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COMMENTARY

Revitalizing Psychodynamics in Psychiatric Training: An Intergenerational Perspective

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In this commentary, we offer perspectives of a recent psychiatry graduate (KA), a midcareer psychoanalyst psychiatrist who works in residency education (YH), and a senior psychoanalyst psychiatrist who served as medical director of a large community mental health organization (DL). We come together with a mutual appreciation for psychodynamic psychiatry, despite having each trained during vastly different eras of psychiatry and psychodynamic psychotherapy. We think our intergenerational perspective highlights the enduring quality of psychodynamics. Here, we advocate that core tenets of psychodynamic psychiatry should be valued and taught as essential components of psychiatry residency training.

We think effective biopsychosocial psychiatric treatment benefits from attention to issues of self and relational functioning, including identity formation, psychosocial development, modes of relating, and motivation. Although other theoretical approaches and therapies can address these issues [1, 2], what distinguishes a psychodynamic approach is its assumption of unconscious contributions to current struggles [3]. Concepts such as transference, countertransference, and internal conflict highlight ways in which the unconscious, or what is out of awareness, may manifest in treatment. We use the term *psychodynamic psychiatry*, instead of *psychodynamic psychotherapy*, to highlight that psychodynamics are at play in all aspects of psychiatry [4].

We are being careful not to insinuate that psychodynamic thinking is a panacea, nor that it should replace other therapeutic modalities or biological interventions. Rather, we are concerned by the overall trend away from psychodynamics in residency training [5]. We propose that a psychodynamic approach is an important tool to enhance clinical care. We present our reflections on the importance of psychodynamics in training residents, its widespread utility in psychiatric leadership, and its unexpected impact in the treatment of a severely symptomatic hospitalized patient.

Psychodynamic Psychiatry: Past, Present, and Future

Over the past several decades, psychotherapy training has significantly declined in residency programs [5]. Psychiatry and behavioral health have shifted away from a psychodynamic approach to psychotherapy [6]. There are many reasons for this shift, including limited resources of time and money; proliferation of time-limited, evidence-based, and manualized psychotherapies, such as cognitive behavior therapy; and the emergence of effective biological treatments.

Psychodynamic psychotherapy is often criticized as ineffective and impractical, despite evidence to the contrary [7]. Like psychiatry, psychodynamic psychotherapy and psychoanalysis have made paradigmatic shifts over many decades. The field now includes some of the leading minds in neurobiological correlates of attachment theory and mentalization [8], as well as treatment of severe personality disorders [9]. Brief, problem-specific, psychodynamic-based treatments have potential for broader dissemination to the community [10]. Cutting-edge neuroscience research may integrate and consolidate the now-defunct "mind versus brain" division and help explicate a psychodynamic model of the mind that incorporates neurobiological underpinnings of self and interpersonal functioning [11].

The field of psychiatry is acknowledging and addressing racial, societal, and political forces that effect behavioral health. These influences start early: it is well established that childhood abuse and neglect increase vulnerability to psychiatric conditions in addition to chronic medical illnesses in adulthood [12]. Further, the recovery movement

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and person-centered care have led the field to embrace individuality, narrative, and self-determination in behavioral health care [13]. For example, the primary outcome for a landmark study on first-episode psychosis treatment was not severity of psychotic symptoms but, rather, quality of life: a sense of purpose, motivation, engagement, and emotional and social interactions [14]. Contemporary psychodynamic models of development have much to offer many of today's most pressing mental health problems, addressing external factors in psychopathology and helping the individual live a full, meaningful life despite difficulties endured.

Midcareer Perspective: Core Psychodynamic Concepts to Enhance Residency Training

For the past decade, I (YH) have taught and supervised residents in outpatient clinic settings. Beginning residents are eager to learn and ready to help, but I have observed it is often easier for residents to master medication algorithms and treatment guidelines than to manage difficulties commonly associated with outpatient psychiatry, including nonadherence, poor alliance, and difficulty with the treatment frame. I will discuss three categories of psychodynamic concepts that I have found can enrich residents' learning, ability to work with patients, and clinical confidence.

