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Teaching Psychotherapy to Psychiatric Residents in Israel

Arieh Y. Shalev, MD

Head, Department of Psychiatry, Hadassah University Hospital, Jerusalem, Israel, and Editor and founder, "Sihot — Dialogue," Israel Journal of Psychotherapy

Abstract: This work examines the rationale for, and the feasibility of teaching psychotherapy to psychiatric residents, and the "what if" of dropping it from the curriculum. Psychotherapy is one of the pillars of psychiatry. However, current economic constraints and the increasing weight of phenomenological and biological psychiatry make it more difficult to prioritize and allocate resources to its teaching. The term psychotherapy encompasses several techniques, some of which are extremely effective. It often confounds skills, attitudes, theory, body of knowledge and specific practices. Looking at each component separately, a stepped curriculum for teaching is outlined; alternatives to traditional theories are offered; and the need to allocate time and resources for teaching and learning are shown as the rate-limiting factor for the survival of psychotherapy within psychiatry. Not limited to residents, the debate about psychotherapy in psychiatry concerns the profession's core identity and its traditional person-centered nature.

Introduction

At first blush, everything is in favor of teaching psychotherapy to psychiatric residents in Israel. Psychotherapy is one of the pillars of psychiatry. Psychotherapy offers effective tools for treating anxiety and mood disorders. Learning psychotherapy improves residents' listening and understanding of their patients. Many medical graduates opt to specialize in psychiatry with the hope of becoming psychotherapists.

Moreover, psychotherapy in Israel is in a renaissance. Much of its core literature has been translated into Hebrew. Cross-over psychotherapy books were among Israel's best sellers. A recent television series that described, session by session, five psychodynamic therapies was highly rated by lay spectators and professionals. Israel has a widely read, peer-reviewed periodical of psychotherapy (Sihot — Dialogue, the Israel Journal of Psychotherapy). Each of Israel's major universities has a psychotherapy program. Learning psychotherapy should be easy in Israel.

Nonetheless, the teaching of psychotherapy to psychiatric residents in Israel is in poor shape. Judging from residents' performance during Board examinations, the achievements are quite limited: Reports of psychotherapies are often hesitant, schematic and poorly articulated. Theory rarely seems to be clear to the examinee, or integrated in his or her report. Many reports quote entire books, or drop names of famous theoreticians, without reference to specific portions of their writings. Examiners often get an impression of insufficient teaching and major gaps between residency programs.

From the residents' perspective, the psychotherapy portion of the Board examination has gained a bad reputation: It is perceived as a major hurdle, and even worse, as having unexpected content and unpredictable outcome. Some residents use surrogate writers to write up their cases. Other residents turn to their supervisors for careful review of their reports in an effort to link their practices to theoretical constructs. Preparing for the examination is, very often, the first opportunity to seriously reflect on previously completed therapies.

Thus, discomfort with teaching of and learning psychotherapy affects both providers and receivers. One can only wonder what the underlying reasons of the discontent are: Is the teaching that bad? Are current residents reluctant to learn psychotherapy? Have other areas and skills become prominent and exclusive? Has psychotherapy grown old — or obsolete? Is there a cultural gap between residents from different countries of origin?

These are important questions, but even more important is the effect, on teaching psychotherapy,

Address for Correspondence: Arieh Y. Shalev, MD, Department of Psychiatry, Hadassah University Hospital, POB 12000 Jerusalem 91120, Israel. E-mail: ashalev@cc.huji.ac.il

of the larger context of practicing psychiatry in Israel. The syndrome-based, pharmacotherapy-oriented approach to treatment is currently prominent. Biological psychiatry dominates psychiatric discourse. Time and economic pressures allow but the reputedly most "effective" diagnostic and treatment modalities. The forthcoming reform in mental health services in Israel adds another dimension to these problems.

Considering the latter, the most important concern becomes whether current residents' future roles truly require that we train them as psychotherapists. We can rightfully expect that psychiatric residents will become fluent diagnosticians and pharmacotherapists by the end of their training. Should we also expect them to become fluent psychotherapists? On the other hand, can we afford *not to train* future psychiatrists in psychotherapy? Wouldn't such omission entail a major loss — e.g., of skills, attitudes, therapeutic repertoire and the understanding of complex clinical situations?

