The RRC Mandate for Residency Programs to Demonstrate Psychodynamic Psychotherapy Competency Among Residents: A Debate

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Allan Tasman, M.D.

Objective: The Residency Review Committee (RRC) requirement that residents must achieve competency in psychodynamic psychotherapy has generated considerable deliberation.

Methods: The authors debated this subject at the 2004 American Psychiatric Association (APA) meetings.

Results: Arguments favoring current requirements emphasize the importance of psychodynamic psychotherapy for psychiatric training and practice, as essential skill and as part of core psychiatric identity. Opposing arguments, while supporting training in basic psychotherapeutic skills, focus on what some consider a skimpy evidence base, competing time requirements, changing practice patterns of psychiatry, and challenges to reliably and validly demonstrating this competency.

Conclusion: RRC decisions regarding current psychotherapy competency requirements will appreciably shape future psychiatric residency training.


T he Accreditation Council for Graduate Medical Education (ACGME) has embarked on an outcomes project requiring programs to attend to the development of specific competencies and to use information derived from ongoing assessment of these competencies to continuously improve educational processes and the capabilities of program graduates. In 1999, the ACGME endorsed a plan requiring all residency programs, regardless of specialty, to assess residents for general competencies in six core areas: patient care, medical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. Starting in 2001, the Residency Review Committee (RRC) for Psychiatry added specific requirements, as follows, in section VI.B.2, which focuses on “Internal Evaluation”:

The program must demonstrate that residents have achieved competency in at least the following forms of treatment: a. brief therapy; b. cognitive behavior therapy; c. combined psychotherapy and psychopharmacology; d. psychodynamic therapy; and e. supportive therapy. (1)

These well-intentioned requirements have generated considerable controversy in the field. Regardless of how favorably or unfavorably individual departments and training directors perceive these requirements to be, the requirements have forced substantial local discussion and variable efforts at implementation. Some psychiatric leaders have questioned the wisdom of these requirements, particularly regarding those psychotherapies for which relatively weak evidence-based research support now exists. Background information regarding the requirements and the attendant disputes were published in a special issue of Academic Psychiatry in 2003 (vol. 27, no. 3). Recognizing the controversies surrounding current recommendations, the APA Scientific Program Committee invited the authors...
to engage in formal debate at the May 2004 annual meet-
ing, in New York City, which was framed around this is-

First Arguments Favoring Maintaining the
Current RRC Requirements as Written:
Lisa Mellman, M.D

Residents should be trained to competency in psycho-
dynamic psychotherapy (1, 2). It provides a unique model
of mental functioning that includes five key concepts,
namely: 1) unconscious mental processes; 2) transference;
3) countertransference; 4) defense and resistance; 5) the
past repeating itself in the present (3–5). In contrast, my
opponents support a world in which psychodynamic psy-
chotherapy is not taught to residents or is poorly taught
and not learned.

What would residency training be like without psycho-
dynamic psychotherapy competency? First let us look at
the concept of the unconscious. Without an understanding
of the unconscious, residents might just accept whatever
patients tell them at face value. For example, a resident
untrained in psychodynamic psychotherapy might simply
accept that a patient “forgot” to call his boss on a sick day,
resulting in his being fired, and might focus on strategies
for remembering to do things, such as using post-its. But
such a resident might not know to help the patient consider
other reasons for forgetting that he was not aware of, such
as not liking his job, or his boss, or being angry that he did
not get the raise he requested. Residents would not con-
sider that their patients, and even they themselves, are in-
fluenced by motivations they are not aware of, such as un-
conscious guilt or competitive strivings. They would not
even realize that they themselves have unconscious feel-
ings toward their patients.

Second, what about transference? Without the concept
of transference, residents would not even know they are
being idealized. They would believe that the patient thinks
they’re great because they’re really great. What a danger-
ous power trip! They would not fully understand that the
intensity of early life relationships is carried into the ther-
apeutic relationship. Or they would not see it coming when
the abused patient experiences them as abusive too. Trans-
ference is a powerful concept that surprises even the most
skilled beginning therapists. What disservice it would be to
train residents without asking them to experience first
hand the importance and intensity of transference from
their patients toward them, and to be able to learn about
it in supervision. Furthermore, should not residents learn
that patients still have transference to them as pharma-
cologists? That patients have transference to the medica-
tions residents prescribe? That these transferences influ-
ence whether they take the medication? Residents need to
learn about transference in an ongoing therapy before they
will be able to see it elsewhere (6).

