The Training of Psychodynamic Psychiatrists: The Concept of “Psychodynamic Virtue”

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Abstract: Competence as a psychodynamic psychiatrist requires more than the acquisition of a body of theoretical knowledge and a set of technical skills. It calls for the acquisition of a set of virtues—attitudes of mind and heart—that are embedded in the character and person of the developing resident. The authors enumerate and explore these psychodynamic virtues. They discuss how residency training can best serve to develop these virtues in residents.

During residency training in psychiatry, our students must balance the stresses of new and changing clinical responsibilities with a range of required learning objectives. They must learn an immense amount of knowledge and acquire many new skills, including interviewing, differential diagnosis, crisis intervention, acute psychopharmacologic management, and many others. Among the learning objectives that all residents must satisfy is the ACGME’s mandate to attain competency in several therapies, including psychodynamic psychotherapy (Mellman & Beresin, 2003). While competency in psychodynamic psychotherapy requires that students learn a body of knowledge and technical skills, true competence requires something more. It has often been noted that the therapist’s “instrument” is his or her own self (Roth, 1987; Shershow & Savodnik, 1976). This idea—that that the person of the clinician is inseparable from technical effectiveness—suggests that specific qualities of the practitioner as a human being are crucial (Grinker, 1952/1994; Tischler, 1968).

Some aspects of the personal qualities required by all physicians are addressed in the medical education literature through the concept of professional identity. Professional identity includes an array of attitudes and values toward patients and the profession of medicine it-
self—attitudes and values that are explicitly and implicitly espoused, and that lead to changes in the student’s way of conceptualizing himself or herself (Fann, Hunt, & Schaad, 2003; Klagsbrun, 1967). In our own field, Louie, Roberts, and Coverdale (2007) emphasize that effective training in psychiatry requires formation of a professional identity, and they advocate fostering greater awareness and emphasis on this aspect of medical education. The concept of professional identity, however, is primarily a cognitive one that focuses on a set of beliefs and attitudes. The requisite qualities of a psychiatrist include such beliefs and attitudes, but these qualities also extend to the entire range of character (Grinker, 1952/1994). Character encompasses beliefs and values regarding the self and the profession, but it also includes temperament, motivation and aspiration, expectable affective states, affective responsiveness, relational inclinations and patterns, and mental and behavioral habits. Extending as far back as Aristotle, such socially desirable and optimal elements of character have been organized under the concept of “virtue” (MacIntyre, 1981).

Coulehan (2005) has made an eloquent case that professionalism should center around the virtues of the physician. He opposes approaches that assess professionalism based on compliance with externally established rules of behavior. Coulehan writes,

Ideally, conduct arises from aims, which, in turn, are conditioned by qualities. For young physicians to become more humane and effective healers, they must demonstrate professional conduct, which they are unlikely to do unless their education also explicitly nourishes motivation and virtue. My criticism of the professionalism movement is that, in the attempt to render professionalism more quantifiable, it may use skills and practices as a surrogate for virtue. (p. 893)

Radden and Sadler (2008) have described a virtues-based approach to conceptualizing clinical excellence and professionalism specific to psychiatrists. In their view, an approach to ethical medical practice based on principles falls short of describing the experience of physicians. They argue instead for a character ethics where the emphasis is placed on what kind of person the physician is, rather than on the physician’s overt actions. It is understood that ethical actions will follow from a character that is virtuous. Radden and Sadler write, “The contrast between prescriptions over particular actions and prescriptions about more holistic and enduring traits has been represented as something like: ‘Do thus and so’ rather than the virtue-focused ‘Be thus and so’” (p. 63). They contend that psychiatric virtues must extend beyond general medical virtues because psychiatric practice has a number of
distinctive aspects. These distinctive aspects include the extent of patient vulnerability; the varying subjective attitudes of patients towards their symptoms; the stigma of mental disorders; the chronicity of many conditions; the way that therapy typically extends beyond symptom resolution and effects changes that are central to the patient’s identity and personhood; and the therapeutic impact of the clinician’s own self on the course of the patient’s treatment. As a result, Radden and Sadler call for the cultivation of the following character traits: trustworthiness; propriety; empathy and compassion; warmth; self-knowledge and emotional intelligence; hopeful patience and perseverance; realism; respect for the patient; and “unselfing,” by which they mean the effacement of one’s personal interests.