This paper addresses these questions. It firstly outlines major trends in the practice of psychiatry and its core knowledge, and their potential to marginalize psychotherapy. Subsequently it explores psychiatry's worldview and leading narrative and the space left for psychotherapy. Then the question of what shall we lose by dropping psychotherapy is raised, and an outline of practical solution drafted.

Indeed, this text is not just about psychotherapy. It concerns psychiatry's changing identity, its shrinking resources, and its ongoing industrialization. Ultimately this article questions our ability to establish preferences under current pressures, and shape the future of our profession by the way in which we train our residents. The text is meant to open a debate — not to close it.

Psychotherapy and Biological Psychiatry

In his seminal article, "New Intellectual Framework for Psychiatry," Kandel (1) appraises the journey traveled by psychiatry between his own residency, at Harvard Medical School, and the profession's current relationship with biological sciences. To illustrate the dominance of psychotherapy, during older times, he quotes the following passage from the then essential textbook, the Harvard Guide of Modern Psychiatry (2).

> The essence of the therapy with the schizophrenic patient is the interaction between the creative resources of both therapist and patient. The therapist must rely on his own life experience and translate his knowledge of therapeutic principles into meaningful interaction with the patient while recognizing, evoking, and expanding the patient's experience and creativity; both then learn and grow from the experience.

Kandel outlines the distance covered between the days in which, following giants such as Freud (who emphasized subjective experiences) or Skinner (who warned against confounding objective observation with neurological assumptions), psychiatry was separated from biology, to current times where biology is central to psychiatry. The earlier separation of the two, he argues, matched "the immaturity of brain science at the time." This is not the case any more.

When I grew up to become a psychiatrist, the same Harvard Textbook of Psychiatry was highly valued, particularly by us residents. We loved its short and concise style and the clarity that it brought to the core question that we had: "What is psychiatry about?"

Starting my residency in Shalvata Hospital, I was also led to believe that personal psychoanalysis was a tool without which I would never acquire true professional qualities. Moving to the Ramat Chen outpatient clinic, my mentors were among the then leaders of existential-humanistic psychotherapy in Israel: the late Franz Brull (3) and the late Yehuda Fried (4).

I was obviously encouraged to take the Psychotherapy curriculum in Tel Aviv University, and it was just natural that I take time from work to be trained in psychotherapy — or to attend my analysis. Importantly, no one opposed my filling my hours with psychotherapies, because prescribing medication, as one of my mentors used to say, was something that you could teach an ape to do. Psychiatrists were needed to do the before, the after and often the instead of prescribing.

What I also remember, very clearly, is that it took me a very long time and much effort to become a fluent psychotherapist — far beyond my time in residency. Aspiring to become a psychotherapist,

however, brought, very early in my training, a change of attitudes towards patients, a different communication style (e.g., wait for the information to flow instead of asking) and focused interest in patients' subjective experiences.

Importantly, learning psychotherapy required one-on-one training and mentorship. It was an apprenticeship. It really helped that many of my teachers and supervisors were psychiatrists, and therefore able to speak both the language of psychotherapy and that of clinical psychiatry. They were good role models in that they personified the combination "psychiatrists-psychotherapists" and showed that practicing that way was possible, professional and rewarding. I continue to hold this view.

Coming back to residents' training: My own learning environment was fair, in that psychotherapy was seen as essential and the required resources were made available to learn it and practice. As a first reflection about today's resident, I wonder whether these two propositions are still sustainable — recognition of relevance and allocation of resources. Specifically, I wonder whether we currently have enough good teachers of psychotherapy among senior psychiatrists, and if the current pressure on residents' time leaves the necessary time for training in psychotherapy.

Frankly, there is more than enough in the biological sciences to require our residents' full attention. Part two of Kandel's article outlines, for example, the essential role of genes, gene expression and gene-environment interaction in psychopathology. The minimal reading tasks that would get our residents acquainted with just the essentials of the above is daunting, e.g., the gene-environment interaction in depression (5), neurogenesis and recovery (6), stress (7) and depression (8), and neuro-circuitary models of OCD (9). Add to that the need to keep abreast of major updates on treatment of mental disorders (e.g., 10, 11) and the resident's entire time for in depth reading is gone.