Identity and Sense of Self

Psychiatric conditions often cause interruptions in self-experience, whether an altered sense of reality in psychotic disorders, feelings of guilt and worthlessness in depressive disorders, or unstable sense of self in borderline personality disorder [15]. Psychosis and other destabilizing experiences can interrupt an individual's life narrative, sense of agency, and cohesive sense of self [16]. As such, it can be helpful for residents to pay attention to patients' identity, self-experience, and subjectivity. For example, helping individuals grieve the loss associated with psychosis or other serious mental illness and incorporate these experiences into a coherent self-understanding can help bolster their hope, purpose, and meaning [17].

Identity development is a core psychodynamic concept. Psychodynamic tenets of identity, such as self-esteem regulation, self-narrative, and self-perception, can help residents transcend an understanding of their patients beyond the "identifying information" [18]. An understanding of who the person is, how the person reacts when vulnerable, and how the person views the person's self and future can be useful when thinking about recovery goals beyond symptom relief. Though this person-centered conceptualization of "patient as person" is not exclusive to a psychodynamic approach or even to psychiatry, a psychodynamic conceptualization of identity and autonomy can facilitate a person-centered stance. In fact, the concept of patient-centered care is rooted in the work of psychoanalysts Edith and Michael Balint [19].

Transference and Sense of Others

Transference is a psychodynamic construct that can help residents understand more about how their patients relate to them. Broadly speaking, transference is the hypothesis that expectations and ideas of others, shaped by people's past and largely out of their awareness, get reenacted in current relationships. It is a keystone of psychodynamics and an inevitability of every relationship [3].

Although fostering and interpreting transference are techniques more appropriate for psychoanalysis or psychodynamic psychotherapy, it can be useful for residents to consider transference in any clinical interaction, including medication prescribing. For example, a person with a lifetime of trauma may have a much harder time trusting the recommendations of a physician than one with secure attachment, who has always had positive interactions with authority figures. Additional differences of race, culture, and socioeconomic status make the interaction even more complex. It is no wonder that medication nonadherence is so prevalent in psychiatry [20]. Medication has many meanings, including dependence on another, trust versus mistrust of the system, and sense of control and agency, to name but a few, all of which can bear on medication adherence [21]. Residents who are attuned to transference will likely create better alliance, which has been demonstrated to strongly correlate with psychopharmacological outcomes [22].

Countertransference, Engagement, and Motivation

The concept of countertransference, the set of feelings elicited in a physician by a patient, is fundamental for residents working with challenging or disengaged patients [3]. When residents experience uncomfortable responses to patients, concepts such as projective identification and nonverbal communication can help residents understand what the patient might be conveying about the patient's struggle. I have frequently found that when residents understand their countertransference, they feel less frustrated and anxious and are better able to hypothesize, reformulate, and empathically return to the treatment.

It is particularly useful to help residents think of their countertransference toward patients disengaging from treatment. Difficulty with treatment engagement for individuals with severe mental illness can lead to worse clinical outcomes and high dropout rates [23]. Individuals with personality disorders may also be difficult to engage and are unfortunately often cast aside as "difficult," which can exacerbate stigma and interfere with treatment [24].

Although there are many external and systemic barriers to engagement, including time, finances, and health literacy, conflicts of motivation may also contribute to many people not receiving services they desperately need. I have found it useful to help residents see disengagement not as a hurdle to overcome, which can lead to punitive power struggles or apathy, but as the work itself. When we teach residents to ask, "What is the patient communicating by disengaging in their particular way?" we can help them understand why someone may want treatment while simultaneously behaving as if treatment is not wanted. This reaction is not because the patient is "manipulative" or confused but because treatment, illness, dependence on another, and wellness all have meanings that are unique and idiosyncratic.

Senior-Career Perspective: Core Psychodynamic Concepts to Enhance Team-Based Work and Leadership

As a late-stage psychiatrist, I (DL) have had the benefit of perspective, witnessing advances that have come and gone and seeing what has endured. It seems to me that psychodynamic theory and practice have evolved in ways that have increased their general psychiatric utility.

In addition to my psychoanalytic work, I served for many years as medical director of a community mental health service treating people with severe psychiatric issues. I was the only psychiatrist working at senior administrative levels within a large agency and had to navigate the always complicated dynamics of leadership. I learned that the psychiatrist administrator, trained in how to listen, can deploy psychodynamic skills to optimize administrative effectiveness.

Interdisciplinary models of treatment, including integrated and collaborative care, are increasingly common [25]. Accordingly, psychiatrists are increasingly called upon to function in supervisory, consultative, and administrative roles in team-based treatment settings.