In this article, we will focus specifically on the development of psychodynamic psychiatrists. Our aim here is the education of psychiatrists who not only are competent in performing outpatient psychodynamic psychotherapy, but who also know that work with all patients rests on a foundation of psychodynamic understanding. The psychodynamic psychiatrist’s work in the full range of psychiatric treatment settings is always infused with the sensibility, perspectives, and techniques that comprise psychodynamics. Gabbard (1994) has defined psychodynamic psychiatry as “an approach to diagnosis and treatment characterized by a way of thinking about both patient and clinician that includes unconscious conflict, deficits and distortions of intrapsychic structures, and internal object relations” (p. 5). We have found it useful to teach students that a psychodynamic approach means creating an experience where the patient can allow himself to tell you what he knows about his predicament, where he can be supported to tell you what he almost knows but keeps just out of awareness, and where together you can gather hints and clues about aspects of his inner life that neither of you can yet imagine. Psychodynamic interviewing conveys to the patient the clinician’s authentic interest in hearing about what truly matters, even though what matters may be painful for both participants to bear.

The specific task of educating psychodynamic psychiatrists can also be understood as a process of cultivating a set of virtues. As noted previously, the psychodynamic therapist must use his or her own person as the tool of therapeutic change. Bobrow (2007) has argued that psychoanalytic training must effect changes in the person of the clinician, resulting in “a way of being which the analyst lives with the patient…. a lived relationship with someone who has distilled the ‘teachings’ into a healing way of living that works for him or her, as a human being, a way of being human in the world, with himself or herself, and with others.” (p. 274) Bobrow’s view of psychoanalytic training can be applied to the training of all psychodynamic psychiatrists.
In the next section of this article, we attempt to define and describe a set of qualities of the psychiatrist that are specific and essential to becoming an effective psychodynamic psychiatrist—a set of psychodynamic virtues. Given the controversy that accompanies any attempt to define essential elements of psychodynamic psychotherapy, this attempt to define the needed traits of the practitioner is likely to be similarly generative of debate, and will be colored by the subjective biases (explicit and implicit) of the authors.

Psychodynamic Virtues

Empathy

Empathy is an essential virtue for physicians of all kinds. This fact is reflected in the formal expectations of medical school training and graduate medical education. For example, the guidelines of the Association of American Medical Colleges (AAMC) (1998) for medical school learning objectives state that “Physicians must be compassionate and empathetic in caring for patients” (p. 4). Although many definitions of empathy are available in the literature on medical education, most suggest that empathy includes both a cognitive component and an affective component (Halpern, 2003; Shapiro, 2002). The cognitive component involves being able to conceptualize the patient’s internal experience, while the affective component involves being able to resonate emotionally with the patient’s feelings. Radden and Sadler (2008) note that empathy is of particular importance for psychiatrists. Psychiatrists are often asked to remain in contact with painful affect for extended stretches of time. Rather than simply providing a context within which treatment can occur, the therapist’s ability to maintain contact with the patient’s feelings may, in itself, be the decisive therapeutic intervention.

