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This Issue

Introduction

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Participation as a patient in individual psychotherapy is often cited as an important aspect of psychiatry residency training. In this issue, we take a closer and more personal look at the perspectives and experiences of residents in psychotherapy. The first article examines the extent to which psychiatry residents seek psychotherapy while in training, their reasons for doing so, and how these trends may have changed over time. Two personal essays written by residents about their own experiences in psychotherapy are also featured. I hope you will agree that their narratives make a compelling case for why personal psychotherapy continues to be a central force in our development, not only as psychiatrists but as healthier individuals.

Residents in Psychotherapy: Where Have All the Hours Gone?

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Competence in psychotherapy is among the more difficult skills psychiatry residents must acquire during their training. While the groundwork for this may begin in the classroom or with a textbook, mastery is only achieved through the experience of being a psychotherapist. But how do residents make the transition from playing the role of psychotherapist to being competent and confident in their abilities?

In other fields of medicine, trainees learn by observing experienced doctors at work, by being observed as they perform an activity, and by receiving feedback on their performance. But for many reasons—e.g., the intimacy of the work, the multitude of acceptable strategies, the protracted treatment—psychotherapy is often a poor fit for this model. To approximate the approach, many residents audiotape therapy sessions and share them with their supervisors, while others choose to summarize and discuss what they identify as important issues from each session. Unfortunately, residents rarely have the opportunity to observe seasoned psychotherapists doing therapy. And when they do, it is usually only for a few sessions.

Historically, another way for residents to learn psychotherapy was to enter into their own treatment. Besides the benefit of directly observing a psychotherapist, residents could learn what it was like to be a patient, develop a deeper empathy for those they treated, and hone their therapeutic skills. In their own individual therapy, residents can also develop a better sense of themselves and address issues that will affect their professional and personal lives (1).

At one time, personal psychotherapy was all but required of residents in training (2). Today, few programs, apart from those with a strong psychoanalytic or psychodynamic focus (3), mandate that trainees enter psychotherapy (4). Instead, residents are left to decide for themselves whether to enter psychotherapy and, if so, what kind of psychotherapist to see as well as the duration of the therapy. Not surprisingly, though, the residents of programs in which psychotherapy is encouraged or supported report higher participation rates (3, 5).

The current research suggests that fewer residents are choosing to enter their own therapy, relative to past years (3, 4, 6-8). Likely explanations include the decreased emphasis on psychodynamic training, robust development of pharmacologic treatments, and costs of being in therapy (4).

Still, residents of a substantial percentage continue to enter their own psychotherapy, although perhaps for different reasons than in the past. In a survey of residents from three training programs (3), psychotherapy participation rates ranged from 6% to 60%. Among those residents in psychotherapy, 78% cited personal reasons as their motivation. Another survey (5) reported that among postgraduate II, III, and IV residents in Manhattan, 56% indicated that they were in psychotherapy. Of these, 60% stated "personal issues" as their primary motivation; 22% reported "educational value;" and 18% reported both personal issues and educational value. Irrespective of initial motivation, residents in both studies reported that being in psychotherapy had a positive influence on their training and professional development.

The reality that large numbers of residents seek psychotherapy because they identify it as potentially helpful in their personal lives is, at once, reassuring and sobering. It suggests that despite the greater emphasis on biological treatments, many residents recognize the benefits that psychotherapy offers. It also serves as a reminder of the many stresses residents face while in training (9-12).

Dr. Christopher is a fourth-year resident and the Editor for this issue.

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The Making of A Good Therapist: One Resident's Perspective

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"As a resident, I sometimes worry about my innate talent to be a therapist."

In *The Unbearable Lightness of Being*, Milan Kundera (1) describes how physicians are defined by a curiosity to know all there is about the human condition, something that goes deeper than talent or skill. To some extent, this is true and not true for psychiatry. It takes a certain finesse to be a psychiatrist, which cannot always be learned and is not completely accounted for by "curiosity." To varying extents, all physicians have to work at it, but there is something about a good therapist that appears to be innate. It's difficult to define. "You either have it or you don't" is what has been explained to me many times by experienced therapists.

Without this idealistic view of a therapist, I might not feel so challenged on a daily basis in my work. A lot of this comes from my own forays into therapy. As a neurotically introspective individual, I view therapy less as treatment and more as lifeblood.

Over the past 10 years, I've been in some sort of talk therapy or another. Even during breaks when I wasn't seeing a therapist, I had discussions with friends as well as journals, writings, and poems to be later unearthed. Once, I went for 3 years without talking to a therapist. Those years were the easiest for me emotionally because I wasn't reflecting on a whole lot. It was the aftermath that was a little more involved. It was during this period when I discovered that an "unwatched" pot does boil.