In a team-based model, psychiatrists work alongside health care practitioners and therapists with a wide range of training and experience. Community mental health teams struggle every day with the baffling behavioral problems afflicting people whose conditions are not sufficiently responsive to medications. For a psychiatrist in this role, supervision is not only about what medication to prescribe and why. Psychiatrist administrators can help clinicians with less experience tolerate overwhelming affects and process the work that they are doing with patients, which can increase team morale and clinician capability [26]. For example, in case conferences, noting that I felt despairing and hopeless as I listened, I would reflect this approach to clinicians and acknowledge that they too must feel despairing and hopeless. We could then speculate whether an overwhelming affect is what the patient was feeling or maybe what the patient could not feel and had to project outward. Such supervisory moments often defused tension and allowed the team to focus on how best to help the patient rather than to be overwhelmed by the feelings.

Unfortunately, the role of the psychiatrist on many interdisciplinary teams is often relegated to prescribing medications [25]. Although much of this relegation is due to the current climate of health care, managed care, and economic constraints, psychodynamic psychiatrists can use their training to serve an integrative function, which can make a significant impact on team culture and patient care.

Recent Graduate Perspective: Core Psychodynamic Concepts to Enhance Inpatient Work

During my psychiatry residency, I (KA) rotated through a state psychiatric hospital with lengths of stay averaging greater than 1 year. There, we treated patients with severe and persistent mental illness, and my experiences working with these individuals have been formative to my psychiatric education.

Vignette

M was a notoriously "difficult" patient on the inpatient unit where I rotated as a junior resident. M would not take medication by mouth, so she received court-ordered intramuscular (IM) injections of lorazepam for treatment of catatonia. My goal as a beginning resident was to get M ready for discharge, but the injections could not be administered in the outpatient setting. Every day, M and I engaged in a familiar conversation in which I struggled to convince her to take medications by mouth. I felt stuck, frustrated, and confused. Although she adamantly stated that she wanted to leave, she refused to do the one thing that would allow her discharge. Why was she doing this?

Every week, my supervisor and I discussed this dilemma and searched for ways to encourage M to explore this behavior with me. My supervisor, trained in psychodynamic psychotherapy, also encouraged me to consider what the medication might mean to M.

One day M, yet again, told me, "It's the control thing we talked about," when I asked her about her "discharge-interfering" behavior. This time, however, instead of pulling back and suggesting less harmful ways to assert control, I continued the line of insight-oriented inquiry: "Yes, I'm sure that's part of it, but…I also think there's something else to it. You know it's safer to take your medicine orally. So, what does it mean for you to receive IMs instead?".

She broke eye contact to look down at the table. Eventually, she tearfully said, "All you people want to call me mentally ill, but I'm not! And I'm not going to take your medication, because I don't need it!" I realized I had not stopped to think about how much her first psychotic break during college had affected her self-esteem and identity. She had lost the sense of herself as insightful, creative, and industrious that she had had as a student. Now she was only a "patient." She had suffered a devastating loss, which no one had acknowledged during her hospital stay as we struggled endlessly about medication. She was reminded of this loss every time we asked her to take psychiatric medications, and I imagine that she unconsciously felt we were reinforcing the notion that she was only "a patient." I hypothesized that her behavior around medications was her desperate attempt to preserve her fragile self-esteem. She was not a "patient" if she did not take oral medications. Embroiled in this power struggle over her medications, I was telling her every day that I was not on her side.

I realized that she needed me to see her strengths. Instead of trying to convince her to take medications, focusing on her limitations, I responded, "If we taper your medication down to zero, I would be the first to celebrate that. If you didn't belong in the hospital, you would attend groups, interact with people on the ward, and take medication the safest way. I think you'll do it because you don't belong here forever."

By virtue of being her doctor, I imagined that part of M's transference toward me was as omnipotent, controlling, and unresponsive. When I expressed positive expectations for her development, I think it helped restore M's self-esteem and showed her that I was trying to understand how to ally with her. After the intervention, she was more responsive on the ward, reciprocating "good morning" greetings for the first time in months. Over time, she began taking oral medications and was successfully discharged to a psychiatric-assisted housing facility.