Third, countertransference. Do you not think it is a good
thing for residents to know why they keep forgetting to call
that one patient back? Or to even recognize that when the
patient talks about anger, they, the therapist, changes the
subject? Psychiatrists must tolerate many affects of their
patients but also so many of their own. Residents who do
not learn that countertransference provides a window into
understanding the patient, and that it helps therapists
know their blind spots, will try to squelch these reactions
rather than become curious about them. Psychodynamic
psychotherapy teaching gives residents ways to turn in-
tense and painful experiences into data that can be ob-
served and understood.

Fourth, defenses and resistances are ubiquitous in all of
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Or they would not see it coming when the abused patient experiences them as abusive too. Transference is a powerful concept that surprises even the most skilled beginning therapists. What disservice it would be to train residents without asking them to experience first hand the importance and intensity of transference from their patients toward them, and to be able to learn about it in supervision. Furthermore, should not residents learn that patients still have transference to them as pharmacologists? That patients have transference to the medications residents prescribe? That these transferences influence whether they take the medication? Residents need to learn about transference in an ongoing therapy before they will be able to see it elsewhere (6).

Third, countertransference. Do you not think it is a good thing for residents to know why they keep forgetting to call that one patient back? Or to even recognize that when the patient talks about anger, they, the therapist, changes the subject? Psychiatrists must tolerate many affects of their patients but also so many of their own. Residents who do not learn that countertransference provides a window into understanding the patient, and that it helps therapists know their blind spots, will try to squelch these reactions rather than become curious about them. Psychodynamic psychotherapy teaching gives residents ways to turn intense and painful experiences into data that can be observed and understood.

Fourth, defenses and resistances are ubiquitous in all of us, including patients and therapists. They protect us from discomfort, yet reveal information about affects and desires. Should not a resident know that when the patient complains that the room is too cold, the patient may be using displacement to avoid saying he thinks the resident
acts coldly? Should not a resident be curious to understand why that exasperating subway makes the patient late most sessions, as though the patient has no control over being late? Without the concept of defense and resistance, our residents will not appreciate how desperately we all try to hide the truth from ourselves. Nor will they appreciate the substantial changes that a patient can make from learning to identify and explore defenses and the affects and object relationship patterns they defend against.

Fifth, the past repeats itself in the present. This concept, recently borrowed from the psychodynamic tradition by Schema therapy, a long-term form of cognitive behavior therapy, emphasizes exploring past relationships and finding patterns that are repeated in one’s current life (7). Why does Ms. Poe continue to fall for men who are losers? It is frustrating for residents to learn that patients can stay entrenched for a long time in maladaptive relationships and patterns of behavior. And it is incredibly gratifying to residents to work with patients long enough to see these patterns change. I believe residents need to be trained in psychodynamic therapy to really understand the pervasiveness and stickiness of this concept that Freud called the repetition compulsion.

My opponents will argue today that psychodynamic psychotherapy lacks evidence for efficacy and effectiveness. Dr. Tasman will debunk this myth. There is evidence, and it is growing.

My opponents may also say that psychodynamic therapy is too hard to teach and that competency is too difficult to measure. They may say that competency in psychodynamic psychotherapy is a postresidency competency, that there is not enough time to teach it in residency, that programs lack the resources (2).

Let me address the following points:

1. Psychodynamic psychotherapy is too hard to teach. Yes, teaching psychodynamic therapy requires didactic teachers, suitable patients and trained supervisors (8). We know that residents learn psychodynamic psychotherapy in those programs that are considered to be the best programs nationally. This requires commitment from the department to use resources to develop a sufficient teaching program (9).

2. Let us discuss competency. According to the ACGME, competency is a level of skill midway between beginner and master (10). What is psychotherapy competency at the point of graduation from psychiatry residency? Competency at graduation should minimally include that residency graduates be capable of conducting psychotherapy but that they be expected to grow in knowledge and proficiency with further education, practice and supervision (3) and that they be able to utilize the concepts I mentioned earlier—unconscious, transference, defense, countertransference in a treatment—to recognize them when they appear and be able to further explore them.

3. Why should we train to a level of competency? Without a standard of competency the field will set the bar only at the level of skill acquisition that programs can already achieve. In some, that would mean having no patients at all in psychodynamic therapy. The competency movement has forced the education field to rethink its goals and to shift from a cafeteria model of Food Sampling to a model of Food Metabolism. Now we need to measure how the resident has actually metabolized the course or rotation and measure what they have actually digested. Standards and accountability are good for our field. Already, training directors are evaluating where they have set the bar, and where it should be reset.

