Do psychiatry residents identify as psychotherapists? A multisite survey

Nicole M. Lanouette, MD
Christina Calabrese, MD
Andres F. Sciolla, MD
Robin Bitner, MD
Georgian Mustata, MD
Jennifer Haak, MD
Sidney Zisook, MD
Laura B. Dunn, MD

BACKGROUND: Psychiatric training was once synonymous with learning psychotherapy, but current psychiatric trainees face many options for integrating psychopharmacology and psychotherapy into their future practices, including providing primarily medication-focused visits. We examined psychiatry residents’ attitudes towards learning psychotherapy, practicing psychotherapy in the future, and overall identification as psychotherapists.

METHODS: We surveyed residents from 15 US residency programs during 2006-2007. The survey included 36 Likert-scaled items inquiring about residents’ attitudes towards their psychotherapy training and supervision, their level of psychotherapy competence, the role of psychotherapy in their psychiatric identity, and their future practice plans. Four items asked about personal psychotherapy experience. Here we describe findings related to attitudes concerning being a psychotherapist and future practice plans.

RESULTS: Among 249 respondents, most (82%) viewed becoming a psychotherapist as integral to their psychiatric identity. Fifty-four percent planned to provide formal psychotherapy, whereas 62% anticipated psychopharmacology would be the foundation of treatment for most patients. Residents with personal psychotherapy experience and first-year postgraduate residents (PGY-1) were more likely to identify as psychotherapists, plan to pursue further psychotherapy training postresidency, and anticipate psychotherapy being central to their future practice.

CONCLUSIONS: Despite concerns about the diminishing role of psychotherapy in the practice of psychiatry and in psychiatrists’ professional identity, most psychiatric residents view psychotherapy as integral to their professional identities and future practice plans.

KEYWORDS: residents, psychotherapy, professional identity
INTRODUCTION

During psychiatric residency training, future psychiatrists begin crystallizing professional identities and formulating future career plans. For many years, psychiatric training was synonymous with learning psychotherapy. As one psychiatrist recounted, “in 1952, becoming a psychiatrist meant becoming a psychotherapist.” In contrast, current psychiatric trainees contemplating their future practices face many options for integrating psychopharmacology and psychotherapy, including providing primarily medication-focused visits. In fact, over the past 10 years office-based psychiatrists have shifted to providing fewer psychotherapy visits and more medication checks.

Some psychiatric educators have expressed concern that diminished attention to psychotherapy training in residency has shifted the profession’s core identity away from psychotherapy. This shift caused one prominent educator to answer “yes” to the provocative title of his paper, “Are psychiatric educators ‘losing the mind?’” Others have suggested psychiatry could play a leading role in medicine by integrating the mind- and patient-centered foci of psychotherapy with neurobiologic advances.

Most psychiatric educators continue to view acquiring the knowledge, skills, and attitudes underlying psychotherapy as essential to a psychiatrist’s role, regardless of future practice setting or career goals. Moreover, according to the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committee (RRC) for Psychiatry 2008 Program Requirements, all psychiatry residents “should demonstrate competence in applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as to assuring exposure to family, couples, group, and other individual evidence-based psychotherapies.”

Whereas all psychiatry residents receive training as psychotherapy providers, not all are exposed to another influence on emerging professional identity—personal psychotherapy. Some argue that personal psychotherapy remains one of the best routes to sophisticated psychodynamic understanding, helping psychotherapists learn to distinguish their own issues from the patient’s. Others believe that along with more mature altruistic motivations, many psychotherapists choose the profession as “wounded healers”—at least partially interested in resolving their interpersonal conflicts. Regardless of motivation, many psychiatry residents continue to engage in personal psychotherapy.

Despite dramatic changes in psychiatric training and practice, strikingly little research has been done on psychotherapy’s role in residents’ identities as psychiatrists and future career plans. Our study sought to fill this gap by directly surveying residents regarding their attitudes on becoming psychotherapists, including what role being psychotherapists plays in their emerging professional identities and to what extent they plan to incorporate psychotherapy into their future careers. We also examined the association of personal psychotherapy experience with these attitudes and hypothesized that residents reporting more personal psychotherapy experience would be more likely to view being a psychotherapist positively and to report stronger intentions to incorporate psychotherapy into their future careers.

