Psychotherapy education and the learning of therapeutic skills play a central role in the training of psychiatric residents. It is well recognized that such training provides residents with a core set of skills essential to the psychiatrist’s identity (1). As a junior resident, I find psychotherapy the most fascinating and rewarding part of my psychiatric training.

Psychotherapy training in the Queen’s University Department of Psychiatry adheres as far as possible to the Canadian Medical Education Directions for Specialists (CanMEDS) guidelines. We have didactic lectures on different theories of therapy and techniques, which include training residents to better understand doctor–patient relationships, providing a learning experience in ethics and boundary maintenance and encouraging a comprehensive understanding of each patient leading to formulation of a treatment plan from a biopsychosocial perspective. These objectives are outlined in the recently published Queen’s psychotherapy resident handbook (1).

Didactic teaching for PGY3 to PGY5 residents consists of three 30-hour blocks (A, B and C) and is taught in the form of weekly seminars. Block A is devoted to psychodynamic psychotherapy, including drive, ego, object relation and self-psychology as well as brief dynamic psychotherapy. Block B covers cognitive-behavioural therapy (CBT) and interpersonal therapy, and block C gives and overview of group therapy, marital and family therapy, as well as child and adolescent therapy, including normal development.

The clinical skills of psychotherapy training take place during the PGY2 to PGY5 years. It is mandatory, and residents are expected to develop both a basic level of proficiency in all modalities of psychotherapy and competency in at least one. Each resident has a minimum of two hours of patient-therapy time and one hour of supervision weekly.

One of the reasons for writing this article was the inspiring book, Myths of Childhood, by Dr. Joel Paris, which summarized and reviewed the empirical research in contemporary developmental psychology and behaviour genetics over the last few years (2). This research either contradicts or frankly disconfirms the basic principles of psychoanalytically oriented theories: intrapsychic conflict, primacy of childhood and epigenesis. As a junior resident, I found the contents of this book very thought-provoking; however, it also led to a conundrum for me. On one hand, I had always been steeped in dynamic psychotherapy as a major part of my residency education; on the other, there is an increasing emphasis on practising psychiatry in an evidence-based model. I decided to try to resolve this conundrum by sharing my thoughts with other residents who might share my concern.

Even though psychoanalytic theory has a long history and continues to influence the practice of many therapists, it is time to critically appraise these ideas. This is particularly important now, when empirical research examining the main principles of psychoanalytically oriented psychotherapies is available. In an adaptation from the article entitled “Future of Psychoanalysis Put on the Couch,” Dr. Erik Gann suggests that the future of psychoanalysis is “not going to be in treatment per se, but in the extension of psychoanalytic thinking into 21st-century culture” (3). If this is so, then “Why should APA remain interested in (psycho)analysis, and more so than in musicology or particle physics or other areas of cultural inquiry relevant to new millennium?” ask Dr. D. Brody and Dr. M. Serby in a letter to the editor of the Psychiatric News (4).

Although some therapists claim dynamic therapies are the best treatment modalities to establish deep and empathetic therapeutic relationships and to provide better understanding of patients, there seems to be little evidence to support this assertion. The existing literature shows that the depth of understanding of our patients’ problems and the quality of the therapeutic relationship do not depend on theoretical orientation of the therapist alone. Understanding our patients depends on nonspecific factors, such as a strong therapeutic alliance, empathy, a nonjudgmental attitude, a healing environment, a problem-solving approach and a genuine interest in patient problems by the therapist (2,5).

Various theories describe causes of psychopathology and the appropriate therapies from very different, and at times contradictory, perspectives. For example, Kernberg’s approach is more confrontational (7), whereas Kohut’s self-psychology advocates an empathic approach (8). It is assumed that both approaches will facilitate a strengthening and development of personality and hence a stronger
sense of self or identity. However, the latter is disputed by current evidence, which does not show that long-term dynamic weekly therapy leads to a core personality change (2,5,6). Thus, I am at a loss to reconcile why CBT, for example, should be viewed by some psychoanalytically oriented therapists as less effective because it deals with symptoms rather than changing the underlying personality. How do we as residents navigate this endless array of theories, models and techniques to come up with the best management for an individual patient?

Perhaps some techniques work better for particular psychiatric problems; in a recently published book, J.W. Livesley states that

Most theories have minimal empirical support, and there is no evidence that one approach is better than another. There is, however, evidence showing that some interventions are effective for some problems (5).

He describes an eclectic approach to psychotherapy that applies interventions on the basis of what is proven to work, presents a rational analysis of what techniques are needed to provide the best care and shows that this approach will ensure flexible and individualized treatment for patients. Even though many psychoanalytically based principles have been disconfirmed, Dr. Livesley incorporates dynamic, mostly interpersonal elements in an eclectic approach, which allows therapists to better understand some contributing and perpetuating factors in the development of patients’ problems. He examines diverse treatment perspectives, including psychodynamic, cognitive-behavioural, interpersonal and biological approaches, analyzing how each might contribute to addressing different features of an illness, based on empirical research (5).

The practical component of psychotherapy training includes integrative psychotherapy experience. However, there is no didactic teaching on the integrative or eclectic approach, assuming that the therapist should use his or her intuition and personal clinical experience to use one or another therapeutic technique, depending on a situation. For trainees with very limited experience, it is a daunting task to combine different theoretical perspectives to come up with the best-suited intervention for an individual patient.

As physicians, we have a responsibility to provide the best possible care to our patients. Thus, evidence-based psychotherapy, or psychotherapy based on theory consistent with or validated by sound empirical research and specifically including outcome studies, needs to be considered a priority in psychotherapy teaching for psychiatry residents.

In conclusion, we need to incorporate the various schools of psychodynamic thought into our training and critically appraise them to better understand the benefits and limitations of the therapies based on these theories. Formal teaching in eclectic therapy is also much needed, as it is perhaps the only approach that provides flexibility and ability to address complex and multifaceted problems with which our patients present. The inclusion of evidence-based texts, such as those mentioned in this article, in a psychotherapy-training resident handbook reading list will lead not only to better understanding and critical appraisal of psychotherapeutic practice but also to better-informed treatment decisions.

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References

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