4. Let us now discuss measuring competency. This is a complex issue since there is no gold standard (11). We must appreciate that the field hasn’t yet established how to set and evaluate competency in psychopharmacology either. However, several methods for evaluating competency in psychotherapy include supervisor evaluations assessing psychodynamic therapy competencies, case write-ups reviewed for understanding of process and technique, oral presentations at seminars where attitudes can especially be gleaned, the Columbia Psychodynamic Psychotherapy Test, video and audio tapes (12), and assessment of process notes (13, 14).

Teaching psychodynamic psychotherapy to competency is psychiatry’s “no child left behind” policy. What is the alternative? Not teaching psychodynamic therapy or not teaching it to competency? No program, and no resident, should be left behind.

First Arguments Opposed to Maintaining the Current RRC Requirements as Written: Eugene Rubin, M.D., Ph.D

The topic of this debate is whether our field should continue the requirement that psychiatry residency training programs demonstrate that residents have achieved competency in psychodynamic psychotherapy. I want to make clear that both Dr. Yager and I strongly believe that it is important that residents receive psychotherapy training and psychotherapy experience. We also support residents receiving didactics and experience dealing with psychodynamic concepts. This debate deals with the issue of ele-
vating psychodynamic psychotherapy to a special level of distinction by creating a separate competency requirement for this technique.

Our position is that a competency requirement in psychodynamic psychotherapy is not in our field’s best interest. This opening statement will revolve around two basic themes. The first deals with flexibility—flexibility to incorporate new, rapidly accumulating, clinically relevant knowledge and flexibility to teach our residents the tools necessary for lifelong learning. Developing true competency in psychodynamic psychotherapy is time consuming, and any individual treatment modality would need strong evidence-based support to justify this expenditure of time. Time devoted to one area detracts from time spent in other areas. We need to ensure that residency programs maintain the flexibility to teach residents the knowledge necessary to follow future advances (15).

The second theme deals with issues of credibility. How credible do we appear if we are spending a large amount of time on a specific treatment modality, psychodynamic psychotherapy, that has limited evidence of support? Let me repeat: we strongly feel that residents should understand and be comfortable administering psychotherapies to their patients. We must be aware, however, that there are an increasing number of evidence-based, effective psychotherapies, and residents are not going to have time to become competent in each. Rather, it is important for residents to learn the common elements underlying all psychotherapies and to understand the process of psychotherapy by having in-depth experience in one or more evidence-based therapies. In-depth experience is different from true competency, however. In addition, residents must understand the risks and benefits as well as the indications of all evidence-based psychotherapies. Some patients will benefit best from an extensive course of a particular formal psychotherapy, and some psychiatrists will elect to provide this formal psychotherapy themselves while others will coordinate this care with other team members.

There have been concerns that psychiatry has moved toward too heavy an emphasis on psychopharmacology. There is no question that we need to integrate both somatic and psychotherapeutic approaches. However, we have to be careful that we do not overreact to a concern about too heavy an emphasis on psychopharmacology by requiring competency in psychodynamic psychotherapy. I have mentioned that flexibility is needed in order to allow programs the time to teach about clinically relevant scientific advances, as well as the tools necessary for lifelong learning—tools derived from genetics, genetic epidemiology, epidemiology, neurosciences, imaging, cognitive sciences, and other areas (e.g., 16), advances that are relevant today or will be over the next several years. For example, Dr. Eric Kandel notes that we are entering into an era of “a new, biologically inspired personalized medicine” (17). We will increasingly have the ability to choose the most appropriate treatment for a specific individual based on that individual’s genetic makeup, propensity for side effects, and even individual risk that a particular drug may result in substantial weight gain (18).

Another rapidly advancing area with clinical relevance involves imaging. Thanks to new processes for imaging amyloid in humans in vivo (19), we will shortly be able to detect preclinical Alzheimer’s disease in individual patients, predict who is developing this illness, and prevent or greatly slow down its development.

We are learning that new neurons are generated in the dentate of the hippocampus throughout life (20), relevant to psychiatrists since medications we use, including mood stabilizers and antidepressants, have substantial influence on the survivability and interconnectivity of these cells. A final example from the field of cognitive sciences involves rehabilitative psychosocial approaches applicable to patients with schizophrenia. Capitalizing on knowledge that certain memory processing skills are stronger than others in patients with schizophrenia, researchers have demonstrated that schizophrenic patients can be more effectively taught work-related skills with a high degree of success (21).

