INTRODUCTION

Harvey Bluestone, M.D., Moderator

I am Dr. Harvey Bluestone, Professor of Psychiatry at the Albert Einstein College of Medicine and Director of Psychiatry at Bronx-Lebanon Hospital Center, a major training affiliate of the medical school. I would like to welcome everyone to the debate on “Should Clinical Training in Long-Term Psychodynamic Psychotherapy Be Mandatory in Residency Training?” The crowded room in the face of exciting competing programs attests to the interest in this subject. The topic today highlights central issues, not only for training but for the future practice of psychiatry.

We are dealing here with both current reality and our vision of the future. What is the psychiatrist of the twenty-first century going to look like? What kind of treatments will he be administering? What will be his model of pathology and treatment in the future?

This debate would have been inconceivable when I was a psychiatric resident. At that time psychoanalytic treatment and theory dominated the field. Within a few short years the map of psychiatry has shifted so much that the old view feels almost prehistoric. There are many reasons for this shift: The development of new biological forms of treatment for specific illnesses. The biological revolution in technology such as brain scans. The increase in emphasis on empirically validated outcome studies (aided by technological advances such as the computer). The DSM-III and its successors with their atheoretical stance. The rise of short-term therapies that appear to have empirical support. And last but not least, economic factors—especially the rise of managed care, which stresses efficiency and cost containment.

The net result is a new, more empirical and medically oriented psychiatry with emphasis on results and accountability. It is clear that psychoanalytic theory and practice with their emphasis on long-term therapy no longer dominates the field. The question, however, remains, “Should clinical training in long-term psychodynamic psychotherapy be mandated in residency treatment?” Since there is so much other material for residents to learn, should they be spending time on a difficult and time-consuming treatment? Are we moving forward to a more enlightened approach, or are we unduly influ-
enced by current trends?

In this debate, we are fortunate to have two distinguished psychiatrists, both of whom are well trained in psychoanalysis, as I am.

For the Affirmative: Norman A. Clemens, M.D., is, in addition to his many other assignments, the chairman of the American Psychiatric Association’s Commission on Psychotherapy by Psychiatrists.

For the Negative: Arthur T. Meyerson, M.D., is, in addition to serving on many APA committees, Professor and Vice Chair of University Behavioral Health Care of the University of Medicine and Dentistry of New Jersey.

If I succeed in moderating this debate as I intend to, you will not know my position on this issue.

FOR THE AFFIRMATIVE

Norman A. Clemens, M.D.

“Should Clinical Training in Long-Term Psychodynamic Psychotherapy be Mandatory in Residency Training?” Twenty years ago, who would have thought that such a topic would even be considered for a debate in the American Psychiatric Association? But here we are, two analytically trained psychiatrists, taking it on. I shall argue for a resounding “yes!” Let me start with a story.

This summer Dick Faegler, a columnist for the Cleveland Plain Dealer, was walking outside Jacobs Field in Cleveland when a boy came up to him and asked the time. He pulled out his watch and said, “Quarter after ten.” The boy irritably said, “But what is the time?” Again, the same exchange. The boy said, “Oh, 10:25?” (A quarter is 25 cents.) The boy couldn’t get it—until the writer said, “no, ten fifteen.” The boy could only think in terms of digital readouts, not of hours and their parts. The columnist used the story to make a point about education in the digital world. I think the story expresses nicely how a young psychiatrist’s thinking would be (or sometimes now is) without clinical training in long-term psychodynamic psychotherapy. All numbers and algorithms, but lacking in comprehension. Not knowing the context or the meaning of the patient’s mental life.

Consider the poverty of thought of a bright young psychiatrist without psychodynamic training: This person knows only symptoms and statistics, neurotransmitters and rating scales. Worthy enough, but there is no awareness of how people tear themselves apart with unconscious conflict, or how they distort their perceptions and their relationships with defense mechanisms like denial, displacement, projection, reaction formation, and so on. This one-dimensional psychiatrist would have no sense of how each person develops over time, stage by stage, from prenatal life until death, and how the expression of genetic potentials is shaped by crucial relationships and experiences. He would not know about ambivalence in relationships, rage and sexuality, repression and the unconscious influences of unresolved loss or trauma, or the tortured expressions of sadism and masochism in self-defeating behavior. Quite a shallow and constricted psychiatrist, this poor fellow—yet board examiners encounter them regularly, and so do discerning patients with enough ego strength to take a walk and find someone else who can help them. The requirement of clinical training in long-term psychodynamic psychotherapy is already honored in name only in some training programs.