However, maintaining empathy is hard! The patient’s feelings are often painful and may include hopelessness, anxiety, fear, sadness, grief, and anger. The patient may also have positive feelings, including hope, gratitude, compassion, and resolve. A psychodynamic perspective on empathy explicitly calls on the clinician to empathize with feelings that may be socially unacceptable or repellent to both the patient and the doctor. These include sadism, masochism, envy, contempt, greed, entitlement, arrogance, and vengefulness, among others (Schaffer, 1983). Poland (2008) has noted that courage is needed for the clinician to uphold the commitment to undirected exploration, even when this process leads to experience that is disturbing. The psychodynamic
perspective also asserts that feelings may be kept out of the patient’s conscious awareness, or only experienced intellectually. Feelings may be diverted into all manner of symptomatic and maladaptive behavior. Therefore, psychodynamic empathy calls for extending one’s empathy even to the patient’s resistance to self-awareness. Given that some of the patient’s most troubling affective experiences may seem to him or her intolerably cruel or ugly, it is understandable that most patients enter treatment with a profound ambivalence about making contact with these feelings. Psychodynamic empathy requires appreciating that the patient’s revulsion and withdrawal from such affect is no less authentic than the affect itself (Schafer, 1983).

**Neutrality and Affirmation**

The psychodynamic psychiatrist must approach every encounter with the patient with an attitude of radical acceptance and suspension of judgment. The clinician hears all of the patient’s communications without criticism. The clinician does not make judgments about morality or relevance. This attitude of acceptance, or neutrality, then allows for a relationship in which the therapist can respond to the totality of the patient with affirmation of the patient’s unique value. These qualities of acceptance, neutrality, and affirmation are necessary for any effective psychotherapy, regardless of the theoretical orientation (Frank & Frank, 1991; Rogers, 1980).

Anna Freud (1966) defined the neutral position of the therapist as “equidistant” from the id, ego, and superego. In recent decades, concern has been raised that this “equidistance” not be misinterpreted to imply a demeanor with the patient that is emotionally distant or aloof (J. Greenberg, 1991; Mitchell, 1993). In this vein, Poland (1975) noted, “neutrality can never mean indifference or disinterest; our underlying acceptance of the patient is vital” (p. 158). In our view, the neutral attitude is best thought of as the clinician striving to remain “equi-close” to every aspect and element of the patient’s internal landscape.

Neutrality and affirmation pose difficult challenges for residents. Physicians have been trained and acculturated to have “expert” opinions on matters of mental health and disease. Modifying this mindset to include an attitude of suspended judgment generally requires significant practice. Our patients appreciate that neutrality and affirmation should not be taken for granted—they may express skepticism early in treatment about whether the clinician’s nonjudgment and affirmation are authentic, as opposed to merely well-meaning acts. The difference
between an authentic acceptance and a forced or artificial version of acceptance requires flexibility in the internal world of the therapist.

Authentic acceptance is particularly hard to achieve regarding the patient’s more destructive or sadistic qualities. Vaillant (1992) suggests that clinicians remember that however terrifying the patient’s inner world may be, it often has its origins in developmental trauma. Schafer (1983) makes a similar point. By holding in one’s own mind the infantile danger situations and how they continue to terrorize the patient, the student clinician can begin to appreciate that current phenomena represent the patient’s best compromise, one that is often hard-won and ingenious in its complexity. Inviting the student to imagine the patient as living in dread of conflict or loss can be an invaluable step toward achievement of a neutral and affirmative mindset.

A Conviction That Meaning Lies Ahead

A psychodynamic psychiatrist operates from deep conviction that there is meaning to be found in the apparently meaningless, and that exploration is of the most profound value, even when this exploration seems unproductive or aimless. Psychodynamic exploration balances unfocused listening that refrains from privileging any particular content, and focused inquiry that follows when either clinician or patient becomes conscious of having stumbled across the trail of previously unappreciated connections. Both states of mind, although profoundly different, can be understood as rooted in the conviction that previously neglected or concealed meaning remains to be discovered, or created, in treatment. As Poland (2002) writes, “One can explore only if one believes that there is something of value yet to be found, that there is more yet to be learned” (p. 817).