Where do we get time to teach all these developments and many more? Insisting that psychodynamic psychotherapy must be mastered to the level of competence puts significant time pressures on residency programs. Requiring time-consuming competency in psychodynamic psychotherapy discourages flexibility in an environment where competition for educational time is severe. Others agree, however. The Institute of Medicine’s recent report entitled “Research Training in Psychiatry Residency” stresses the need to increase flexibility of psychiatry residency training (15).

The second theme involves credibility. The U.S. population is growing, and the number of psychiatrists leaving the field due to retirement or death matches or exceeds the number entering the field. Consequently, the shortage that already exists will increase. If psychiatrists were to increase their practice of long-term psychodynamic psychotherapy, access to psychiatrists would be further limited for a large number of very sick patients. Society’s needs should
be our field’s major focus. Certainly, psychiatrists must have excellent clinical skills. However, competency in psychodynamic psychotherapy, as opposed to experience with psychodynamic techniques, is not required to administer first-rate care.

How can we justify to the public that we are spending a substantial amount of time teaching residents to be competent in a technique that has limited evidence of efficacy and, if formally practiced by most psychiatrists, takes time away from teaching current advances and would decrease our ability to treat the large number of patients requiring our skills? How can National Alliance for Research on Schizophrenia and Depression (NARSAD), National Alliance for the Mentally Ill (NAMI), and the Depression and Bipolar Support Alliance (DBSA) champion us if we continue in this direction?

Our past has been fascinating and our future will be extraordinary (22). To remain relevant and “cutting edge,” we need to be both flexible and credible. This is the very essence of the discussion we are having at this debate.

Second Arguments Favoring Maintaining the Current RRC Requirements as Written and Response to Dr. Rubin: Allan Tasman, M.D.

Dr. Rubin’s arguments focus on several issues. He argues that singling out psychodynamic psychotherapy to a separate level of distinction is inappropriate, that requiring competency in psychodynamic psychotherapy severely compromises training flexibility in other areas, and that focus on psychodynamic psychotherapy—with the assertion of its limited effectiveness—leads to a lack of credibility. Further, he suggests that if most psychiatrists practice psychodynamic psychotherapy, we would be unable to treat the large number of patients with severe psychiatric illnesses needing treatment. Let me respond to each point.

Competency Certification

Residency directors must certify that residents, at the completion of training, are competent to practice psychiatry. This attestation, a requirement for residents to sit for American Board of Psychiatry and Neurology exams, is universally interpreted to incorporate all required areas of the residency review committee (RRC) criteria, not just psychotherapy. While RRC requirements specifically highlight required competencies in five areas of psychotherapy the expectation is that residents will demonstrate broad competency in clinical practice. Training residents to competently evaluate suicide risk is time intensive, but no one argues that we should compromise expectations that residents achieve competence in these evaluations. The same holds for essentially every aspect of clinical practice. Learning to be a competent practitioner is time-consuming. Further, competency in psychotherapy is embodied in criteria for successfully completing Part 2 of the ABPN examination.

Dr. Rubin also argues that “a competency requirement in psychodynamic psychotherapy is not in our field’s best interest.” He argues that if we devote time to this area, we will lack time for others. It is tautological to argue that time spent on one area is time unavailable to other areas of training. Why does Dr. Rubin single out psychodynamic psychotherapy for different treatment? He argues that it takes too long to teach or learn it. I fear this reflects the zeitgeist of the ultrafast-paced world of sound bites and factoids where everything must be learned quickly.

Flexibility

I agree that we must maintain flexibility to teach residents knowledge necessary to follow future advances. He highlights two areas, genetics and brain imaging, as examples. I agree that genetics is extremely important. Not, however, a simplistic form of genetics. We must teach a broader view of genetics including clear understanding of interactions between genetics and environment on development. Dr. Rubin cites Dr. Eric Kandel’s work to justify his viewpoint. Please understand that Dr. Kandel would very likely support my perspective in that he clearly recognizes that developmental stress and experiences influence genetic expression. His Nobel Prize was based on just such a discovery. Therefore, studying modulation of brain function through psychotherapeutic techniques offers tantalizing future opportunities for better understanding how psychotherapy influences genetic expression.

