34 years, seven males and one female) at the SNUH (Seoul National University Hospital) Department of Psychiatry, Seoul, Republic of Korea, where I belong to. The Seoul National University College of Medicine with its affiliated hospital is the oldest and most prestigious medical institution in Korea, out of 41 medical colleges and schools with their affiliated hospitals. In 1957, it held the First Sigmund Freud Symposium in Korea, and about 2,500 attended it. It is also the germinating place of the Korean psychoanalytic movement by former Professor Doo-Young Cho in my department. He eventually led five other alumni psychiatrists to the organization of the Seoul Psychoanalytic Study Group on May 6th, 1980 (with no connection with the IPA at that time) in commemoration of Sigmund Freud’s birthday. It is also the place of the 31st Anniversary International Symposium of the Korean Association of Psychoanalysis (KAPA), held from September 23rd to 25th, 2011, in memory of Freud. I have been working at the hospital as a full-time faculty since 1985.

The interview was done for one hour individually, focusing on each resident’s experience of PAP as well as collecting background information. It was done during their last working month, i.e., within a month after the national board-certification examination.

After the interviews, a 15-item questionnaire was developed. It consisted of the initial motivation for choosing psychiatry, follow-up on the interests across biological, psychoanalytic, and social psychiatry, PAP experience and degree of satisfaction, and obstacles/suggestion for improvement. The last question was about the intention to employ a psychoanalyst as full-time faculty in the hypothetical position of department chair.

All PGY-4 residents were asked to answer the questionnaire. As a comparison group, I chose the eight PGY-2 residents (26-32 years, five males and three females). They had no exposure to the formal PAP education/training (individual and group supervision, and book reading). PGY-1 is the starting year of psychiatry residency, after the one-year internship.

**Results**

All of them, eight PGY-4 and eight PGY-2 residents, completed and returned the questionnaire.

*Distribution of Interests*. None of the PGY-4 and PGY-2 residents developed an exclusive interest in biological psychiatry before choosing psychiatry. In a comparison of ‘Before’ and ‘Before’ between the two groups, all the eight PGY-2 residents reported less interest in psychoanalytic psychiatry than PGY-4 ones.

Five PGY-4 residents as shown in Table 1 expressed a higher or equal interest in PAP on graduation from the four-year residency (refer to ‘After’). Please note that ‘Intra’ is what they on graduation thought they had obtained from the training. And in comparison of ‘PGY-4’s After’ and PGY-2’s ‘Before’, all the eight PGY-4 residents reported more or equal interest in psychoanalytic psychiatry.

**Table 1. Distribution of Interests in Biological (B), Psychoanalytic (P), and Social (S) Psychiatry Among PGY-4 Residents (N=8) Before-, Intra- and After- Training in Psychiatry**

PGY-4 Before Intra After PGY-2 Before

B/P/S B/P/S B/P/S B/P/S

50/50/0 90/10/0 20/**70**/10 30/**50**/20

45/45/10 75/20/5 50/40/10 40/**40**/20

50/40/10 85/10/5 30/**50**/20 50/**30**/20

40/40/20 60/20/20 40/**40**/20 60/**30**/10

50/40/10 70/20/10 50/35/15 50/**25**/25

50/40/10 80/10/10 60/30/10 70/**25**/5

40/30/30 60/20/20 50/**30**/20 70/**20**/10

70/20/10 85/10/5 65/**25**/10 80/**10**/10

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*About the Hypothetical Question*. All sixteen residents in two classes except one in PGY-4 responded that as chair of the psychiatry department, they would employ a psychoanalyst as a full-time faculty.

*PAP Experience.* During the four years, four PGY-4 residents had 3-5 PAP cases, three had 6-10 cases, and only one experienced more than 10 cases. A total number of individual supervision ranged from 20 to 90 sessions (median 40). An average number of supervisions per patient ranged from 3 to 20 sessions (median 9). All PGY-2 residents were in the beginning phase of PAP training.

On the degree of satisfaction with PAP training, all PGY-4 residents reported ‘unsatisfactory.’ All agreed that their PAP training had been insufficient, in spite that half of them ranked within the top five in the board-certification examination (PAP competency assessment is a significant part of it). All except one in PGY-2 residents expressed the same concern.

*Obstacles to PAP Training.* Three major obstacles mentioned by the PGY-4 residents were educator/supervisor shortage, limited time allocation for PAP training, and unfavorable medical care environment. Another one was the issue of government-controlled national health insurance system. Interestingly, they did not regard the progress of biological psychiatry as a significant obstacle to PAP training.