METHODS

Participating programs
The University of California, San Diego (UCSD) Training Director (Dr. Sidney Zisook) posted a study description and invitation to participate on the Association of American Directors of Psychiatry Residency Training (AADPRT) listserv, which includes approximately 150 programs. Twenty-one programs responded, and 15 programs ultimately participated: UCSD (coordinating site); Case Western Reserve University; Emory University; Mayo Clinic; Michigan State University, Kalamazoo; Maricopa Health Systems, Phoenix; St. Elizabeth’s Hospital, Washington, DC; State University of New York (SUNY) at Buffalo; SUNY at Syracuse; University of California, Los Angeles; University of California, San Francisco; University of Kentucky; University of Oklahoma; University of Texas Southwestern; and University of Wisconsin. Six of the initially responding 21 programs did not participate in survey distribution.

Survey development and content
The survey was developed at UCSD and finalized with input from collaborating site coordinators. The final survey included demographic items, as well as 36 Likert-scaled items (rated from 1 = “strongly disagree” to 5 = “strongly agree”). These items inquired about: perceived attitudes toward psychotherapy training at one’s program; perceived quality of psychotherapy training and
supervision; perceived psychotherapy competence, given one’s level of training; role of psychotherapy in identity as a psychiatrist; and future plans to study and practice psychotherapy. Four yes/no items asked about personal psychotherapy experience and access to personal psychotherapy at one’s program. Three items inquired about patient and supervisory contact hours. One open-ended item provided space for general comments about psychotherapy training. Here, we present data from the items on attitudes concerning being a psychotherapist and plans for incorporating psychotherapy into future practice.

### Procedures

Participating programs invited their residents and fellows to participate; the e-mail invitation specified confidentiality procedures and contained a link to the Internet-based survey. Each program’s Institutional Review Board (IRB) approved (or exempted from review) the survey. Local investigators sent up to 3 follow-up e-mails recruiting responses. The coordinating site (UCSD) collected and analyzed data from all sites. To ensure participant confidentiality, we purposely analyzed the data only in aggregate and did not do individual program analyses.

### Data analysis

Five-point-rating-scaled items were subjected to repeated measures Item (within subjects repeated measures) × Training Level (PGY-1 vs PGY-2 vs PGY-3 vs PGY-4 to 6, between subjects) × Sex (between subjects) × Personal Psychotherapy Experience (yes or no, between subjects) multivariate analysis of variance (MANOVA). Conceptually related item sets were contrasted as the repeated measures factors in each analysis; items were reverse scaled as appropriate for consistent direction in analysis. Cohen’s $d$ is reported as a standardized effect size measure.

### RESULTS

Surveys were completed by 249 of 567 psychiatry residents (43.9% response rate). Programs ranged in size from 15 to 76 residents (mean 38). TABLE 1 provides participant characteristics. Approximately one-half of respondents (47%, $n = 118$) reported previous or current personal psychotherapy; 49% ($n = 122$) had not been in psychotherapy, and 4% ($n = 7$) did not respond.

### Identity as a psychotherapist

Most psychiatry residents agreed or strongly agreed (responses of 4 or 5 on the scale, where 1 = “strongly disagree,” 2 = “disagree,” 3 = “neutral,” 4 = “agree,” 5 = “strongly agree”) with the statements “I am proud to be a psychotherapist” (79%), “being a psychotherapist is integral to my sense of identity as a psychiatrist” (81%), and “psychotherapy training influences my life outside of work” (77%) (FIGURE 1). From 9% to 13% gave neutral responses, and 5% and 12% disagreed or strongly disagreed, respectively. Forty percent agreed or strongly agreed that “conducting psychotherapy is the most rewarding aspect of my work”; 39% gave neutral responses and 21% disagreed or strongly