How does this affect the field of psychiatry, present and future? Let’s look at the American Journal of Psychiatry. In an eloquent editorial, Nancy Andreasen,1 editor and researcher, expressed her concern about the biological one-sidedness of current trends in psychiatry and warned that the “soul” of psychiatry was slipping away. In another editorial, Gary Tucker,2 known for psychopharmacology research, decried the loss of emphasis on learning the narrative of the patient’s life—on knowing the patient as a person. These are not champions of psychotherapy in the increasingly irrelevant debate about body versus mind; they are people who see the big picture. While they did not identify long-term psychotherapy training (or any specific remedy) as a necessary ingredient, I maintain that it is.

What kind of training are we talking about? Psychodynamic psychotherapy comes from an immense body of knowledge built over a century on accretions of single case studies by psychoanalysts. It aims to accomplish significant changes not only in symptoms, but also in the way people conduct their mental lives. It does so through understanding and mastery, most immediately and effectively within the relationship with the psychiatrist. Yes, the past is important in determining who we are now. But equally vital is the present and the way the patient balances many dynamically interacting forces—hence the term psychodynamic. Dynamic psychotherapy is an adaptation of psychoanalysis to more limited goals and circumstances, for which it is often more appropriate than analysis is.

In residency training, the concept of “long-term”
therapy is a relative one compared with what these young psychiatrists may do later in their careers. I have seen a few patients for as much as 34 years. We have grown old together. But two years of work with a patient would be quite fortunate and unusual for most residents, far different from the few months at a community mental health center that is frequently the mode. So duration might be measured in months rather than years. But also contained in the concept we call “long-term” is intensity: sessions that last most of an hour and that occur once or (better) twice a week. And also process: an open-ended structure that follows where the patient leads—through free association, dreams, fantasies, and enactments—into deeper understanding, and that pays close attention to the relationship between the patient and the psychiatrist, the transference and the countertransference. Long-term psychotherapy is the culture medium for a substantive experience, rather than a superficial intellectual acquaintance, with psychodynamic treatment.

What is unique and important about what a resident gains from this experience? First, she learns to sit still and listen and be prepared for surprises as the relationship deepens. She learns that illness doesn’t fit into neat packages, that her patients have a life, that patients’ character structure, relationships, and social environment greatly affect their symptoms, mental processing, and emotional state. She gets a sense of personality development, growth or deterioration over time, the intimate relationship between Axis I and Axis II. She gets a feel for the pace of change, how it occurs gradually over months, through trial and error, emotional experiences, working through, internalization, and neurobiological processes we have just begun to understand, as noted by Kandel. She experiences the intensity of the treatment relationship, works with transference, and begins the maturational process of using countertransference constructively for the patient’s and the resident’s own growth.

This is the seedbed for humility, self-awareness, a more realistic view of psychiatry and what it can and can’t do, and living with uncertainty and human complexity—including one’s own complexity. Long-term psychodynamic therapy, modified to the needs of the patient, also may be an opportunity for learning to manage dependency and to provide both autonomy and measured support when internalized change is limited. Flexibility and individualization of treatment are the hallmarks of a psychodynamic approach—in contrast to very structured, time-limited psychotherapies.

Of course, this flexible, individualized, open-ended, person-centered approach is exactly what managed care companies like least, because they can’t control it. I think this control issue is a paramount factor in managed care thinking about psychodynamic psychotherapy. Should the managed care marketplace control the training of our residents? I say “no!” Not only are there good clinical reasons for saying no, but the managed care approach is very short-sighted both for our patients and for the profession.

Psychiatry rarely deals with short-term disorders. If our residents only work with patients episodically in the managed care fashion, they will have no grasp of the natural history of the disorders we treat. To go back to the boy and the non-digital watch, they will not know what time it is. They will not see how commonly panic disorder becomes recurrent despite initial success with medications or CBT [cognitive-behavioral therapy], or how often it is comorbid with depression or personality disorders or substance abuse. They will not follow major depressions through recurrence or deal with the dysthymia of double depression. They will not struggle with the obsessional personality structure that often contributes to depression. They will only do 45-minute evaluations and 15-minute medication checks, or engage in an ultra-brief psychotherapy that limits the patient to one small wedge of the pie. It will be like treating diabetic acidosis without learning how to regulate diabetes, or treating a single schizophrenic episode without seeing the course of the disease.