Nonetheless, Kandel's own argument takes another turn, now presenting psychotherapy as just another biological intervention:

> …when a therapist speaks to a patient and the patient listens, the therapist is not only making eye contact and voice contact, but the action of neuronal machinery in the therapist's brain is having an indirect and, one hopes, long-lasting effect on the neuronal machinery in the patient's brain; and quite likely, vice versa. Insofar as our words produce changes in our patient's mind, it is likely that these psychotherapeutic interventions produce changes in the patient's brain.

And later:

> Psychotherapy and pharmacotherapy may induce similar alterations in gene expression and structural changes in the brain. (1)

Kandel is replicating, almost verbatim, the above-mentioned Day and Semrad text. Indeed, his subsequent "Biology and the Future of Psychoanalysis" (12) mentions several good reasons to keep psychotherapy within psychiatry, namely (a) the efficacy of psychotherapies in several mental disorders, (b) analogies between the unconscious and modern findings of implicit memory, (c) similarities between associative thinking and conditioned learning and (d) demonstrated biological link between early life experiences and adult's psychopathology.

Other scholars (13, 14) have similarly criticized psychiatry's progression from being *brainless* to becoming *mindless* (i.e., without underlying psychological theory). These authors accept the idea that psychotherapy had dominated the practice of psychiatry when "there were no treatments of demonstrated effectiveness. Psychiatric diagnosis had low inter-rater reliability. The 'brain sciences' were largely irrelevant to clinical practice" (14). The author argues, however, that what grew up from struggling with these constraints was extremely important: "psychiatry made a virtue of the failure of its biomedical science by remaining the one medical specialty with a persistent interest in the patient as a person…"

And now that we have somewhat better biomedical sciences to play with — are we turning away from our central interest in the patient as a person? We might, in fact, be doing just that when we preferentially attend to clusters of symptoms in our client's communication, and subsequently follow pre-set treatment guidelines. By turning our attention to symptoms and their course, we might be neglecting information about our client's individual experience, the effect of his or her life trajectory, his or her worldview, formative experiences, significant bond-

ing objects, projected fears and interpersonal style. We (and our residents) are at risk of doing that because biological psychiatry is now becoming our new ethos.

Psychiatry's New Ethos

A patient I saw a few days ago was convinced that he lacked serotonin in his brain. Another said that his body was depleted of Lithium. Many prefer to perceive their illness as brain disorder, rather than having a disease of the spirit (*nefesh*). Our patients do not get these ideas from thin air: they reflect psychiatry's new vista of mental disorders, its current belief system.

Scientifically, however, there are more holes than cheese in this scientific system. Do we really understand the biological mechanism behind depression (where the emphasis has recently moved from receptors and second messengers to neurogenesis)? Can we reliably explain the biology of schizophrenia? Do we actually know — or do we guess — why do our medications help some patients and not others, or why most pharmacological therapies apply across disorders and diagnoses? In other words, can the achievements of biological psychiatry sustain a coherent *worldview* of mental illness?

The answer is that it really does not matter. A worldview does not require coherent or plain evidence. A worldview is there, in fact, to *create coherence*. It does so by bridging logical gaps, reconciling conflicting findings, and making a whole out of patchy puzzles. A worldview is a map (with terra incognita allowed). Once we have a map we can pretend to know where to go — whilst we still err. One is reminded of Freud's adage, "When he who walks in the dark whistles, he feels better, but doesn't see better."

Before biology, psychodynamic psychotherapy provided the map. It gave its believers enough clarity to proceed, and license to make mistakes. A patient in those days could ask whether his or her panic attacks expressed unconscious warnings — or superego assaults — and therapists would scratch their heads and reply. Some patients improved, many did not: it didn't matter much. Once you accept a dogma, failures can only reinforce it — and a vocabulary develops to explain them within the theory. Failing in psychotherapy could be attributed to a therapists' failing to do the right moves, or to the patient's "resistance," "reluctance" or his or her being unfit for a therapy (e.g., those with psychopathic personality).