Dr. Rubin highlights research regarding diminished hippocampal neuronal generation in depression but does not mention the association found between chronic stress and suppression of hippocampal neuronal growth. The fact is that successful psychotherapy leads to more adaptive thinking and behavioral patterns, ameliorates stress, and can prevent previously stressful experiences from having significant effects on the individual. Thus, psychodynamic psychotherapy has significant pertinence to the role of hippocampus in depression. Finally, Dr. Rubin highlights advances in brain imaging. Over 20 years ago, Eric Kandel himself wrote that someday imaging techniques would be-
come sophisticated enough to demonstrate the effectiveness of psychotherapy in altering brain function (23). We are on the threshold of such ability. None of these arguments support eliminating psychodynamic psychotherapy competency from the armamentarium of future psychiatrists.

**Credibility**

Dr. Rubin argues that teaching psychodynamic psychotherapy competence is not credible, as he asserts lack of an evidence base supporting its effectiveness. The Institute of Medicine’s report on evidence-based medicine notes that evidence includes both formal research studies and clinical experience (15). Psychodynamic psychotherapy meets both criteria. Well-conducted meta-analyses and critical reviews involving scores of studies using psychodynamic psychotherapy suggest that this approach is effective and usually comparable to other psychotherapies (24). Additionally, thousands of clinical reports support the role of psychodynamic psychotherapy in symptom relief and resolution of psychological problems.

Dr. Rubin also maintains that we lose credibility if significant numbers of psychiatrists would not treat severely ill patients because they practiced psychodynamic psychotherapy. In reality, studies by APA Psychiatric Research Network indicate that caseloads for psychiatrists nationally are heavily weighted toward severe psychiatric illnesses and that the same psychiatrists indicate that psychotherapy is a significant part of their overall practice. Thus, this argument is easily dismissed. Training residents to competence in psychodynamic psychotherapy does not cause them to focus on a therapeutic intervention with limited evidence for efficacy. Nor does it impede our treating large numbers of patients with severe psychiatric illnesses.

Arguments in support of requiring psychodynamic psychotherapy competence go well beyond those Dr. Rubin criticizes. A still relevant article, published in 1990 in *The American Journal of Psychiatry*, that I coauthored listed many important reasons to continue teaching psychodynamic psychotherapy (25). Some of these reasons pertain to learning the skills and knowledge base necessary to competently practice psychodynamic psychotherapy, but several address other significant areas of training. These reasons include:

1. Concepts of psychodynamic psychotherapy are intimately related to the psychosocial underpinnings of all doctor-patient relationships. Psychotherapeutically competent psychiatrists should be able to provide more effective consultation to medical colleagues and manage their own nonpsychotherapy doctor-patient relationships more effectively.

2. Psychotherapy training enhances learning about managing other dyadic relationships such as supervision, consultation, and mental health administration.

3. Psychotherapy training enhances basic interviewing expertise by providing opportunities to observe longitudinally the course of psychopathological and normal mental phenomena present in an initial interview. This enables residents to recognize emerging mental phenomena earlier, more accurately, and more confidently.

4. Psychotherapy training provides residents with in-depth and longitudinal understanding of both conscious and unconscious normal or pathological mental functioning, related to efforts to change thinking, feeling, and behavior. Such efforts require ongoing relationships between therapist and patient and involve inevitable obstacles, resistances, strengths, and clinical opportunities for understanding these phenomena, essential to managing virtually all psychiatric disorders.

5. Psychotherapy provides observations of complex pathological and normal mental functioning over time, complementing observations of similar mechanisms in inpatient, consultation, and emergency room settings. Furthermore, it provides access to primary materials on which psychodynamic theory is based. As such, psychotherapy training enhances learning psychodynamics as a basic science within psychiatry.

6. With its emphasis on the complex dyadic emotional interplay between psychiatrist and patient, psychodynamic psychotherapy training enhances psychiatrists’ ability to anticipate, analyze, and manage their feelings toward patients and avoid ethical dilemmas and transgressions.

7. Finally, psychotherapy training forces residents to observe, analyze, and attempt to understand extremely complex interactive phenomena. This enforces intellectual rigor and discipline in observing behavior, developing hypotheses, and analyzing theories and data.

Even if uncertainties exist about the role psychotherapy will play in psychiatrists’ future practices, these issues highlight the importance of psychodynamically competent training. There is little evidence that these lessons of psychodynamic psychotherapy training can easily be learned in other ways. I doubt that residency programs devote adequate attention to these issues outside of traditional psychodynamic psychotherapy training.