In the development of psychoanalysis, Freud (1912/1958b) appreciated that the analyst must achieve a state of unfocused and unlimited receptivity and interest—what he described as “evenly suspended attention.” Freud wrote that “as soon as anyone deliberately concentrates his attention to a certain degree, he begins to select from the material before him…. In making the selection, if he follows his expectations he is in danger of never finding anything but what he already knows” (p. 111). In dialectic tension with this unfocused receptivity, the psychodynamic clinician also brings to the treatment an insatiable and searching curiosity, a pervasive interest in the details of people’s lives (Nersessian, 2000; Roth, 1987; Sharpe, 1930). This mode of thinking is focused
and logical, requiring therapists to immerse themselves in the details of the patient’s narrative so as to better see where the contradictions and omissions lie. How do our students learn to negotiate this tension between unfocused attention and focused curious inquiry? Again, learning the proper balance between these modes of listening is very difficult.

**Embrace of Complexity, Uncertainty, and Humility**

While the psychodynamic psychiatrist has a conviction that even the most apparently senseless communications will ultimately be found to be meaningful, he or she simultaneously resists closure or finality of meaning (Galatzer-Levy, 2001). The principle of overdetermination, in Schafer’s (1983) view, means not only that there are multiple causative factors for every psychic phenomena, but also that no level of explanation or causation should be seen as the “real meaning.” Instead, the therapist must maintain a consistent interest in “further meaning, weightier meaning, more disturbing meaning, more archaic meaning or more carefully disguised meaning.” (p. 8). It is typical for explorations of intimate relationships, for example, to lead to enriched perspectives on the myriad specific aspects of love, while also revealing the entwined presence of hate, resentment, and envy.

This complexity necessitates long periods of uncertainty for both clinician and patient, as both become aware of an ever expanding network of associated thoughts, memories, yearnings, fears, relational patterns, and affect. It may be a long time before clinician and patient can bring order to this network and to formulate the structure of connections (Gabbard, 1994). Schafer (1983) emphasizes the capacity to “tolerate ambiguity or incomplete closure over extended periods of time, accept alternative points of view of the world, and bear and contain the experiences of helplessness, confusion, and aloneness that not infrequently mark periods of analytic work” (p. 7). Faced with these circumstances, the psychodynamic psychiatrist develops a deep humility regarding his or her hypotheses, understanding, and interventions. Poland (2008) emphasizes the challenge in remaining “open to reexamining and questioning all principles previously cherished” (p. 559). Student clinicians who are educated in an environment that encourages knowing the answer quickly will find it difficult to embrace the uncertainty and humility required for psychodynamic psychotherapy.
Openness to Transference

Although transference—the displacement of thoughts and feelings from past relationships onto present ones—is probably ubiquitous in all therapeutic relationships, psychodynamic treatments are designed to foster the experience of relatively intense transference phenomena. Exploration of the transference to advance the goals of treatment is one of the distinguishing characteristics of psychodynamic treatments (Freud, 1912/1958a; Shedler, 2010). By allowing the transference to develop, conflicts can be brought to life and worked through in a rich, complex process that draws on affective and instinctual urgency (Freud, 1912/1958a; Loewald, 1960).