### TABLE 1

**Demographic characteristics of responding psychiatry residents**

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>96</td>
<td>38.7%</td>
</tr>
<tr>
<td>Female</td>
<td>152</td>
<td>61.3%</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>146</td>
<td>58.6%</td>
</tr>
<tr>
<td>Asian</td>
<td>47</td>
<td>18.9%</td>
</tr>
<tr>
<td>African American</td>
<td>15</td>
<td>6.0%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>12</td>
<td>4.8%</td>
</tr>
<tr>
<td>East Indian</td>
<td>11</td>
<td>4.4%</td>
</tr>
<tr>
<td>Other</td>
<td>11</td>
<td>4.4%</td>
</tr>
<tr>
<td>Did not specify</td>
<td>6</td>
<td>2.4%</td>
</tr>
<tr>
<td>Native American</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Marital status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>132</td>
<td>53.0%</td>
</tr>
<tr>
<td>Single</td>
<td>85</td>
<td>34.1%</td>
</tr>
<tr>
<td>Living with partner</td>
<td>25</td>
<td>10.0%</td>
</tr>
<tr>
<td>Divorced</td>
<td>7</td>
<td>2.8%</td>
</tr>
<tr>
<td><strong>Training year</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PGY-1</td>
<td>57</td>
<td>23.1%</td>
</tr>
<tr>
<td>PGY-2</td>
<td>60</td>
<td>24.3%</td>
</tr>
<tr>
<td>PGY-3</td>
<td>57</td>
<td>23.1%</td>
</tr>
<tr>
<td>PGY-4</td>
<td>55</td>
<td>22.3%</td>
</tr>
<tr>
<td>PGY-5</td>
<td>17</td>
<td>6.9%</td>
</tr>
<tr>
<td>PGY-6</td>
<td>1</td>
<td>0.4%</td>
</tr>
<tr>
<td><strong>Program type</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General psychiatry</td>
<td>218</td>
<td>87.6%</td>
</tr>
<tr>
<td>Fellow</td>
<td>23</td>
<td>9.2%</td>
</tr>
<tr>
<td>Combined psychiatry/other</td>
<td>8</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

FIGURE 1

...
disagreed. Most respondents (83%) disagreed or strongly disagreed that “psychotherapy training does not influence my daily work in the residency,” whereas 11% agreed and 7% gave neutral responses. Almost all psychiatry residents (93%) disagreed or strongly disagreed that “psychotherapy is not a skill necessary to being a competent psychiatrist”; only 3% agreed or strongly agreed and 4% gave neutral responses.

Respondents with personal psychotherapy experience were consistently more positive about psychotherapy in responses to items concerning identity as a psychotherapist (Personal Psychotherapy Experience main effect, $F[1,224] = 11.51, P < .001$) (TABLE 2). Those with personal psychotherapy experience expressed more pride in being a psychotherapist (respective means = 4.34 vs 3.96, Cohen’s $d = 0.39$), that being a psychotherapist is integral to a psychiatrist’s identity (means = 4.23 vs 3.97, $d = 0.28$), that psychotherapy training influences life outside of work (means = 3.99 vs 3.65, $d = 0.35$), and that practicing psychotherapy is the most rewarding aspect of their work (means = 3.43 vs 3.18, $d = 0.26$). They also more strongly disagreed that psychotherapy training does not influence daily work in residency (means = 1.85 vs 2.12, $d = -0.28$) and that psychotherapy is not necessary to being a competent psychiatrist (means = 1.43 vs 1.72, $d = -0.31$).

**Psychotherapy in future practice**

More than one-half of respondents (54%) agreed or strongly agreed that they plan to provide a great deal of formal psychotherapy to patients in their postresidency practices (FIGURE 2); 23% disagreed or strongly disagreed, and 23% were neutral. Sixty-two percent agreed or strongly agreed with the statement, “I plan to incorporate my psychotherapy training in my practice after residency, but psychopharmacology will be the foundation of treatment for most of my patients,” whereas 19% disagreed or strongly disagreed, and 19% were neutral. About one-third (37%) agreed or strongly agreed “psychotherapy is a potentially lucrative way to make a living as a psychotherapist,” 32% disagreed or strongly disagreed, and 32% gave a neutral response. More than one-third (38%) agreed or strongly agreed they will pursue additional training in psychotherapy outside residency, 42% disagreed or strongly disagreed, and 20% gave neutral responses. Two-thirds (67%) disagreed or strongly disagreed that “psychotherapy is too time-consuming and costly to be
a practical way to address psychiatric problems," whereas only 12% agreed or strongly agreed.