In hindsight, this interaction may seem like a simple intervention. I stopped to think about M as a person and what she was trying to communicate to me by not taking her medications as prescribed. I supported her inherent strengths, saw a future for her, and acknowledged that she was more than a patient, but only after considering concepts of self-esteem, identity, countertransference, and behavior as communication. I pulled myself out of the power struggle, investigated my frustration, and wondered what I was missing in my work with her. This powerful experience in my residency taught me that thinking about psychodynamic concepts with patients who are severely ill can be useful for their treatment and outcome, especially if I am feeling stuck.

Conclusion and Recommendations

We hope to encourage a revitalized interest in contemporary psychodynamic psychiatric concepts in residency training. We are not advocating that all psychiatrists become practitioners of psychodynamic psychotherapy. Other therapies (e.g., cognitive and behavioral therapies) are the treatment of choice in many cases [1]. We also are not advocating for extensive programming. Rather, we encourage programs to focus on foundational psychodynamic concepts such as transference, countertransference, unconscious conflict, and identity formation. These concepts can be applied to clinical interactions beyond the conventional psychotherapy frame, including in community settings and for patients with severe mental illness.

Although we think it is beneficial for residents to have clinical experience conducting long-term psychodynamic psychotherapy, we are aware that many programs are not resourced with supervisors who are psychoanalytically trained and that many training settings are not equipped for long-term psychodynamic treatment. However, we suggest that trainees can nevertheless learn and appreciate psychodynamic practice while working in many different settings [19]. An example is the application of transference-focused psychotherapy (TFP), based on psychoanalytic object relations theory. Although TFP as a therapy modality is complex and difficult to master, TFP principles can be broadly taught and used in various clinical settings to meet public health service needs [27].

Another solution might be for US programs without robust psychodynamic faculty to connect with psychoanalytic training programs across the country for supervision or teaching. These arrangements have been demonstrated to be mutually satisfying and enriching [28]. Additionally, classes via videoconference and asynchronous "e-courses" can offer psychodynamic teaching to programs that do not have many faculty members versed in psychodynamic psychotherapy [29]. Programs might also consider multidisciplinary learning and enrichment opportunities, such as case conferences for trainees, clinical unit staff, and teaching faculty, incorporating psychodynamic conceptualizations to clinical encounters both common and complex.

Our proposal is consistent with Accreditation Council for Graduate Medical Education Milestones [30]. For example, Patient Care 2, Psychiatric Formulation and Differential Diagnosis, states that residents will recognize and use emotional responses of clinician and patient as diagnostic information. Although they are not explicitly referred to as "transference" and "countertransference," we argue that these psychodynamic conceptualizations can help residents in their clinical functioning.

It is an exciting time to be training in psychiatry. The field is evolving and advancing at a rapid rate. But psychiatrists need not abandon what we already know: that each person is unique in motivations, identity, and narrative. Psychodynamic psychiatry is a powerful way to maintain humanness in clinical work and avoid reductive thinking, which has the potential to pathologize and alienate the very people psychiatrists are trying to help. Psychiatrists need every available tool, and psychodynamic thinking can have a profound impact when appropriately and tactfully applied to life's difficult moments.

Declarations

Ethical Considerations This paper contains a clinical vignette. Identifying details of the patient have been changed to protect the patient's privacy.