Before the recommendation for psychodynamic psychotherapy is made, patients are screened for their capacity to manage the complex task of allowing themselves to have strong reactions to their doctor, while simultaneously maintaining some capacity to question the accuracy and reality of these responses (Gabbard, 2008; Roth, 1987). It is not always easy for patients to bear this ambiguity; Friedman (2005) eloquently conveys the paradoxes involved in expecting patients to engage with us in a kind of “virtual reality.” Similarly, it can be difficult for residents to tolerate the patient’s transference reactions. These may include attributions—such as being seductive, withholding, patronizing, and sadistic—that are at odds with the clinician’s self-image or professional identity. Complicating the situation, the clinician generally contributes something in reality that serves as the hook on which the transference rests. This fact makes the task of recognizing and tolerating transference even harder for the student clinician, who must allow for the possibility that some unwanted truth about himself or herself is expressed in the transference. Finally, Sandler (1976) has described the “free floating responsiveness” required of the psychodynamic therapist, so that he or is available to be engaged by the patient in whatever role is required. The therapist must allow elements of his or her own unconscious to be activated in response to the specific needs of the role in which he or she has been cast (Bollas, 1983; Bromberg, 1995). The capacity to be made use of in this manner by the patient, while allowing for uncertainty regarding which elements of the transference are projection and which are drawn from within, constitutes an important virtue for the developing psychodynamic clinician. Self-knowledge, self-acceptance, and (again) flexibility on the part of the student clinician are required. Indeed, the demand to accept and tolerate the transferences of patients places a new and special burden on our students, who are young, inexperienced, and vulnerable themselves!
Restriction of Gratification

Gratification is an important and multifaceted subject in psychodynamic psychiatry and can be discussed at various levels. All psychiatrists must be cognizant of the ways in which they are compensated by their patients, as the special vulnerabilities of the psychiatrist-patient relationship increase the possibilities of even inadvertent exploitation. Psychiatrists confine their compensation to the payment of the patient’s fee; beyond that payment, the psychiatrist/physician is expected to set aside his or her own desires and focus only on the interests of the patient. And yet, one of the aspects of the psychiatric profession that is especially appealing to students is that psychiatrists have deep and lasting relationships with their patients. Furthermore, it is not unreasonable for students to anticipate that one of the rewards of their labors will be the grateful appreciation of the patient and his or her family.

In psychodynamic psychiatry, however, the clinician is asked to cultivate a relatively restricted range of acceptable gratifications. Psychodynamic psychiatrists understand that the patient’s appreciation is a complicated and ambiguous phenomenon. For example, the patient’s appreciation may serve to mask a resistance to deeper exploration; alternatively, the absence of appreciation may indicate that the patient is able to take more ownership of personal success and feel less dependent on the expertise of the therapist. A patient’s appreciation is also always seen in part as a transference manifestation that must be held up to the same scrutiny as all reactions to the clinician. Accordingly, the psychodynamic psychiatrist must cultivate the capacity to refrain from engaging in a set of gratifying experiences that are part of the routine pleasures of being a physician. Fortunately, as Gabbard (2000) has noted,

The patient’s gratitude is not the only source of the analyst’s gratification. Learning is a profoundly gratifying aspect of our work. Each patient is our teacher and the subject matter is endlessly fascinating. Moreover, a satisfying and hard-won gratification stems from establishing and maintaining a human connection through the slings and arrows of outrageous transference and countertransference. (p. 713)

However, even the satisfaction of a job well done becomes modified for a psychodynamic psychiatrist. Rather than enjoying experiences of cure or symptom relief, the clinician refocuses again and again on the quality of the therapeutic process, rather than on immediate results. Indeed, it is difficult for our students to believe us when we say that...
these complex and subtle forms of gratification await them if they refrain from indulging in the obvious and immediate. The gratifications that accompany the practice of psychodynamic psychiatry are real, but hard-won.

**HOW DO WE FOSTER PSYCHODYNAMIC VIRTUES IN PSYCHIATRIC RESIDENCY?**

Having described a set of virtues necessary for the psychodynamic clinician, we turn now to the question of how we might best foster the development of these virtues in our students. We will also consider the ways that we may unintentionally contribute to the failure of our students to develop virtue, or even to their becoming less virtuous! As with individuals, systems of training may have “blind spots” where unnoticed factors work at odds with espoused values. This has been well described in general medical education as a “hidden curriculum” at work (Hafferty, 1998). Kernberg (2000), writing about psychoanalytic institutes, observed that while institutes aim to produce greater maturity and flexibility in clinicians’ thought, they often foster regression and hierarchy. We will attempt to explicitly describe strategies and interventions that will promote the virtues that we espouse.