First-year residents agreed more strongly than more senior residents that they planned to provide a great deal of formal psychotherapy postresidency (means = 3.86 vs 3.15 to 3.44, maximum $d = 0.66$, Item × Training Level interaction $F_{[12,586]} = 2.79$, $P < .01$). First-year and more senior residents did not differ significantly in their responses to items about psychotherapy practice being potentially lucrative (means = 3.16 vs 2.96 to 3.12, maximum $d = 0.18$) or being too time-consuming/costly to be practical (means = 2.51 vs 2.16 to 2.31, maximum $d = 0.30$).

Again, residents with personal psychotherapy experience were consistently more positive about psychotherapy in future practice (Personal Psychotherapy Experience main effect, $F_{[1,224]} = 19.32$, $P < .0001$) (TABLE 3). In particular, residents with personal psychotherapy experience agreed more strongly than respondents without experience that they planned to obtain additional psychotherapy training outside residency (means = 3.25 vs 2.80, $d = 0.41$). They more strongly anticipated including a great deal of formal psychotherapy in their postresidency practices (respective means = 3.59 vs 3.24, $d = 0.32$), and agreed less that psychopharmacology would be the foundation of treatment for most patients (means = 3.29 vs 3.75, $d = -0.42$).

Other mental health professionals as psychotherapists
Forty-two percent of participants agreed or strongly agreed other mental health professionals such as psychologists or social workers are better trained as psychotherapists than psychiatrists; 35% disagreed or strongly disagreed (FIGURE 2). Only 16% agreed or strongly agreed that other mental health professionals should be better trained as psychotherapists, whereas 68% disagreed or strongly disagreed. Residents with personal psychotherapy experience disagreed more strongly than those without such experience that other mental health professionals should be better trained (respective means = 2.15 vs 2.50, $d = -0.30$, Item × Personal Therapy Experience interaction $F_{[1,227]} = 4.77$, $P < .03$) (TABLE 3). Women disagreed more than men that other mental health professionals should be better trained than psychiatrists as psychotherapists (means = 2.15 vs 2.51, $d = -0.32$, Item × Sex interaction $F_{[1,227]} = 7.57$, $P < .01$).

**TABLE 2**

Attitudes of psychiatry residents concerning being a psychotherapist, by experience with personal psychotherapy

<table>
<thead>
<tr>
<th>Attitude itemb,c</th>
<th>Previous or current personal experience of psychotherapy as a patient or client</th>
<th>Overall (n = 240)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Yes (n = 118)</td>
<td>No (n = 122)</td>
</tr>
<tr>
<td>I am proud to be a psychotherapist</td>
<td>4.34</td>
<td>3.96</td>
</tr>
<tr>
<td>Being a psychotherapist is integral to my sense of identity as a psychiatrist</td>
<td>4.23</td>
<td>3.97</td>
</tr>
<tr>
<td>Psychotherapy training influences my life outside of work</td>
<td>3.99</td>
<td>3.65</td>
</tr>
<tr>
<td>Conducting psychotherapy is the most rewarding aspect of my work</td>
<td>3.43</td>
<td>3.18</td>
</tr>
<tr>
<td>Psychotherapy training does not influence my daily work in the residency</td>
<td>1.85</td>
<td>2.12</td>
</tr>
<tr>
<td>Psychotherapy is not a skill necessary to being a competent psychiatrist</td>
<td>1.43</td>
<td>1.72</td>
</tr>
</tbody>
</table>

$^a$Cohen’s $d$: A measure of effect size that is the standardized mean difference.
$^b$Scaled from 1 = “strongly disagree” to 2 = “disagree” to 3 = “neutral” to 4 = “agree” to 5 = “strongly agree.”
$^c$Means are from a repeated measures Item × Training Level × Sex × Personal psychotherapy experience MANOVA. Item effect $P < .0001$; Personal psychotherapy experience effect $P < .001$.
Pooled SD = 0.97. Item mean differences > 0.19 within Personal psychotherapy experience groups or > 0.13 overall differ at $P < .05$ by Fisher’s Least Significant Difference.

**DISCUSSION**
By directly surveying current psychiatric residents, this study provides needed data about psychotherapy’s sta-
Most psychiatric residents (approximately 80%) in our 15-site study were proud to be psychotherapists and viewed being a psychotherapist as integral to their identity as a psychiatrist. Almost all (93%) thought psychotherapy is a skill necessary in a competent psychiatrist. Greater than one-half (54%) planned to provide a great deal of formal psychotherapy (CBT, IPT, dynamic psychotherapy, etc.) to patients in their practice after residency. More than one-third (34%) also planned to incorporate psychotherapy in their daily work as well as their life outside work (27%).