In addition, competent psychopharmacology practice, highlighted by Dr. Rubin, requires outstanding skills in psychodynamic psychotherapy. When a patient says “I’m
not taking my medicine anymore,” psychotherapeutic skills are necessary to understand the patient’s motivations. A psychiatrist at that moment must understand psychological defense, transference, countertransference, and symbolic meanings in the patient’s decision and be able to listen empathically while maintaining a productive therapeutic alliance. We know that the medication prescriptions embody several meanings for patients. One is embodied in the “illness belief system,” i.e. to what causes patients attribute their illnesses. Second, medications themselves may have symbolic meanings to patients, easily distorted by severely ill patients. Finally, patients attribute meaning to psychiatrists’ decisions to prescribe medications. The best pharmacotherapy requires competence in assessing these aspects of medication treatment as well as all other aspects of clinical pharmacology.

In closing, I’ll return to the issue of genetics that Dr. Rubin raised. I believe our greatest future challenge will be to more fully understand interactions between our genetic makeup and the impact of developmental experiences. The lack of 100% concordance in schizophrenia among monozygotic twins, for example, could reflect subtle developmental difference between siblings. Our ability to understand and modulate the impact of these differences will continue to be essential to psychiatrists’ future roles, enacting true biopsychosocial practice, and would require competence in psychodynamic psychotherapy.

Second Arguments Opposing Maintaining the Current RRC Requirements as Written and Response to Drs. Mellman and Tasman:

Joel Yager, M.D.

Dr. Rubin focused on whether we should require competencies in psychodynamic psychotherapy. In contrast, I’ll focus on whether such competencies could actually be achieved and reliably and validly assessed during residency. Briefly, No. First, from a 1947 meeting supporting the scientist-practitioner model of clinical psychology: “We have left therapy as an undefined technique which is applied to unspecified problems with a nonpredictable outcome. For this technique we recommend rigorous training” (26). Sadly, for psychodynamic psychotherapy this situation hasn’t changed much since.

Again, we certainly don’t oppose psychodynamic psychotherapy training. We oppose the current RRC wording specifying that programs “must demonstrate that residents have achieved competency in ... psychodynamic psychotherapy” (27). This requirement is misguided because as stated it is unachievable with available time, personnel and assessment methods; encourages training directors to act hypocritically; and subjects programs to potential litigation. Moreover, better wording could preserve the underlying good intentions.

Semantic Considerations

What does professional “competency” mean to you? Competence-based educators (28) have dummed down the definition to demonstrate all sorts of “competencies” for educational and professional accountability (29–31). Whereas counting to 100 might constitute an early “math competency,” you would not consider this to represent Competence in math. Most professionals—and laymen—reject trivial definitions, preferring to believe that “competency” actually signifies proficiency in performing a meaningful procedure. For competency in psychodynamic psychotherapy, demonstrating mastery over a small subset of knowledge or skills—“formative competencies” in educational jargon—such as defining transference or demonstrating (through carefully selected moments of videotape) a therapeutic alliance, or describing aspects of therapeutic interactions does not come close to assuring possession of comprehensive skills needed to really perform psychodynamic psychotherapy competently from start to finish for the usual spectrum of clinical problems for which it is used. Demonstrating an array of small, measurable “competencies” (little “c”s) does not add up to actual Competency (a big “C”). Consider: when you need coronary bypass surgery, will you be satisfied simply knowing that your surgeon has satisfactorily mastered some “formative competencies”—passing tests on anatomy and suturing? We doubt it. You’ll expect Competency (big “C”)—that your surgeon has capably performed this complex surgery from beginning to end. Competency for psychodynamic psychotherapy should convey similarly high expectations, not necessarily for “masters” or “experts,” but certainly better than novices.

Resources Will Be Insufficient to Meet the Requirement

Medicine teaches by “see one, do one, teach one.” But, although residents may observe slices of psychodynamic therapy in training, probably none ever observes several cases treated from start to finish. How are trainees to model or reflect on expert performances?

Furthermore, educators suggest that multiple assessments of defined skills in different situations are necessary to assure assessment validity (the number eight has been mentioned) (32–34). How many residents anywhere con-
duc this number of psychodynamic psychotherapies observed by supervisors? Have any of you observed residents conduct a therapy from start to finish?