**Creating a Supportive and Generative Training Environment**

If we have succeeded in recruiting trainees with the appropriate potential, they will quite naturally develop many of the qualities described here, unless the stress of residency is more than they can successfully bear and integrate. William Greenberg (2004), toward the end of a successful tenure as a training director, defined the role as essentially “providing safe passage for the residents” (W. Greenberg, personal communication, 2004). As we know, empathy can become limited by fatigue. In this regard, we are fortunate to be training this generation of residents in an era of duty-hour limitations. In addition, recurrent frustrating experiences of feeling overwhelmed can lead to cynicism, which deadens the resident’s capacity for empathy and confidence in the value of understanding. Semrad (cited in Rako & Mazer, 2006).

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1. William Greenberg, M.D., was Director of Residency Training at Beth Israel Hospital in Boston from 1988 to 1994 and at Harvard Longwood Psychiatry Residency from 1994 to 2010.
1983) advised, “You need to help the resident keep working and not go through these periods of being as stymied as the patient. You have to help the resident not to go dead” (p. 187). Feeling insufficiently supported or alone during challenging clinical experiences can cause a degree of anxiety or a feeling of helplessness that is not optimal for growth, but instead leads to a defensive withdrawal and emotional deadening. It may be less important to have supervision present than for residents to know that supervision is not only available, but also appreciative of being called upon.

However, just as important as support is the maintenance of expectations that the resident will do the difficult work of acquiring the many virtues we have described. Loewald (1960) described the therapist’s task of engaging the patient at his or her current developmental level, while simultaneously holding in mind a vision of this same patient’s future self. This is a valuable model for training as well. It implies that educators expect ongoing professional maturation in the resident, even while accepting that the resident is still a work in progress. Residents will vary greatly in the amount of shame that accompanies their apprehension of the gap between their professional ideal and their current state. Educators must always employ a good deal of tact in helping trainees navigate this gap (Jacobs, David, & Meyer, 1995; Poland, 1975). Thoughtful and judicious disclosure and reflection on one’s own developmental stumbles can be valuable, as can direct expressions of confidence that the desired virtues are indeed achievable.

It is also important that residents feel empowered to address difficulties in the program itself, and to express complaints about their experience. The training program and the department are regularly presented with powerful opportunities to model openness to hearing about negative experience. As with communications from patients, complaints from residents may represent distortions that residents need help to work through. Other complaints represent painful truths about the program that demand a real response. In either case, the response of authority to apparent negativity can illustrate the virtues of empathy, suspension of judgment, embrace of complexity, humility, and the confinement of the supervisor’s gratification to the job well done.

Accordingly, when training programs endeavor to build a sense of community, the benefits extend beyond the residents’ quality of life and workplace satisfaction. The experience of being part of a community provides an overarching structure of containment and support that in-

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2. Elvin Semrad, M.D., was Clinical Director of the Massachusetts Mental Health Center from 1956 to 1976 and was a highly regarded teacher of psychotherapy.
directly nurtures many of the attitudes and qualities of character described here. The training program can foster this atmosphere of community through providing opportunities for group bonding among the residents and protecting this time (e.g., training groups, resident retreats, movie nights). At the same time, programs should empower residents to provide their own leadership and strategies for conflict resolution. Signs of a healthy resident community include spontaneous rallying of support for peers in crisis and the absence of obsessional tracking of patient loads, service hours, days on call, division of duties between faculty and residents, and so on. Instead, the group has a sense that all are “in this together” and one can see a fluid and generous system of workload sharing that is rooted in the confidence that reciprocity and mutuality are expected.