Although psychotherapy appears important to residents’ identities, it is not the sole influence. Most residents (62%) anticipated their future practices would center around pharmacotherapy, and 42% did not plan to obtain additional psychotherapy training after residency. Similarly, a lukewarm endorsement of the statement “conducting psychotherapy is the most rewarding aspect of my work” was observed: 39% gave neutral responses, and 21% disagreed or strongly disagreed.

Our findings are similar to those from a survey of Canadian psychiatry residents (N = 385, 63% response rate). Two-thirds of them indicated the prospect of learning and practicing psychotherapy was a factor in deciding to become psychiatrists, 87% considered psychotherapy ability important to their identities as psychiatrists, and 84% anticipated practicing psychotherapy in some capacity.20 The only other US survey examining aspects of psychiatric education considered essential by residents included only psychoanalysis.22 We cannot compare that study and ours because we included multiple psychotherapy modalities.

Residents in our survey generally agreed with department chairs and residency directors, surveyed in...
1987,\textsuperscript{13} that psychotherapy is an essential skill for psychiatrists. Again, comparison between studies is difficult. The chairs and training directors were asked to rank many skills in terms of relative importance, whereas our study asked whether psychotherapy is an essential skill. In a recent study, psychiatric graduates (N = 134) from the last 3 decades felt psychopharmacology should be emphasized during residency but believed continued psychodynamic therapy training also is important.\textsuperscript{23}

We confirmed our hypothesis that residents with personal psychotherapy experience would be more positive in response to questions about psychotherapy’s role in their professional identities and would intend more strongly to incorporate psychotherapy in their future practices. Additionally, they more frequently reported planning to pursue additional psychotherapy training. These findings are consistent with prior studies in which three-quarters of mental health professionals with personal psychotherapy experience reported their personal treatment had been one of the greatest influences in their professional development and career choice.\textsuperscript{24-26}

These associations between personal psychotherapy and professional identity and career plans have several possible explanations. One is that residents with personal therapy experience have had more therapist role models

| TABLE 3 | Attitudes of psychiatry residents concerning psychotherapy in future practice, by personal psychotherapy experience |
|---|---|---|---|
| Item\textsuperscript{a} | Previous or current personal experience of psychotherapy as a patient or client | Overall |
| | Yes (n = 119) | No (n = 124) | Mean (n = 243) |
| | Mean | Mean | d* | Mean | (SD) |
| Plans for psychotherapy in future practice\textsuperscript{c} | | | | | |
| I plan to incorporate my psychotherapy training in my practice after residency, but psychopharmacology will be the foundation of treatment for most of my patients | 3.29 | 3.75 | -0.42\textsuperscript{*} | 3.52 | (1.02) |
| I plan to provide a great deal of formal psychotherapy (CBT, IPT, dynamic psychotherapy, etc.) to patients in my practice after residency | 3.59 | 3.24 | 0.32\textsuperscript{*} | 3.41 | (1.07) |
| Psychotherapy is a potentially lucrative way to make a living as a psychiatrist | 3.18 | 2.93 | 0.24\textsuperscript{*} | 3.05 | (1.13) |
| I plan to get / I am currently pursuing additional training outside of my residency to improve my psychotherapy skills | 3.25 | 2.80 | 0.41\textsuperscript{*} | 3.03 | (1.24) |
| Psychotherapy is too time-consuming and costly to be a practical way to address psychiatric problems | 2.15 | 2.48 | -0.30\textsuperscript{*} | 2.31 | (0.93) |
| Other mental health professionals as psychotherapists\textsuperscript{d} | | | | | |
| Other mental health professionals (psychologists, social workers, etc.) are better trained as psychotherapists compared with psychiatrists | 3.07 | 3.04 | 0.03\textsuperscript{*} | 3.06 | (1.21) |
| Other mental health professionals (ie, psychologists, social workers, etc.) should be better trained as psychotherapists compared with psychiatrists | 2.15 | 2.50 | -0.30\textsuperscript{*} | 2.33 | (1.10) |

\textsuperscript{a}Cohen’s d: A measure of effect size that is the standardized mean difference.

\textsuperscript{b}Scaled from 1 = “strongly disagree” to 2 = “disagree” to 3 = “neutral” to 4 = “agree” to 5 = “strongly agree.”