I have cried in therapy and laughed in therapy and been attracted to, frightened of, and disparaged by my therapists. I have never felt that one was like a mother or father figure, though. I don't always leave therapy feeling well, and it annoys me when people teach that therapy always brings about relief and "your patients should leave sessions feeling good." I've had as many easy sessions as hard, and some of the best therapy sessions left me feeling awful.

My first therapist was a graduate student in psychology. I was a sophomore in college and had just transferred from one small school near my home to a larger one in the city. The dormitory I lived in was specifically for transfer students. I wouldn't be surprised if a lot of us were in therapy that year.

What I remember most about my therapist, "Cindy," was that she never made eye contact. To this day, I still don't know why. Was she testing some new method in managing countertransference? Or was she just too nervous to meet my eyes? Nonetheless, together Cindy and I made some headway into my dysphoria, sorting out some of my difficulties in assimilating to a new school and city. My tendency is to ruminate. Cindy helped me turn some of those ruminations into self-reflection. By the end, I didn't even notice that she never did look me straight in the eye.

My least effective therapist never played by the rules. I saw her very briefly in medical school, during my second year. Somewhat scatterbrained, "Susan" was constantly putting on makeup, eating her lunch during our therapy sessions, and giving me unsolicited advice. Even so, I learned how to express myself during one of the least creatively stimulating times of my life. In many ways, medical school deadened the artistic energy I had taken so many years to cultivate in high school and college. Thank goodness that is over. And I made it through partly because of Susan. For what it is worth, I owe her a hand.

The therapist I see now, "Audrey," works within a circle of practitioners in my town. I rarely run into her outside of our sessions, although our town is small. But her influence quite often works its way into the therapy sessions I have with my own patients. For example, when I'm at a loss for words, I'll use Audrey's. Sometimes it works. Other times it is a non-sequitur, a deviation from my natural response that distracts both me and my patient. It takes an effort to suppress Audrey's voice from overshadowing my own therapy voice, especially if I'm feeling tired or uncertain.

In conclusion, it is important to note that all of my therapists have played a role in who I am today: still neurotic but more appreciative of it and always self-aware. In the future, I'm likely to feel as comfortable sitting in front of the couch as I have on it in the past.

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http://ajp.psychiatryonline.org/misc/Residents_Journal.dtl

Manifest Similarities: More Than Skin Deep

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"The trouble with people is not that they don't know, but that they know so much that ain't so." –H.W. Shaw

I'm on my third interview and it's only been 2 hours.

It is another busy call day during my month of nights. For now though, time has slowed. I am sitting across from Dr. P. She is a second-year surgery resident who was brought in by a friend because of a comment she had made during an argument.

"So what's been going on?" I ask.

"It's been hard for a while now." She looks away toward the frosted window of the interview room. I imagine she is looking for a way out. I stay quiet. Her tears are welling. She is finally forced to blink, and the tears roll down. She takes a deep breath and sits back in her chair utterly defeated. "I've been practicing what I'd do in my head….I'd go out into the woods and take a bunch of pills. Then I would numb my wrists and I'd take a scalpel and I'd cut down to my radial artery…." Her eyes meet mine. They are expressionless, blank behind the veil of tears; her voice is barely audible: "I'd make sure I wasn't coming back." Slowly, she looks back down at her hands folded in her lap. She is still, save for her right thumb picking at her left cuticle.

The silence between us lengthens. "It must be so painful to feel that way, that…." I fumble for the word, "desperate." She looks up at me; she is listening. "To feel that it is impossible to get up out of bed, to carry on with everyday, to live."

Something in my words strikes a chord. There is a resonance between us, and I feel exposed. I've said nothing profound or revealing, but to me the self-disclosure is apparent. She shifts slightly in her chair and with some effort leans toward me. Her gaze is penetrating. I fight not to shrink from it. I am an impostor, and she has seen through me to the truth. Any action now would be an admission, acquiescence that the similarities between us do not end with our gender and training: that we both suffer from major depression. The difference between us is only a matter of degrees.

Most people who meet me would say that I am cheerful to a fault, outgoing, and carefree; however, I have been in treatment for major depressive disorder since January 2007. The course of my illness likely precedes this diagnosis. I started with months of cognitive behavioral therapy, was transitioned to schema treatment, and have been referred for medication management. Until recently, the true extent to which I have been impaired at any one time has only been known to me and to my therapist.