Residents should treat at least several long-term cases to get a variety of experience and not be overinvested in one patient. At the same time, residents must learn the structured psychotherapies, CBT and IPT [interpersonal psychotherapy] and short-term psychodynamic approaches that single out the core conflictual relationship. They must have a full arsenal of weapons to deal with illness. Individualized psychodynamic treatment often means very short-term, focused treatment. But residents’ experience with in-depth, psychodynamic psychotherapy can enrich their application of short-term approaches. Short-term, focused work is demanding. It can involve very complex thinking. Selecting a focus comes easier to an experienced clinician who can put the patient’s illness into the context of a life course. For example, the dynamics of short-term work with an acute depression make much more sense with the perspective of having worked in depth with the personality variables that contribute to depression or having seen other pa-
tients deal with depression, bereavement, or life-cycle stresses over time. James Shore, former chair of the American Psychiatric Association’s Council on Medical Education, said this very well in his Vestermark lecture at the 1998 APA annual meeting in Toronto.

Short-term, structured treatments were developed mostly by clinicians whose basic training was in long-term psychodynamic psychotherapy. Although the methodology of cognitive-behavioral psychotherapy and interpersonal psychotherapy now seems far removed from psychodynamic technique, there still remain problems such as dealing with resistance to doing homework or changing cognitive patterns; or devising a strategy when the basic approach fails to relieve symptoms or change behavior; or reckoning with the feelings that patient and psychiatrist have about each other. On the APA Commission on Psychotherapy by Psychiatrists that I chair, there are esteemed researchers in CBT and IPT. They readily admit that in their own practices they commonly deviate from the very structured approaches required in their research manuals. I suspect that their psychodynamic backgrounds subtly contribute to their thinking when they tailor the treatment to the patient.

This was borne out by a recently published study by Ablon and Jones that employed a methodology for studying what actually occurs in therapies. I quote from a précis by Dr. Enrico Jones:

Panels of experts in psychodynamic and cognitive behavioral therapy created prototypes of ideal treatment sessions. . . . These prototypes were then used to assess the extent to which treatments in three relatively large samples conformed to the prototypes. The degree to which the treatments adhered to the prototypes was measured quantitatively and correlated with treatment outcome. The psychodynamic prototype constructed by experienced analysts was consistently correlated with positive outcome in both brief psychodynamic and CBT. In other words, the more psychodynamic elements present in CBT, the better the outcomes were in these treatments. In contrast, the CBT prototype created by experts in this approach was not strongly correlated with positive patient outcome in either psychodynamic therapy or CBT.

The comparison here is between brief treatments, but I maintain that experience in long-term or intensive psychodynamic treatment contributes to skill in doing brief treatment of any sort. Similarly, in the management of medications, clinicians are often confronted with psychodynamic issues. For most serious psychiatric illnesses, medications are a long-term rather than a short-term treatment. Much more astute management can occur when the clinician can draw out and deal with the fears, fantasies, or interpersonal situations that interfere with compliance. A patient who needs to suffer to satisfy a sadistic superego may find it difficult to continue an effective medication. Transference and countertransference feelings can be a major issue that derails the treatment, unless the clinician can tune in to what is going on and do what it takes to work it out, including looking within oneself. Experience with intensive psychodynamic psychotherapy is essential to bring one’s psychopharmacological practice to that level of awareness and practical skill. Clinicians who are not so attuned are at a disadvantage.

Now you may be saying, all well and good, but should such training be mandatory? It has been proposed simply to educate residents about psychotherapy but not to train them unless they have a special interest in such training. Although some residents will no doubt want more psychotherapy training than others, I believe that it would be a tragedy not to require all residents to have a real life experience with long-term or intensive psychodynamic psychotherapy. Otherwise they will not know what it is really about; you can’t learn it from a book. They will have no respect for its subtlety, adaptability, and usefulness. And they will be deprived of essential tools. The residents who are not going to practice much psychodynamic psychotherapy in the future are those who most need basic, mandatory clinical training in it now. In the post–managed care era, I believe that the psychiatrist who can practice skilled psychodynamic psychotherapy based on trust and confidentiality, fully integrated with the appropriate use of medications, will be very much in demand. We will grievously shortchange our residents if we don’t prepare them for that renaissance.

REFERENCES

FOR THE NEGATIVE

Arthur T. Meyerson, M.D.

To address the issues that are at the heart of this debate I will, like the youth and elder at the Passover seder, ask and answer four central and related questions.