\textsuperscript{c}Means are from a repeated measures Item × Training Level × Sex × Personal psychotherapy experience MANOVA. Item effect P < .0001; Personal psychotherapy experience effect P < .0001; Item x Training Level interaction P < .01. Pooled SD = 1.08. Item mean differences >0.23 within Personal psychotherapy experience groups or >0.16 overall differ at P < .05 by Fisher’s LSD.

\textsuperscript{d}Means are from a repeated measures Item × Training Level × Sex × Personal psychotherapy experience MANOVA. Item effect P < .0001; Item x Personal psychotherapy experience interaction P < .03; Item x Sex interaction P < .01. Pooled SD=1.16. Item mean differences >0.23 within Personal psychotherapy experience groups or >0.16 overall differ at P < .05 by Fisher’s LSD.

\textsuperscript{e}Personal psychotherapy group means differ at P < .05 by Fisher’s LSD.

CBT: cognitive-behavioral therapy; IPT: interpersonal therapy; LSD: least significant difference; MANOVA: multivariate analysis of variance; SD: standard deviation.
than residents without such experience. Another is that personal therapy provides an environment for developing familiarity with concepts such as transference and countertransference. For a physician, becoming a psychotherapist can be a complex emotional and developmental process, and personal psychotherapy could help facilitate this growth. For example, personal psychotherapy—if positive and productive—could help establish conviction about psychotherapy’s validity and efficacy, as well as facilitate internalization of the healer role. Perhaps being in therapy helps de-stigmatize or demystify psychotherapy. Alternatively, the same personal characteristics leading some residents to be more amenable to personal therapy also may make them more open to learning and practicing psychotherapy.

Our study highlights some previously noted challenges residents face in developing and implementing psychotherapy skills. Although a minority (16%) of residents agreed that other mental health professionals should be better trained as psychotherapists, a greater proportion (42%) thought other mental health professionals are better trained in psychotherapy. This latter finding may be of particular concern; if this large subset of psychiatric trainees views other mental health professionals as being better trained in psychotherapy, what does this say about the state of psychotherapy training?

More than one-third of respondents agreed they planned to pursue additional psychotherapy training outside residency. This finding could indicate some residents are especially eager to continue improving their psychotherapy skills, possibly viewing becoming a psychotherapist as a lifelong process and seeing residency as 1 step along this path. No doubt most training directors would agree with this assertion and would be disappointed to learn that 42% of their residents do not plan to pursue additional psychotherapy training after residency.

Only 12% of residents thought psychotherapy is too time-consuming and costly to practically address psychiatric problems. Only about one-third (37%) agreed providing psychotherapy is potentially lucrative, however, reflecting previously noted economic challenges to psychotherapy in practice. This is consistent with findings from the 1996-2005 National Ambulatory Medical Care Survey that psychiatrists who provided psychotherapy to all their patients had more self-pay patients and fewer managed care visits in their practices.

The only sex difference emerging from these data was that women disagreed more with the notion that other mental health professionals should be better trained in psychotherapy. In the absence of other sex differences, interpretation of this finding appears unwarranted. The only difference noted across postgraduate years was that first-year residents agreed more strongly than PGY-2 through PGY-6 residents that they planned to provide a great deal of formal psychotherapy in postresidency practice. Because this was not a longitudinal study, we can only speculate about reasons for this difference. Because PGY-1 residents typically have not had training in providing therapy, this raises interesting questions about how these expectations regarding their future practice arose. One possibility is that reimbursement and third-party-payer issues—typically learned later in residency—could lead more senior residents to anticipate providing less psychotherapy than they previously planned. However, the results of the present study do not support this possible explanation. There was no significant difference between first-year and more senior residents in their views of psychotherapy as either potentially lucrative or too time-consuming or costly to be practical. Follow-up longitudinal studies, as well as more in-depth interviews with residents, would clarify these questions.