Next, since most therapy training occurs during PGY 3 and 4, performance problems may be impossible to remediate within this time-course. What consequences would ensue if by the end of training residents fail to achieve psychodynamic psychotherapy competency?

Finally, programs lack enough time for trainees to achieve competency in psychodynamic psychotherapy. Even advocates agree that this competency is a developmental process that requires time; some suggest at least 2 years following residency to “consolidate” psychotherapy skills and even start feeling “competent.” This impression was verified by graduates from strongly psychodynamic programs, interviewed by Tanya Luhrmann for her excellent book, Of Two Minds (35).

Current Methods Are Inadequate for Reliably and Validly Assessing This Competency

Although we lack agreement on exactly what constitutes psychodynamic psychotherapy competency, Drs. Mellman, Beresin and others have provided an excellent start, defining competency through a body of knowledge and 14 specific skills (see Appendix 1) (36). However, we lack ways to reliably and validly assess these skills. The Psychodynamic Psychotherapy Competency Test (37, 38) falls short of testing any of the 14 in a manner that serious evaluators would accept as sufficient for certifying Competence. Using paper case vignettes and multiple-choice questions to test abilities to conceptualize psychotherapy interactions and appropriate psychotherapeutic responses, this test may assess residents’ intellectual grasp of basic concepts but shows nothing about what they would do in actual practice. And we know that clinicians’ responses to paper-and-pencil vignettes does not necessarily represent their actions when facing those situations in practice (39). Further, research shows how difficult it is to reliably and validly test “live” psychotherapy skills (40). Experienced supervisors independently rated residents’ videotaped psychotherapy interviews using a detailed instrument. Interrater agreement was uniformly low and significantly poorer for judgments about techniques than communication skills, suggesting that methods purporting to assess psychotherapy skills require careful methodological testing before acceptance as reliable and valid. Bottom line: we still cannot demonstrate criterion, concurrent, discriminant, and/or predictive validity for most psychodynamic-process formative competencies.

Forcing Programs to Comply Will Inevitably Generate Dishonesty in Training Directors and Faculty

Unrealistic, arbitrary rules set by authorities inspire managers to develop ingenious, often hypocritical methods for meeting the letter—but not the spirit—of these rules (41). This misguided RRC requirement has already fostered patchwork solutions that are clearly more show than substance. Ultimately, the RRC will be forced to accept programmatic charades for certifying this competency or, alternatively, “get real” about the requirement. Training directors must dissemble to certify unverifiable competencies. Ask yourself: “How honestly could I have certified that every graduate from my program achieved big ‘C’ competency in psychodynamic psychotherapy?”

Under Current Requirements Training Directors and Programs Potentially Risk Punitive Administrative Actions and Litigation

In an increasingly litigious world psychiatrists who are sued for incompetent practice, and their patients, may decide, in turn, to sue the training programs for failing to assure required competencies. A prescient licensing board for psychologists states “candidates are not expected to be competent in all or even almost all areas. . . . Psychologists are expected to practice within their areas of competency. Future complaints against a psychologist who is practicing in an area that was not an area of competency when licensed will place a general burden of proof of competence on the psychologist in addition to the specific issues of the complaint” (42). Legally, you are held accountable to the standards you set.

Better Ways Exist to Fulfill the Requirement’s Intentions

Showing greater realism, one Canadian residency program states “residents are expected to develop both a basic level of proficiency in all modalities of psychotherapy and competency in at least one” (43). (By the way, what’s “proficiency”?)

We suggest that the RRC rethink its current language and recast requirements more realistically, as, for example: “Residency programs must show that all residents can demonstrate knowledge about the evidence base, theories and rules of practice supporting at least the following forms of treatment. . . . In addition, programs must demonstrate by means of patient logs, taped recordings and other documentation that all residents have conducted [specify types, numbers and durations of psychotherapies] . . . under qualified supervision.”
Summary of the Positive Position:
Allan Tasman, M.D.

The primary argument supporting psychotherapy competency pertains to its value as an important, effective psychiatric treatment intervention, no less valuable than any other accepted form of treatment. The negative position asserts that psychodynamic therapy has little supporting evidence base. This argument is easily dismissed by large numbers of research studies and thousands of published case reports. They also argue that such training is too time consuming, but this case could be made for any aspect of clinical practice. Further, the argument that requiring psychodynamic psychotherapy competency leads to psychiatrists in practice not seeing severely ill patients is belied by evidence collected from contemporary practitioners.