PGY-2 residents also mentioned on educators/supervisor shortage and limited time allocation for PAP training. External factors such as medical care environment/health insurance system did not seem to be their concerns yet. PGY-2 residents also mentioned the progress of biological psychiatry the least as an obstacle.

*Residents’ Wishlist for Improving the PAP Training.* PGY-4 residents indicated more diverse ways of improving the PAP training in a broader perspective than PGY-2 residents (Table 2).

**Table 2. Wishlist about PAP Training by Psychiatry Residents**

#wished-for

PGY-4 PGY-2

More functional patient referral system 2 1

More time/ accessibility 1 2

More frequent case discussion 1 -

More systematic supervisor availability 1 1

More education on the theory/psychodynamic formulation 2 1

More individual attention 2 -

Innovation on healthcare system/ insurance 1 -

Improvement on low fee structure 1 -

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In comparison with PGY-2 residents, PGY-4 residents took account of external factors (the healthcare system/insurance/fee structure) in addition to internal educational/training factors.

*Subjective Experiences Collected from Interviews*. Current patient referral system at the SNUH Department of Psychiatry was reported to be significantly dysfunctional. PGY-4 residents raised two most manifest issues. First, the majority of PAP referrals was made by faculty members. It makes residents have difficulty with refusing unsuitable cases. One PGY-4 resident recalled that one out of five referrals had not been suitable. Secondly, the majority of referred patients was on multiple medications. The patients made a regular visit to the referring faculty for refill prescription and a supportive therapy.

One of the graduating PGY-4 residents half-jokingly complained: In teaching PAP to them, they should have been treated like a toddler vs. a school child. He added that it was traumatic sometimes, knowing he was not good enough and not knowing what to do about it.

PGY-4 residents considered individual supervisions as most helpful, with group supervisions and book reading following.

**Discussion**

I have a strong feeling that I have re-discovered my residents in the process of going through this study. In spite that I have committed myself to teaching PAP for the many preceding years, I confess that I have not yet known them well enough. Interviewing graduating PGY-4 residents enabled me to understand more who they are and what they want from PAP training. It was a big relief that they maintained and expressed significant interest in psychoanalytic psychiatry after ‘unsatisfactory’ PAP training.

I am the only psychoanalyst faculty at the SNUH Department of Psychiatry. It enrolls 31 full-time (17, 10, and 4 in three separate hospitals) and 22 clinical faculty members, 43 post-residency fellows, and 37 residents. All of them are in a busy schedule of inpatient/outpatient care, education/training of medical students/ residents, and clinical/ basic research activity. Resident rotation schedule is always very tight covering the three main and one affiliated hospital. Time limits the consistency of training programs, and PAP training is not an exception. Some residents are busier with graduate programs for Master or Ph.D. degree

Among the 31 full-time faculty members, there is one junior faculty with partial Freudian psychoanalytical training, other than myself. Among the clinical ones, there are one Freudian psychoanalyst and a few Jungian analysts as well as various therapists covering from group to sex therapies. The diversity of clinical faculty’s expertise is designed to be helpful to residents. However, it is also a potential source of confusion and disintegration in PAP training.

Findings in this study support that in my department of psychiatry, PAP training needs significant improvement. The department is far from meeting the residents’ expectation to obtain a quality training in PAP and to become a competent psychoanalytic psychiatrist.

In 2014, one resident from my department failed the board-certification, due to the low score in PAP competency assessment. Then, I introduced two solutions. First, I maximized residents’ exposure to PAP education/training. I asked all PGY residents to join me for all PAP training except individual supervisions. It includes book reading (one semester) and group supervisions for PGY-2 and PGY-4 residents (each, one semester). I also encouraged them to attend extra-mural programs open to them. It included lectures, case discussions, and group supervision programs offered by psychotherapeutic/psychoanalytic societies. Secondly, I chose a manual-like book on PAP for seminar vs. those with much theoretical sophistication. I found it impractical for busy working residents to read difficult books or papers on psychotherapies. In the seminar, I tried to attract their attention to several key psychoanalytic concepts of immediate utility in their diagnostic/therapeutic encounter with patients. Simultaneously, I kept asking them open-ended questions to help them strengthen the PAP ‘muscles.’