Our study has several limitations, including possible sampling and response biases. Only 15 of a possible 150 programs participated, likely because of the time commitment required. Program participation depended, first, on the training director responding to the initial AADPRT listserv invitation, and second, enlisting at least 1 resident in their program to be the coordinating resident for that site. Being a resident coordinator included contributing to the survey development, obtaining IRB approval or exemption, and inviting residents in their program to participate. Therefore, it is certainly possible that participating programs may have been more likely than nonparticipating programs to have residents interested in psychotherapy training. Another limitation was the ultimate response rate among residents at participating programs, which was 44%. Residents who responded may have had stronger views, either positive or negative, about psychotherapy’s role in psychiatry. To protect participant confidentiality, we purposely analyzed the data only in aggregate and thus did not compare findings across residency programs. We also did not examine whether residents more strongly identify with particular forms of psychotherapy, nor can we speculate about which forms they are most likely to practice. For the residents with personal psychotherapy experience, we did...
not obtain data on when or what type of psychotherapy they had received. Additionally, because this was a cross-sectional self-report survey, we do not have data on how much psychotherapy these residents actually incorporate in their postresidency practices.

Despite these limitations, we believe this small study provides a timely portrait of psychiatry residents’ perceptions of psychotherapy’s role in their professional identities. Although today’s residents face many competing demands on time and educational needs, most of the participants in this study view psychotherapy as a skill essential for psychiatrists. The majority also view becoming psychotherapists as integral to their professional identities as psychiatrists and plan to incorporate psychotherapy in their future practices.

Future studies should build on these findings by examining changes in resident attitudes towards psychotherapy over time. Also needed is a deeper understanding of how training in specific forms of psychotherapy affects identity. A key finding of our study was the importance of personal psychotherapy to trainees’ identities as psychotherapists. This reinforces that programs should ensure residents have the resources, including access to affordable personal psychotherapy, necessary to develop their psychotherapy skills and their professional identities as psychotherapists.

ACKNOWLEDGEMENTS: The authors thank Katherine A. Green Hammond for her statistical assistance. They also wish to thank the participating sites and residents: Irina Korobkova, MD, Case Western Reserve University School of Medicine; Deeba Ashraf, MD, and Meg Weigel, MD, Emory University; Ranji Varghese, MD, Mayo Clinic; Preti Kalani, MD, Michigan State University, Kalamazoo; Shabnam Sood, MD, Maricopa Health Systems, Phoenix; Ashraf Fanous, MD, Diana Martin, MD, Salman Wahid, MD, and Snejana Sonje, MD, St. Elizabeth’s Hospital, Washington, DC; Jennifer Haak, MD, and Jesus Ligot, Jr., MD, State University of New York at Buffalo; Georgi Mustata, MD, State University of New York at Syracuse; Nicole Lanouette, MD, University of California at Los Angeles; Melanie Deluna, MD, and Robin Bitner, MD, University of California at San Francisco; Jeffrey Tuttle, MD, University of Kentucky; Nicole Washington, DO, University of Oklahoma; Andrea Kim, MD, University of Texas Southwestern Medical Center in Dallas; and Cynthia Singley, MD, University of Wisconsin. Dr. Dunn had full access to all of the data in the study and takes responsibility for the integrity of the data and the accuracy of the data analysis.

DISCLOSURES: Dr. Zisook receives research support from Aspect and Pamlab. He receives honoraria for speaking from GlaxoSmithKline and AstraZeneca. Drs. Lanouette, Bitner, Mustata, Haak, Dunn, Calabrese, and Sciolli report no financial relationship with any company whose products are mentioned in this article or with manufacturers of competing products.

Nicole M. Lanouette, MD
Department of Psychiatry
University of California, San Diego
San Diego, CA, USA

Christina Calabrese, MD
Department of Psychiatry
and Addiction Medicine
Southern California Permanente Medical Group
San Diego, CA, USA

Andres F. Sciolla, MD
Department of Psychiatry
University of California, San Diego
San Diego, CA, USA

Robin Bitner, MD
Department of Psychiatry
University of California, San Francisco
San Francisco, CA, USA

Georgian Mustata, MD
Department of Psychiatry
SUNY Upstate Medical University
Syracuse, NY, USA

Jennifer Haak, MD
Department of Psychiatry
University at Buffalo
Buffalo, NY, USA

Sidney Zisook, MD
Department of Psychiatry
University of California, San Diego
San Diego, CA, USA

Laura B. Dunn, MD
Department of Psychiatry
University of California, San Francisco
San Francisco, CA, USA

Introduction by
Philip G. Janicak, MD • Rush University Medical Center, Chicago, Illinois