Biological psychiatry similarly gives us enough certainty to proceed, and allows us to win some cases and convincingly rationalize our failures in others. Even the same terminology applies: "resistant depression"; "refractory schizophrenia," a case with "co-morbidity," a patient with an "Axis II," or just a bad patient. Biological psychiatry is our current worldview. Psychotherapy was dethroned.

Therefore, psychiatrists can be bred and qualified without getting the basics of human psychology. Moreover, training residents against the prevailing worldview, or tangentially to it (i.e., insisting that they allocate time and attention to psychological formulations) is a daring enterprise. It is the fringe.

Except for the other reality: most of our clients have very complex conditions. We see more and more patients with co-morbid, atypical, treatment-resistant or refractory disorders. Young patients come to see us, who do not want to live, and we can diagnose them as much as the book allows — they need psychotherapy. We admit unreachable anorectics to hospitals and fail to change the course of their illness: This does not happen without true bonding. We diagnose borderline personalities in patients who do not properly meet DSM-IV TR Axis I definitions (or meet too many of them). The success of early pharmacological studies cannot be replicated any more. Shouldn't we reconsider psychological therapies?

What Do We Mean by "Teaching Psychotherapy?"

In a strict sense, the term "psychotherapy" invokes treatment (a "therapy"). However, a wider and more frequent use of this term encompasses three distinct domains: (a) a set of interventions, (b) underlying knowledge and theory and (c) a required set of skills and attitudes. In the following I want to argue that each of these domains should be treated independently and that confounding them might explain some of our disappointment with "psychotherapy" and its teaching.

Here are some conundrums:

Because our knowledge about the doctor-patient relationship is informed by psychodynamic constructs (e.g., "transference," "acting out," "secondary gain") we tend to keep teaching the related theory despite its futility. However, we do not have to use psychodynamic constructs to describe our relationships with patients. We can use other terms, such as "patient-centered care," "boundary violation" and "communication skills." The general medical literature includes thorough discussions of "Physician-Patient Relations," "Communication Barriers" or "Nonverbal Communication," etc. These are, in fact, proper MESH terms and therefore retrievable by simple Medline search. Using this terminology will also help us discuss the problems that we see in psychiatry (e.g., how to relate to difficult patients, how to break bad news, how to communicate alarming or pessimistic diagnoses, how to obtain intimate information, reach consent, to maintain patients' trust, etc.) using the same generic terms that other care-providers employ. Most importantly, we shall not have to buy into a belief system when we use these generic terms.

Not that transference or acting-out do not exist. Indeed they are extremely powerful descriptors of patient-therapist interaction. However, their use should be reserved for explaining interactions with a specific patient during specific instances of a therapy. Not everyone who doesn't comply with our prescriptions is acting out. Some need more information, and many would comply if we care to provide soothing human contact, along with the recipe.

Along the same line, as long as we erroneously accept that psychodynamic theories offer accurate and sufficient descriptions of personality development, we remain blind to alternatives, such as attachment theory, the childhood resilience literature (e.g., 15), stress and coping theory (e.g., 16) and straight childhood development literature. Ignoring that knowledge, we may erroneously assume that personality disturbances require transference- or relationship-based psychotherapies.

In sum, the first step towards re-thinking "psychotherapy," in the context of teaching, involves examining each of its components separately. Once disassembled, each component can have its own proof of validity, and thereby its right of access to the curriculum. The teaching of interventions should be judged by criteria related to efficacy, effectiveness and cost-benefit. The theory component should be assessed for congruity with current knowledge. The skills and attitudes component must be seen as the basis for all effective therapeutic relationships — including those in which the therapeutic tool is medication — and should always be taught.

Psychotherapy as theory

An outline of the theories behind psychodynamic, behavioral and cognitive-behavioral psychotherapies is beyond the scope of this article. Therefore, I will only make few comments on theories, their scope and their place in our curriculum.

Freud and his followers have built an extremely well-developed array of theoretical statements about the human psyche. Areas within this theory refer to human growth, human motivation, interpersonal relationships, the structures of the mind, bonding, loss, the foundations of human culture and, of course, treatment, its principles and its techniques. Freud's ability to "package" so many different areas in one theoretical opus is probably behind the robustness of his "project" and its constant appeal despite inconsistencies and contradictions. No other theory offers such a comprehensive view.