Question number 1 is, “Has long-term psychoanalytic therapy sufficiently proven itself a valid medical treatment (both valid and medical are necessary) so as to be a required competency for all residents?”

Until the last several decades, medicine had considered treatments valid if proven by single or serial but small-number case reports. The introduction of a new surgical technique, even the introduction of a new antibiotic, was based on subjective impressions of clinicians. Thus, psychoanalytic psychotherapy was introduced and accepted by medical practitioners in an era when the case study method and clinical impressions were the governing forces in the acceptance of medical therapeutics. Although I am not arguing the question of whether long-term dynamic therapy is efficacious, it is unarguable that it is unproven as such by the standards by which all of the other major forms of psychotherapy and psychopharmacology are accepted, the placebo-controlled randomized clinical trial or, next best, the controlled trial versus a known, effective treatment. These standards allow replication of studies, establishing a more detached and objective verification of utility. Cognitive-behavioral therapy, brief dynamic therapy, interpersonal psychotherapy, and all of our major pharmacological breakthroughs, and the combination of these, have proven efficacious by these standards for a variety of conditions. This has not been the case with long-term dynamic therapy. When this lack of proven efficacy is coupled with the relative cost of the treatment intervention, particularly when done by physicians, the question of relative cost/efficacy becomes compellingly answered in the negative.

Even if a treatment is of unproven efficacy and high cost, it may be medically justified by the severity of the illnesses it treats, their mortality and morbidity. The treatment may cure or at least beneficially modify the course. Is that the case for long-term analytic therapy? Proponents like my worthy opponent argue yes. The pain and suffering of the typical patient, he contends, plus the modification of adaptation, function, and affective modulation all speak to justify the treatment.

However, in a world where all of the major Axis I disorders [such as schizophrenia and major affective disorders], with their severe morbidity and mortality, had enough psychiatrists to treat them with known effective methods, then perhaps the leftover psychiatric time would be used to treat the “good case” for analytic therapy. We are not in that world, and fully half to three-quarters of the major cases in the United States go untreated by psychiatrists.

Finally, on the question of the medical nature of long-term dynamic therapy, one must recognize that while the treatment has little to prove its efficacy, neither has it been tested whether lay persons do it any less well than psychiatrists. Since the American Psychoanalytic Association was forced to accept psychologists as full members and trainees, no one has done a randomized clinical trial demonstrating superior outcomes for the physicians. With identical training for both types of clinicians, if being a psychiatrist provided some particular benefit, that should be demonstrable in a study with a straightforward design. Why train residents to do an unproven treatment that others may do equally well?

Proponents like Dr. Clemens argue that the training of residents provides them with particular ability to handle the combination of pharmacological therapies with psychotherapy and in addition the psychotherapy of those with medical conditions. The latter proposition requires the same proof as any assertion for efficacy and physician superiority. However, I will concede that combined treatment may make for a special case where seeing only one person, the M.D., leads to cost efficiency and efficacy. Maybe, but maybe not! The field still has to demonstrate the efficacy of long-term dynamic therapy for specific conditions, by acceptable standards, as a precondition for asserting our need to require this training of residents even for combined treatment.

Thus, on the basis that long-term psychodynamic psychotherapy has not proven itself an efficacious and cost-effective treatment, one should conclude that it need not be a requirement of the RRC [Residency Review Committee] for the training of psychiatric residents, and indeed that the time might be better spent pursuing the development of other clinical skills better designed to meet the public health needs for psychiatrists that are so underserved in this country.

Question number two is, “Do residents currently graduate with this skill at a level suitable to practice? If not, why not?”
Grand Rounds

Many examiners for the American Board of Psychiatry, and in particular those expert in long-term dynamic therapy, decry the fact that most candidates cannot do, indeed do not know what constitutes, a dynamic formulation. Most senior residents in most programs are anywhere between clumsy and inept in the performance of analytic therapy, if one believes supervisors.

Why might this be? The causes are both widespread and apparent.

Many, if not most, residents come to the field no longer primarily drawn by the dynamic model—which has receded in the public mind, the medical establishment, and medical school programs to one of many aspects of the field, if it is highlighted at all. Moreover, we train many international graduates in the United States who have no exposure to the field, and even the concepts may be alien to the basic way they think about mind and body.