Role Modeling and Internalization

Psychiatry residents form strong identifications with their attending physicians and internalize professional attitudes, habits, and other aspects of character (Lim & Rohrbaugh, 2007; Louie et al, 2007). This inclination for identification may be accentuated in psychotherapy supervision, where the resident is actively learning how to use his or her whole person as the instrument of healing (Gabbard, 2005; Jacobs et al., 1995). The question, then, of “how to be” attains even greater urgency. In a qualitative study of the experience of residents in supervision, Tischler (1968) noted, “The resident regards supervision not only as an opportunity to learn how to do psychotherapy, but also as an experience where he can learn how to be a psychiatrist” (p. 418).

The supervisor has two kinds of opportunities to provide a model for emulation. First, he or she can demonstrate how to interact with a particular patient or how to approach a particular challenge in the clinical setting. For psychotherapy supervisors, this may occur through articulating how to listen to the patient’s associations and how to verbalize the constant flow of hypothesis formation and modification. In more acute settings such as the emergency service, inpatient units, or consult teams, the supervisor has the opportunity to interview patients and families in the presence of the resident, who will thus be provided with vivid scenes of exploration and intervention to draw upon (Lim & Rohrbaugh, 2007). For several years, one of us (A.B.) has taught a psychodynamic interview/case conference at our residents’ county jail rotation with the intention of illustrating the conviction that all patients have unexplored depths of meaning and that it is possible to establish
empathy even with those whose behavior seems alarming or reprehensible. Bowers (1999) has written thoughtfully about the values that are implicitly imparted in this way; he includes the sense of being privileged to do this work, the tolerance of ambiguity and uncertainty, the appreciation of narrative, and the balance of grace and humility with which we should face bad outcomes.

Second, in addition to demonstrating how they interact with patients, supervisors provide a very powerful and memorable model for identification by showing how they interact with the residents themselves. Residents are going through a time of tremendous flux in their personal and professional lives. On the positive side, they are consolidating a nascent professional identity and often are settling down with partners and beginning families of their own. On the more painful side, difficulties within romantic relationships and marriages are common, and pregnancy and childbirth can be as fraught with fear and disappointment as they are cause for celebration. Professionally, residents are just beginning to accumulate the positive outcomes that provide them with faith in their value as clinicians; a single bad outcome with a patient can shake them to the core. In each instance, faculty can demonstrate appreciation and affirmation of normal developmental stress and can model how to stay in contact with disturbing feelings. The experience of meeting with someone who makes space and time to engage with the resident’s deepest concerns generally makes a deeper and more lasting impression than the best intentioned and most articulately delivered supervisory advice.

Supervision also provides an opportunity to foster the resident’s capacity to find meaning in complex material. When the supervisor asks the trainee to articulate the possible connections and latent meanings in the content of an interview or therapy session, the supervisor shows confidence in the resident’s capacity for discerning meaning. The supervisor may model how to use such an approach to organize seemingly inchoate material, but he or she will soon also provide space for the trainee to exercise his or her own developing capacities. One of us (FK) recalls a valued supervisor’s frequent remark, “It seems like this is what you’re making of it [the patient’s communications] at this time” (J. Reichard, personal communication). Only over time did it become possible to appreciate the elegance of this simple comment. It demonstrated affirmation and acceptance—in this case the supervisor’s acceptance of the trainee’s perspective. And yet at the same time, it suggested to the supervisee that his attempts to bring clarity to confusing material might represent a preemptive closure of a complex area of meaning in the patient’s dynamics.
The experience of empathic supervisors during training leaves a profound and lasting impression on all residents. One of our teachers was known for his clinical aphorism, “Never worry alone”; importantly, this was accompanied by his real availability to worry with you (T. Gutheil, personal communications). Residents who feel safe enough to bring their fears and losses into a supervisor’s office can then receive the support needed for that particular incident or stressor. Even more valuable may be the internalization of a way of being with someone who welcomes painful feelings and who provides acceptance and containment of intense affect.