The traditional practice of Freudian psychoanalysis, however, required effort and discipline. There were strict rules concerning the frequency of psychoanalytic sessions. The rule of abstention (abstaining from act) encompassed both therapist and his client. Its counterpart, the requirement to divulge every bit of thought to the therapist made the intimate language of the psychoanalytic encounter very different from everyday discourse. A special taxonomy classified the therapist's interventions into specifics such as "interpretation," "clarification," "confrontation," "reconstruction" and the proper use of each could be the subject of teaching and supervision. A grammar of reporting and formulating cases included obligatory mention of "structural," "dynamic," "economic" and "genetic" components. Much of our current practice (and teaching) would have been classified by Freud and his early followers as "savage psychoanalysis," that is, using the "golden rules" erroneously and "out of context."

Importantly, Freud and early psychoanalysts essentially referred to life experience as the source of

current misery. Consequently you had to know a lot about your patients: their parents, the color of the room where they grew up (which could appear as an association in a dream), the smell of their mother's breast, etc.

These well-regulated practices are gone. Subsequent theoreticians, and particularly Kohut's self-object theory, Klein and followers' object relation theories and Winnicott's opus, offer much more freedom and laxity. The resulting practices mainly address the relational aspects of the patient-therapist encounters — at the expense of specific knowledge about patients' biographical makeup. This makes learning and reporting quite easy. In fact, residents often use Kohutian terminology to describe, post hoc, what they had done intuitively: they "held" the patient, "nurtured" him or her, "provided," "contained," "mirrored" or just "were with" the patient. One can argue that this is a degraded use of psychodynamic construct. However, imitating Kohut, or being about-good-enough Winnicott, is often as much as current teaching resources allow. **Teaching residents to theorize, post hoc, is truly perverting and must be stopped.**

Behavioral and cognitive-behavioral therapies rely on operational theories. These theories offer powerful generic propositions about some aspects of the human mind (e.g., associative learning, cognitive schemata) — without pretending to explain everything. Because of such parsimony, these theories have generated extremely effective practices and, most importantly, practices that could be submitted to empirical evaluation. These practices are, therefore, at the forefront of evidence-based psychiatry and, as such, must be taught. The teaching of CBT, in particular, involves concrete and specific steps, which can easily be mastered by residents, with little previous experience.

Surprisingly, the better researched theories (e.g., attachment theory, stress and coping, resilience) have not been translated into specific practices. **Attachment Theory** has more empirical findings behind it than psychoanalytic psychotherapy. **Stress Theory**, and its two offshoots, Traumatic Stress and Stress and Coping contain pertinent information for use by clinicians (e.g., the constructs of "crisis;" "fear conditioning," "cognitive appraisal"). Childhood development studies of **resilience** are a masterpiece of reinstating the role of normal adaptive processes in regulating behavior under strain. All these should be known to every person who attempts to understand people's behavior — and presumably to young psychiatrists.

Psychotherapy and communication skills

Regardless of planning a personal career in psychotherapy, residents must acquire relational skills and attitudes. As argued above, the teaching of those was neglected, probably because they were subsumed as part of teaching psychodynamic psychotherapy. Notwithstanding, learning to listen is essential — or else one has no reliable source of information about the patient. Becoming a participant observer is not a natural skill. Recognizing, respecting and affecting patients' subjective views is a powerful tool — even for enhancing compliance with medication. Getting the patient to play *the* active role in his or her healing is squarely at odds with the practice of prescribing — yet it is essential to many branches of medicine. Becoming the patient's remedy, rather than the provider of treatment, is extremely rewarding — but goes against many of our habits.

None of these can be truly acquired without systematic teaching. I have argued, above, against confounding such teaching with practicing psychotherapy. Nevertheless, if such confusion must persist, then teaching communication skills is the best reason to keep psychotherapy within psychiatry.