At first, I believed myself to be clever. Sure I was a few minutes late here and there. But whatever it was that I had to handle, I left it at home. I couldn't get up to be at work on time everyday to save my life, but I always made sure to use a cold compress on both eyes to get rid of the swelling. I had been spending my daily commutes to work ruminating, but by blasting music on my car radio and singing loudly, I could drown out the thoughts. Once I was at the hospital, the symptoms would slowly fade, and by midday, I would feel normal. On the days it was hard to focus, I used the mantra "I'll think about it later." Gradually, I repeated it less and less, and there were fewer and fewer days I needed it.

In the back of my mind, there was a nagging suspicion that it was all pretend—that I would be unmasked and seen for what I was: a charlatan. But then I would examine the evidence: I cared about my patients. My patients got better. I got the work done. I took comfort in the fact that at least I could do my job. Soon the days I needed compresses dwindled and that doubt began to subside. There was no way anyone could know I was depressed. I just didn't fit the mold.

What I believed to be working for me, and what ultimately did me harm, was the stereotyped idea of depression. All psychiatric diagnoses are essentially stereotypes (by its strictest definition): a formulaic conception or image of what it means to have a particular disorder. Of course our stereotypes are different than those of popular media; ours are based on evidence. People who are depressed tend to have poor appetites, have little energy, and are fatigued. They wake in the early morning hours and can't get back to sleep. Depending upon the severity of illness, they may even appear disheveled or poorly groomed. They isolate themselves, stay at home, and hide under their blankets. They are despondent. Tearfully, they speak softly and slowly about hopelessness, worthlessness, guilt, and sometimes suicide. Often, this is what we see, but the same can be said for any stereotype. They have to come from somewhere. However, we miss a great deal when we mistake stereotypes for reality.

What I didn't realize was that my lack of adherence to this construct was really beside the point; there was something about my manner that just wasn't right. Even though no one could give me specifics (besides my lateness), attendings noted there was something wrong with me. Suddenly, I found myself under a microscope. The lateness was now under strict surveillance. All I had to do was come in on time, but it seemed even harder. More and more, things became increasingly difficult. Basic responsibilities (going to lecture, remembering supervision, finishing notes) were now proving to be monumental challenges. As the details were enumerated, they grew in number.

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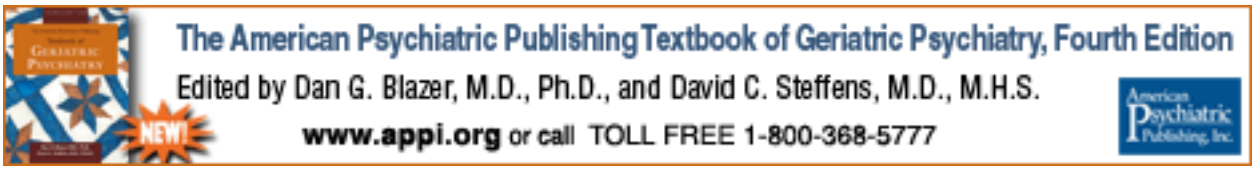
The truth is I was dissolving into a role. I was becoming the "delinquent resident." A well-groomed, smiling person is not depressed. A well-groomed, smiling person who cannot get to work on time is unprofessional. A well-groomed, smiling person who starts to miss meetings and lectures is irresponsible. A well-groomed, smiling person who cannot get her notes done in a timely manner is not fit to practice. The depression insinuated itself into all aspects of my life and gained ground. Depression was no longer a problem I was having. I was the problem. That suspicion, the specter that haunted the back halls of my mind, was real, had been real, continues to be real. It's not the depression; I've been incompetent all along.

That is where my struggle lies, where my roles as doctor and as patient continue to clash. While the depression is a dark cloud capable of blinding me to my own condition, it is a gateway to understanding the individuals I treat. Knowing patterns delineated by DSM-IV, being able to put a name to the disorder from which patients suffer, while important for treatment, often says little about their quotidian existence.

As I sit across from Dr. P, I feel her eyes on my skin, my safe veneer of "doctor" stripped away, flesh exposed, nerve endings raw and tender. I hope that my face remains expressionless, yet empathetic. I try not to move, breathe, speak, fearing that anything more would only further reveal my weakness. As my anxiety mounts, it occurs to me that she too has experienced this doubt, this vulnerability, perhaps even now. We look at each other for what seems like an eternity, when, finally, she breaks the silence: "What should I do?" Her eyes are now pleading, hoping against hope I have the answer. With that, the balance is restored. My secret is safe, and I do my job.



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Since 1971, the Committee has represented resident opinions and issues within the Association and has established effective and meaningful liaisons with many components of APA, as well as with many other organizations that are involved in training and the profession.

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