Helping the Resident Know His or Her Own Unconscious

Self-knowledge itself is a valuable trait for psychiatrists; it is also an important foundation for the development of a capacity for psychodynamic work in particular (Radden & Sadler, 2010). Early practitioners of psychoanalysis felt confident in the capacity of the process of psychotherapy itself to yield such self-knowledge. Freud (1912/1958b) wrote that the clinician’s own analysis would result in awareness “of those complexes of his own which would be apt to interfere with his grasp of what the patient tells him” (p. 116). Contemporary perspectives are somewhat more modest in aspiration. Gabbard (2005), for example, hopes that we will succeed in promoting “curiosity and reflectiveness about oneself in the resident” (p. 337).

The development of self-knowledge can be a particularly thorny challenge when the trainee’s deepest motivations to become a psychodynamic psychiatrist are rooted in the wish to remain unaware of disturbing psychic material. Sharpe (1930) suggested that it is not unusual for a career in medicine to be rooted in early experiences of anxious vulnerability. Sharpe proposed that when a clinician is threatened with anxiety from personal unconscious sadism, it may be especially reassuring to assume the role of the one who is an expert in what others are thinking. This reversal is a defensive compromise that can be professionally adaptive, yet may prove inadequate when the beginning clinician is asked to weather the intensity of a psychotic or borderline patient’s murderous affect. Therefore, Sharpe recommended that the resident be encouraged to expand insight into his or her own unconscious, writing that “the more that deep level (of infantile sadism and consequent anxiety) is brought to consciousness … the more we can seek for real and not phantastic assurances (and) the more we can tolerate the affects of others” (p. 259).
Some have advocated that the supervisor be alert to instances where the resident’s lack of self-awareness is impacting his or her work and to explore this in the supervision. When defending against disturbing affects, psychiatry residents may manifest any of the typical modes of resistance that a relatively high-functioning patient would demonstrate in psychotherapy. For example, overidentification with the patient may result in reluctance to notice more subtle manifestations of psychopathology, which can be minimized or rationalized away. In their classic work on education in psychotherapy, Ekstein and Wallerstein (1958) call such difficulties “problems of learning” and advocate for the supervisor’s active role in bringing these to the resident’s attention and attempting to elucidate them. Jacobs et al. (1995), in their discussion of supervision in psychodynamic therapy, describe the complexity involved in defining the border between supervisory and therapeutic interventions. Given that supervision must address the trainee’s capacity to bear painful affect and to make sense of personal countertransference, it is difficult to prescribe what is appropriate content and what crosses the line into treatment. Frawley-O’Dea and Sarnat (2001), writing from a relational perspective, suggest that the line between “teaching and treating” is inevitably blurred and must be uniquely and mutually constructed in each supervisory relationship. Alternatively, numerous authors have recommended that personal psychotherapy during residency training is the appropriate venue for such growth (e.g., Brenner, 2006). Habl, Mintz, and Bailey (2010) surveyed psychiatry residency directors and found that the overwhelming majority of respondents felt that personal therapy was helpful in developing the ability to manage emotional reactions to patients, in developing empathy, and in forging a professional identity.

CONCLUSION

Competence as a psychodynamic psychiatrist requires more than the acquisition of a body of theoretical knowledge and a set of technical skills, although these are of course essential. It also calls for the development or acquisition of a set of virtues—attitudes of mind and heart that generate habitual responses—that are embedded in the character and person of the developing resident. These psychodynamic virtues include a subtle and demanding type of empathy, an attitude of acceptance and affirmation, a curiosity and confidence regarding underlying meaning, humility in the face of uncertainty and ambiguity, an openness to immersion in transference, and satisfaction in a restricted range
of potential gratifications. Residency programs attempt to screen for the potential for these qualities during the application process. However, residency programs must also work explicitly to foster the development of these qualities during training. The creation of a supporting yet aspirational environment, internalization of supervisory role models, and the encouragement/opportunity to learn about their own inner worlds are some of the potential avenues through which we can help residents to acquire virtue, and thereby to achieve their potential as psychodynamic psychiatrists.

REFERENCES


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