Organizational and economic constraints

Superficially, the terms of the forthcoming reform in mental health services in Israel provide coverage for psychotherapy for many disorders. This is a step forward, from a situation in which psychotherapy was most often paid out of pocket and carried in the private sector. However, powerful economic pressures might lead to leaving psychotherapies to psychologists and social workers, leaving psychiatrists to diagnoses and prescribe.

Arguments in favor of such division of labor include the fact that psychiatrists are somewhat more expensive, less available, less well-trained, etc. The essence of the debate, however, is not who is available or at what cost (cognitive therapists are even more difficult to find) — but rather what medicine is about and where it is going.

This is, indeed, the essence of the debate: whether or not one goes along with the growing industrialization of medicine (and psychiatry) — or else if one assumes that this trend is essentially wrong, and might deprive psychiatry (and medicine) not only of their special flavor but, indeed, their core identities.

Patients have clearly made up their minds — and for lack of person-sensitive medicine (that is — for lack of careful listening, time allocation, and "holistic" integration), go by hordes to "alternatives" (e.g., homeopathy, herbal therapy and what not) — practices that pertain to address the whole person — not just his or her pocket.

Taking away psychotherapy from psychiatry is part of a larger trend towards the industrialization of medicine. At least two prominent aspects of industrialization are already with us: (a) standardization of procedures and (b) evaluating performance by its most accessible parameter (in our case — by counting the number of patients seen). The standardization in psychiatry concerns both diagnosis (the DSM algorithm) and treatment (the treatment guidelines). If this trend continues then future psychiatrists will not have time to consider patients for psychotherapy. Indeed, they will not have enough time to properly evaluate a patient — other than by his or her most salient symptoms. They'll make errors — but their errors will cost less than the time required to assure a higher quality of observation and decision making.

Far from being a prediction — a prominent residency program in Israel has already scheduled a patient every 20 minutes in the residents' outpatient portion. In view of these facts, the current chatter about teaching psychotherapy — indeed about teaching person-oriented psychiatry — seems very anachronistic.

Therefore, if the Israel Psychiatric Association decides to maintain the teaching of psychotherapy then such a decision *must* include a strong statement about time allocation. Psychotherapy cannot be taught without protected time. Indeed, protected time is needed to keep psychiatry as the "medical specialty with a persistent interest in the patient as a person." Therefore, the debate about psychotherapy is part of the larger debate about the profession's identity.

A Stepped Approach to Teaching Psychotherapy

For years, we expected our residents to jump, head first, into the most complex task of their profession, namely psychotherapy. Once in the outpatient clinic (i.e., often in their second year of training) each of them was to sit with a patient and provide a "therapy" — squarely without the required knowledge — and often without prior training in basic communication skills.

Having previously subdivided the construct of psychotherapy into three components, I can offer a tentative way to improve the situation. An internet survey of residency training programs in the U.S. can retrieve similar templates (e.g., www10.uchc.edu/education/residency/psychotherapy_curriculum.php for the University of Connecticut; http://psychiatry.wustl.edu/c/Education/resident/b_psyco. for Washington University at St. Louis, etc.). Following is a proposal, in a prescriptive language, however, as a base for further elaboration.

Teaching psychotherapy — phase I

Residency training should start by teaching skills, such as interviewing, taking history, attempting psychological formulation, identifying the psychological component in disease trajectories of patients with major disorder, handling families' distress. Residents should be evaluated at the end of their first year for their ability to create a rapport with disturbed patients, by their being able to understand and express the depth of psychological situations (such as those affecting the families of schizophrenic patients). Residents' ability to identify, characterize and share their emotional responses to patients should receive special attention, as well as their ease in asking difficult question in clinical interviews (e.g., about sexuality, hallucinations or suicidal plans).

Many of my residents describe their first year in psychiatry as particularly distressing because of their contact with mental disorders. As responsible teachers we should make sure that these experiences do not get them too scared or overwhelmed in their clinical experiences. Becoming defensive and overly protecting their hearts and minds can lead our residents to become remote and technical — even as future therapists. How to do that? By being with them,

that is, by considering residency training as, essentially, an apprenticeship.