The final criticism relates to competency attestation. Over 20 years ago, Yager and Borus argued for higher quality standards in psychiatric residency training. Establishing such requirements, they asserted, would require programs to take steps to measure quality education and assess program quality for accreditation purposes (44). Dr. Yager seems to have abandoned his wish for quality by essentially arguing that since we do not yet know how to define competency or measure it, we should not expect anyone to require it. Without requiring demonstrations of competency, improved quality will be impossible to reach.

The RRC recognized difficulties in defining and measuring competency when they established these requirements. They recognized that establishing this criteria would require developing new curricula and new methods for evaluating competency in several areas. (The ACGME’s overall competencies were also established without adequate methods in place for demonstrating these competencies. These requirements were also implemented with expectations that implementation of the requirements would stimulate the development of measures to assess competencies as well as the associated curricula.) The same expectations should hold for training in psychodynamic and other psychotherapies, and other areas of psychiatric practice.

Of course we must teach a vast array of knowledge and skills. But it is also true that most therapeutic transactions in psychiatry will continue to occur in the context of dyadic physician-patient relationships. Furthermore, patients have not suddenly lost the capacities for symbolic meaning or to suffer from the vagaries and vicissitudes of developmental conflicts and developmental deficits just because we are learning about genetics and biology of brain function. If we expect to maintain and improve our clinical excellence, we must rededicate ourselves to these psychodynamically based issues. I can think of nothing more important to ensure continued excellence for our educational and clinical enterprise.

Summary of Negative Position:
Joel Yager, M.D.

We are not against psychodynamic therapy, nor are we against training in psychodynamic therapy. But do not confuse support for psychodynamics with specific regulations requiring that programs demonstrate that all graduates have achieved competency in psychodynamic psychotherapy—that is very different.

The ACGME’s requirements for competency-based education concern Patient Care; Medical Knowledge; Practice-Based Learning and Improvement; Interpersonal and Communication Skills; Professionalism; and Systems-Based Practice—none specific procedures. We should not require Competency for psychodynamic psychotherapy because we cannot reliably agree on what it should be in practice and haven’t specified the clinical problems for which its competence should be demonstrated. We lack the time, resources and methods to train up to, remediate if necessary, and reliably and validly assess Competency during residency. Formative skills do not assure summative Competency. To meet the requirement, programs will trivialize the meaning of “competency” and/or dissemble. Furthermore, psychotherapy training can still be supported by requiring supervised training in the concepts, tactics and practice of useful psychotherapeutic strategies, requiring that residents demonstrate knowledge about theories and practices of these strategies and have documented supervised experience, and having the RRC monitor these requirements.

Conclusion

Although no formal follow-up to this APA debate is planned, the field as a whole will continue debating these issues in several educational and political venues. We all hope that efforts devoted to psychiatric training and assessment will produce ever-improved methods for educating and assessing our residents and for increasing their professional proficiencies. How details are worked out will be up to psychiatry’s talented array of educators and influence-leaders.
APPENDIX 1. Suggested Core Competency Skills for Psychodynamic Psychotherapy

1. The resident will be able to evaluate the capacity of the patient to engage in and utilize psychodynamic psychotherapy.
2. The resident will be able to display effective interpersonal skills in building and maintaining a collaborative therapeutic alliance that promotes self-reflection and inquiry into the patient’s inner life.
3. The resident will be able to establish treatment goals with the patient.
4. The resident will be able to establish a treatment frame with the patient.
5. The resident will be able to engage the patient in exploring his/her history of experiences, sociocultural influences, relationship patterns, coping mechanisms, fears, traumas and losses, hopes and wishes in order to understand the presenting problems.
6. The resident will be able to effectively listen to the patient to understand nuance, meanings, and indirect communications.
7. The resident will be able to recognize and identify affects in the patient and himself/herself.
8. The resident will be able to recognize, utilize and manage aspects of transference and countertransference, defense and resistance in the course of treatment.
9. The resident will be able to utilize self-reflection to learn about his/her own responses to patients to further the goals of the treatment.
10. The resident will be able to utilize clarification and confrontation.
11. The resident will be able to utilize interpretation to manage transference/countertransference that impedes or disrupts the therapeutic process.
12. The resident will be able to manage and understand the meanings of termination.
13. The resident will be able to write a psychodynamic formulation.
14. The resident will be able to seek appropriate consultation and/or referral for specialized treatment.


References

1. www.acgme.org/RRC/Psy_Req.asp