To sufficiently master long-term therapy requires a proper didactic underpinning followed by sufficient clinical experience with appropriate patients, under supervision, for a sufficient time so that the resident reaches a level of competence to do the work independently. Does Dr. Clemens claim that the current one-year continuity requirement (unstated by the RRC but generally conceded) is sufficient for most residents to achieve that competence? Do most training programs have sufficient numbers of sophisticated clinicians to supervise? Do inner-city and rural residencies have a critical mass of patients? Is there sufficient funding to augment the poor-to-absent reimbursement of resident-conducted cases? The answer to these questions is in many cases no.

We graduate residents who are considered competent to do long-term analytic therapy simply because they complete an RRC-approved residency. Most of us in academic psychiatry and psychoanalysis know this is nonsense and would not send a patient to the majority of our graduating residents for dynamic therapy, if we had any other choice. I do not wish to assert that there are no individual or programmatic exceptions—there are—but we are talking about the rule. Clearly the two or three cases that residents now treat are not nearly enough when coupled with the fact that many of their supervisors, in many programs, have had no more training than the same residency program provided a few years earlier.

Once upon a time, in the good old days of my residency, long-term psychoanalytic therapy was the only psychotherapeutic intervention available and, coupled with a few medications and ECT, was the only thing we could do for our patients except for supportive work.

We were trained from day one, on the inpatient services, to make dynamic formulations of schizophrenic and major affective cases based on Freud and Abraham’s notions of melancholia, Kanner’s ideas of the symbiotic basis of schizophrenogenic mothering, Lewin’s thesis of the dynamic triad that underlay bipolar illness, and so on. Patients were asked to free-associate, and we did our best, along with our conscientious supervisors, to treat these suffering human beings.

In outpatient settings, we were able to see some patients who, like ourselves, had neurotic and characterological problems of adaptation to life’s vicissitudes, and we further refined our intellectual and practical skills with them. Yet even then we recognized that to do the work really well we would have to go on to psychoanalytic training. Residency was thought to provide only the most rudimentary of clinical skill-building in long-term analytic therapy.

How can we now claim, with the enormous amount of information about brain and behavior, and the wide range of clinical skills that are truly the core of clinical psychiatry, that we have time to adequately train residents to achieve competence as analytic therapists in long-term dynamic work? We can’t and we shouldn’t.

Our residency is now four years, compared with three for pediatrics, general, and family medicine. Do we wish to prolong our residency even further to accommodate adequate experience with therapy, and could all programs do this effectively? I don’t think so.

Even now, we graduate many residents who have a straight medicine or pediatric first year, followed by only two in psychiatry, who then go on to child or some other subspecialty training. Does anyone believe that even the majority of these graduates are competent long-term analytic therapists?

Should some psychiatrists practice analytic therapy? Yes, it’s a free country, and while one could argue their time and education might be better spent using interventions of proven worth to treat the major public health priorities, for the sake of discussion let’s drop that argument. However, to be assured of competence, we should have two-year fellowships in long-term dynamic therapy available for those who wish to do this. The field is certainly as technically challenging as geriatrics and consultation/liaison psychiatry, and we would be able to provide a truly meaningful learning experience for the trainee with appropriate patients and supervisors in a few
designated centers in contrast to the pseudotraining most programs provide residents now.

Question number three is, “Does the experience of psychoanalytic therapy provide the resident with an essential set of tools in dealing with the therapeutic relationship in general, including issues of transference, countertransference, and compliance?”

In this regard, the proponents of clinical training of residents in this modality believe the experience is essential to the residents’ development of a full appreciation of these phenomena and their clinical utility in all aspects of psychiatry, indeed of the healing arts. Perhaps! However, since there is no empirical evidence to support such a view, let us examine what would be required as proof and what evidence that does exist might support.

First, to establish that clinical experience in long-term dynamic therapy enhances the trainee’s ability to bring about compliance with treatment, it would be helpful to know if patients in analytic therapy with experienced, well-trained analytic physicians complied more readily with treatment plans, medication prescriptions, and so on, than those seeing physicians who were less well trained from an analytic point of view. I know of no such evidence, do you?

What about transference and countertransference? In the absence of any data for the “pro” side, allow me to put forth an alternative hypothesis, to wit, that sensitive, ethical residents of any school, with or without clinical dynamic training, will deal with these issues better than residents trained with any therapeutic technique, including the dynamic, who are not by nature sensitive, empathic, and ethical.

Let me offer another hypothesis, to wit, that good outcomes, compliance, and a positive working alliance are achieved or not achieved as a result of a multitude of factors—including the personality and character of each of the dyadic pair, the fitness of the mix, life circumstances, among others—as much as by the resident’s specific clinical training in dealing with transference and countertransference.