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References

1. Cabaniss DL, Holoshitz Y. Different patients, different therapies: optimizing treatment using differential psychotherapeutics. New York: Norton; 2019.
2. Clark DA. Finding the self in cognitive behavioral perspective. In: Kyrios M, Moulding R, Doron G, Bhar SS, Nedeljkovic M, Mikulincer M, editors. The self in understanding and treating psychological disorders. Cambridge: Cambridge University Press; 2016. p. 40–9.
3. Auchincloss EL. The psychoanalytic model of the mind. Washington: American Psychiatric Publishing; 2015.
4. Gabbard GO. Preserving the person in contemporary psychiatry. Psychiatr Clin North Am. 2018;41(2):183–91.
5. Crocker EM, Brenner AM. Teaching psychotherapy. Psychiatr Clin North Am. 2021;44(2):207–16.
6. Plakun EM. Finding psychodynamic psychiatry's lost generation. Psychodyn Psychiatry. 2022;50(2):212–25.
7. Leichsenring F, Abbass A, Heim N, Keefe JR, Kisely S, Luyten P, et al. The status of psychodynamic psychotherapy as an empirically supported treatment for common mental disorders - an umbrella review based on updated criteria. World Psychiatry. 2023;22(2):286–304.
8. Fonagy P. The effectiveness of psychodynamic psychotherapies: an update. World Psychiatry. 2015;14(2):137–50.
9. Clarkin JF, Meehan KB, De Panfilis C, Doering S. Empirical developments in transference-focused psychotherapy. Am J Psychother. 2023;76(1):39–45.
10. Busch FN. Problem-focused psychodynamic psychotherapies. Psychiatr Serv. 2021;72(12):1461–3.
11. Newman LK. Psychodynamic formulation in the era of the brain - towards integration. Australas Psychiatry. 2017;25(3):230–2.
12. Hughes K, Bellis MA, Hardcastle KA, Sethi D, Butchart A, Mikton C, et al. The effect of multiple adverse childhood experiences on health: a systematic review and meta-analysis. Lancet Public Health. 2017;2(8):e356–66.
13. Mead N, Bower P. Patient-centredness: a conceptual framework and review of the empirical literature. Soc Sci Med. 2000;51(7):1087–110.
14. Kane JM, Robinson DG, Schooler NR, Mueser KT, Penn DL, Rosenheck RA, et al. Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE Early Treatment Program. Am J Psychiatry. 2016;173(4):362–72.
15. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 5th ed. Washington: American Psychiatric Association; 2013.
16. Wiesepape CN, Lysaker JT, Queller SE, Lysaker PH. Personal narratives and the pursuit of purpose and possibility in psychosis: directions for developing recovery-oriented treatments. Expert Rev Neurother. 2023;23(6):525–34.
17. Ridenour JM, Hamm JA, Wiesepape CN, Lysaker PH. Integrating loss and processing grief in psychotherapy of psychosis. Psychiatry. 2023;86(3):173–86.
18 The psychodynamic formulation collective. Psychodynamic Formulation: An Expanded Approach. Hoboken: Wiley Blackwell; 2022.
19. Weinberg E, Mintz D. The overall diagnosis: psychodynamic psychiatry, six-minute psychotherapy, and patient-centered care. Psychiatr Clin North Am. 2018;41(2):263–75.
20. García S, Martínez-Cengotitabengoa M, López-Zurbano S, Zorrilla I, López P, Vieta E, et al. Adherence to antipsychotic medication in bipolar disorder and schizophrenic patients: a systematic review. J Clin Psychopharmacol. 2016;36(4):355–71.
21. King I, Shapiro Y. "Science of the art of prescribing": from evidence-based algorithms to individualized medicine in psychiatric care. J Psychiatr Pract. 2022;28(5):409–20.
22. Krupnick JL, Sotsky SM, Simmens S, Moyer J, Elkin I, Watkins J, et al. The role of the therapeutic alliance in psychotherapy and pharmacotherapy outcome: findings in the National Institute of Mental Health Treatment of Depression Collaborative Research Program. J Consult Clin Psychol. 1996;64(3):532–9.
23. Dixon LB, Holoshitz Y, Nossel I. Treatment engagement of individuals experiencing mental illness: review and update. World Psychiatry. 2016;15(1):13–20.
24. Koekkoek B, van Meijel B, Hutschemaekers G. "Difficult patients" in mental health care: a review. Psychiatr Serv. 2006;57(6):795–802.
25. Rosen A. The community psychiatrist of the future. Curr Opin Psychiatry. 2006;19(4):380–8.
26. Menninger RW. The therapeutic environment and team approach at the Menninger Hospital. Psychiatry Clin Neurosci. 1998;52(Suppl):S173–6.
27. Hersh RG. Applied transference-focused psychotherapy: an overview and update. Psychodyn Psychiatry. 2021;49(2):273–95.
28. Fishkin R, Fishkin L, Leli U, Katz B, Snyder E. Psychodynamic treatment, training, and supervision using internet-based technologies. J Am Acad Psychoanal Dyn Psychiatry. 2011;39(1):155–68.
29. Ruble AE, Romanowicz M, Bhatt-Mackin S, Topor D, Murray A. Teaching the fundamentals of remote psychotherapy to psychiatry residents in the COVID-19 pandemic. Acad Psychiatry. 2021;45(5):629–35.
30. Accreditation Council for Graduate Medical Education. Psychiatry Milestones. 2020. https://www.acgme.org/specialties/psychiatry/milestones/. Accessed 5 Jan 2024.

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