In 2015, all PGY-4 residents passed the board-certification examination and four of them ranked within the top five. Nevertheless, relief is temporarily warranted, reflecting on their overall dissatisfaction with PAP training and PGY-2 residents’ apparently reduced interest in psychoanalytic psychiatry. Dissatisfaction tends to lead to frustration. Frustration is likely to produce hostile feeling.

I suppose that currently in my country and quite probably world-widely, the relationship of PAP (and psychoanalysis) with departments of psychiatry are at crossroads, challenging the choice of friendship vs. animosity by residents. External reality is not friendly at all. Healthcare delivery system and insurance system, both of them under rigid control by government and health maintenance organizations, do not and will not encourage residents to maintain sufficient interest in PAP after graduation. Internally, the training system in residency is dysfunctional in many aspects.

Here are suggestions:

1. The department of psychiatry should open and broaden the residents’ accessibility to individual supervision. The training program director or group supervisors should encourage residents to seek supervisions actively from outside resources.

I argue that competent psychotherapist/psychoanalyst should do initial supervisions for beginning residents. It is crucial because supervisees develop the first impression (‘imprinting’) on PAP depending on such experiences. The supervisions should offer practical solutions vs. complex conceptions.

‘Fireman’ supervisor should also be available to residents for crisis intervention. It would be beneficial not only to resident therapists but also to patients.

1. Book- and paper-reading is much better to be focused on ‘easy and quick’ method. Residents are busy, and attendance is inconsistent. Unsystematic, incoherent, and irrelevant education is the source of confusion, frustration, and possible animosity. Vignettes and sharing supervisor’s clinical experience of PAP are helpful for them. Identification is not only educational and but also emotionally supportive.
2. The department of psychiatry should establish a well-functioning PAP referral system. The system is advised to refer relatively uncomplicated patients to beginning residents. We have to consider realistically that once-a-week therapy prevails among them. In that way, we might lessen confusion and enhance the therapeutic confidence. Secondly, the referral should focus on medication-free patients, solely for PAP vs. supplementing drug therapy. Otherwise, distorted therapeutic relationship and consequent lowering of confidence might occur.
3. The department of psychiatry should make efforts to enhance the faculty members’ supervisory capacity. The ‘capacity’ is likely to be taken granted in departmental politics, although a significant number of them may not have been practicing PAP for years. It would be helpful not only to itself but also to possibly rekindling their buried interest in psychoanalytic psychiatry. Regular workshops on how to do PAP supervision could be a most feasible option. On the other side, teaching residents ‘how to use supervisors’ will help them to prepare themselves well and to extract learning from the experience.
4. Peer group supervision among residents should be encouraged. It could function as a self-help group, increasing the knowledge/ skills and boosting morale. It would be ideal to set up one group per each PGY class. The training director should support the groups by arranging a faculty member to attend them as a guest.
5. The training program should offer PGY-1 residents basic training in psychodynamic formulation/PAP during the first year of residency. They should not be confined to learn mostly drug therapy for inpatients. Particularly, open ward inpatient experience should include active PAP experience. They should be encouraged to learn how to think psychotherapeutically early enough.
6. Psychoanalytic communities should actively invent feasible measures to attract biology-dominant departments of psychiatry to recruit psychoanalyst(s) as a full-time faculty member(s), without waiting in vain. Surprisingly, in this study almost all the residents agreed to the necessity of having psychoanalyst faculty within the department. However, there are practical issues. One is how to persuade hospital management about the value (including the financial one) of it. The other is how to devise the way for the psychoanalyst faculty to survive and succeed in promotion and acquisition of the tenured position. I suggest that the most feasible way should be for a psychoanalyst to develop and maintain double specialties. It is in my personal case ‘sleep disorders medicine and psychoanalysis.’ And it has worked.

Considering the present and the near future, the political climate in psychiatry appears to be far from developing into warm and pleasant one for psychoanalysis and psychoanalytic psychotherapy. I suggest that we should stop worrying and complaining and should focus on making small bit-by-bit changes, with the ultimate aim of making friends with more psychiatrists. It does include resident trainees, and they are also good candidates for future psychoanalysts.

In various aspects, it is essential and crucial for us to offer residents in psychiatry a quality PAP training. In this study, it is reassuring that the residents gave the least attribution to the progress of biological psychiatry as an obstacle to PAP training.

There are some limitations in this study. It depended on self-report/ interviews, and the data was from one particular university hospital. It only had a small number of participants, not allowing serious statistical analyses. So, the arguments made here may need further validations. I have a plan to extend further the study.

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