Even if it were true that currently the clinical experience in analytic therapy provides the resident with the best model and understanding of transference and countertransference, that is not a compelling argument for including dynamic therapy in the curriculum, since the “pro” argument I am addressing is about the generalizability of these skills to other forms of treatment.

Indeed, many community psychiatrists find themselves appalled at the lack of ability “good residents” show in working with seriously ill schizophrenic or other patients. Those with an analytic bent are often, arguably, the least sensitive to the needs of these patients, who often lack the psychological mindedness, insight, or education to be considered “good” therapy cases.

A good psychiatrist doing evaluations, other forms of psychosocial interventions, or biological interventions will be a good psychiatrist, with or without clinical training in long-term dynamic therapy. I don’t here argue that this experience can’t be enriching, enhancing, or efficacious. I do, however, argue that it is unproven in all these dimensions and, even if so proven, might be only one of a variety of maturing clinical and life experiences, such as undergoing one’s own personal psychotherapeutic treatment, rearing children, or getting a liberal arts education.

Indeed, at the present time it is plausible to argue that residency experience in analytic therapy predisposes some residents to contempt for the seemingly less intellectually challenging and complicated therapeutic interventions, whether they work or not.

Question number four, the final question before us, is, “Why, given the poverty of intellectually sustainable, evidence-based arguments to be made for requiring residents to have experience in long-term dynamic therapy, do chairmen, residency directors, and my distinguished opponent still support its inclusion in the RRC requirements?”

Let me venture a dynamic formulation for this behavior, which, like all irrational, maladaptive manifestations in individuals and groups, deserves our close attention and sympathy. Like all complex behaviors, I believe this one to be multidetermined.

Lest I be accused of using my own dynamic training to argue against such training I will readily admit that my ability to hypothesize about the origins of such behavior could be aped, and probably improved upon, by any reasonable person with a social science background interested in the beliefs of a specific social group, in this case psychiatrists, and particularly that subset with psychoanalytic propensities as manifested by practice, training, or teaching.

One significant factor may be nostalgia, which is a powerful force in human behavior, and those of us trained in the era of dynamic therapy’s dominance of the field remember those times with a longing for the almost ubiquitous explanatory power of the analytic model and the richness of the human experience involved in the
therapy two to five times per week for years with a patient. Differential diagnosis and medication, even when short-term psychotherapy is involved, cannot compare with the satisfaction of our curiosity about human beings, our personal need to feel unimaginably significant to the patient, the intellectual richness of supervision, readings, and case discussions. We loved these things and want to repeat them as teachers and mentors.

If one wanted a less positive interpretation of this nostalgia, one could raise the suspicion that the long hours of supervision, the intense fear of the supervisor, the feelings of bewilderment at understanding the patient’s associations, our own sense of helplessness with those who did not respond (like the schizophrenic or even sometimes the neurotic person), left us with a need to identify with the aggressors, the analytic supervisors/parents of our traineeship/childhood. I won’t go that far.

Another related factor is represented by the tangible rewards that went with the older generation’s training in analytic therapy, namely prestige and money. Prestige was everywhere to be found in the artistic and intellectual centers of America, from Hollywood to Broadway. Think of filling your practice for years with just 10 or 15 patients, most of whom were bright and productive, and many of whom were artists and intellectuals. We long for the return of that golden era when medical psychoanalysis and analytic psychotherapy were king and queen, and we want to pass that on to our successors.

Finally, I will turn to self psychology to help us understand another of the roots of the irrational and unsustainable belief that clinical experience in dynamic therapy should be required of all residents. It lies in our clinging to a professional identity that was hard won, earned with honor, and yet is seriously challenged in the current era.

Almost anyone who trained before the early eighties had clinical experience in dynamic therapy as a goal for training and practice. It was part of our fantasied professional identity before we entered the field, and after years of patient care, and hundreds of hours of supervision and reading, we graduated residency knowing that the core of our personal identity as professionals and psychiatrists was analytic competence. Many of us were so convinced that we went on to years of psychoanalytic training, as did I and my opponent.

As the field has changed, as biological explanations and psychotherapies of shorter duration, less cost, greater availability, and proven efficacy have emerged, some have not had the adaptive capacity to modify their professional identities to match the realities of a changing field, changing as all fields change. Indeed, as all fields change, there is always the old guard, clinging to its youthful ideals and experiences, values and identities, that fights to keep the field in stasis. Noble in some cases, selfish in others, this attempt always fails, and should.