Psychiatrists can only rely on information obtained from patients and relatives. They have no laboratory and no x-ray behind them to correct their clinical impressions. Therefore, the teaching of these essential technicalities can be equated with the teaching of basic surgical skills to future surgeons. If you miss that phase — you'll never make a good surgeon. The teaching objective of this phase is the following: **At the end of this phase the resident should be able to provide all the non-specific effects of a therapeutic encounter**. He or she should become a therapist (or have a therapeutic presence) well before the first formal psychotherapy.

Teaching psychotherapy — phase II

The second phase should be dedicated to developing specific skills and extending the residents' knowledge of normal human development. Supervised training in CBT should take place at this stage. At the same time the resident can learn to become more insightful into his or her reactions to clinical situations and more assured in his or her ability to monitor and direct clinical contacts with patients. Too often, we see, in the final exams, residents who are unable to conduct a proper interview — or let the patient dictate the pace, the structure and the content of the session. This is not a fault of character — it is lack of dedicated teaching.

This phase should get the residents to become relatively fluent providers of CBT. **At the end of this phase, the resident should be able to integrate and practice his knowledge of human psychology in his understanding of patients, and become a provider of structured psychological therapy.**

Teaching psychotherapy — phase III

Finally, residents should be allowed to choose among the many trends of psychodynamic or other therapies the one that they wish to develop and further proceed to learning the technical specifics and the underlying theory of that particular approach. Resident should not be required to know every existing theory. They should rather explore one approach in depth, practice it under due supervision, master the related literature and be able to discuss its proper implementation. **At the end of this phase the resident should be able to implement, in practice, one body of psychological theory, acquire the underlying literature, conduct a therapy under supervision and realistically assess its achievements.**

Drop Psychotherapy?

The teaching of psychiatry in Israel is handicapped by there being no full-time residency training directors, by residents' starting their residency at any given day of the year, and by the total absence of formal reporting of residents' progress. Systematic teaching of psychotherapy, therefore, will not occur without a supervising body, recommended literature and specific guidance of program directors. Without these, and the above-mentioned protected time, we should seriously consider dropping psychotherapy from the curriculum. It is the role of the Psychiatric Association to make the choice, and eventually establish the necessary structures, or else dismiss the case.

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Teaching Psychotherapy to Psychiatric Residents in Israel — The Residents' Point of View

Renana Eitan, MD, Aviva Cohen, MD, and Ayelet Budick Sharon, MD

Department of Psychiatry, The Hebrew University — Hadassah Hospital, Jerusalem, Israel

> ***It is not incumbent upon you to finish the task, but neither are you free to absolve yourself from it.***
> *(Ethics of the Fathers, Chapter 2, verse 21)*

Biological psychiatry is not considered revolutionary to the recently trained doctor. Quite the opposite, the medical based classification of mental disorders, evidence based medicine and the constant search for pathophysiological mechanisms responsible for mental disorders is a natural progression of today's training of the medical student. With this in mind, the choice of a medical student to dedicate his career to the study of mind and soul is often associated with a halo connected with partaking in psychotherapy. Psychotherapy is considered a fascinating area that combines a unique relationship between therapist and client, combining therapeutic skills with rich theory that allows glances and occasionally the opportunity to reach the inner world of the client.

As trainees, we are witnessing an ongoing battle in the understanding and treatment of mental health patients that vacillates between biological psychiatry and psychotherapy. But we should always remember that both biology and psychodynamics are models, often temporary and changing, of the vast scope of human behavior, emotion and cognition. At our stage in the training process we obviously do not have the ability to win this battle, but the desire to know as much as possible about both biological psychiatry and psychotherapy remains strong. Moreover, given the great amount of "unknowns" even in contemporary psychiatry, we should not aim to develop one authoritative approach to mental health but rather to obtain as broad a basis of information as possible to enable us to discuss and contemplate the complexity of each patient, in conjunction with the psychological and biological knowledge at our disposal.

Looking ahead to the next decade when we will function as independent psychiatrists, we have a responsibility to the survival of both psychotherapy and biological psychiatry, within the psychiatric realm. The future contribution of our research in biological psychiatry by psychiatrists is essential. By the same token our future contribution to the maintenance and development of psychotherapy in the psychiatric context is also crucial and cannot be replaced by non-medical therapists.