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Dear Academy Members,

On May 14 of this year I was honored to become the 56th President of our Academy, the American Academy of Psychoanalysis and Dynamic Psychiatry.

Sixty years ago the Academy was founded as a small, intellectually powerful psychoanalytic organization whose members were frustrated with the orthodoxies of traditional psychoanalytic thought. The founders of the initial Academy were an elite group—movers and shakers, physicians with outstanding academic training, questioners of the very conservative psychoanalytic precepts of the 1950s, probably the most conservative decade in the history of psychoanalysis .

This was a wonderful beginning. Since then the Academy has always been the place where creative thinkers in psychodynamic thinking have presented their ideas and found colleagues and critics to support and challenge them.

Of course, in sixty years a lot happens. The Academy has opened its doors not only to physicians who have completed training at a psychoanalytic institute, but to psychiatrists who have taken the pains to learn psychodynamic principles and use them with their patients. Both groups treat many patients for whom psychoanalysis is unrealistic, yet who need a psychiatrist with a sophisticated understanding of what George Engel called the *bio-psycho-social* approach to development—how development affects functioning, psychopathology, and ability to cope with adversity. Ideas from psychoanalysis like that of a *dynamic unconscious*—a vitally important concept for understanding all mental illness and psychological functioning—are part of psychodynamic understanding that we rely on daily.

More recently, not just psychoanalysis (never a treatment for the many) but also psychodynamic psychotherapy has become endangered as economic pressures from insurance companies, pharmaceutical manufacturers, and government initiatives have continued to limit access to talking treatments, especially treatments that require a high level of skill to do them. With these economic and social forces working adversely against the welfare of psychiatrically ill people, opportunities for psychiatrists to provide psychodynamic psychotherapy have withered. Psychodynamic psychotherapy—not just psychoanalysis-- whether practiced by physicians or other mental health professionals, has become endangered.

Similarly, *training* in psychodynamic psychotherapy for psychiatric trainees, has become more and more difficult to obtain. Except for a few cities in the US where residency programs have supervisory relationships with nearby psychoanalytic institutes, it has become progressively more and more difficult for psychiatric residency programs to ensure the required competency in psychodynamic psychotherapy which is required by

accrediting bodies. Later on in the year, I'll return to the topic of what the Academy is doing to address challenges in training psychiatric residents in psychodynamic psychotherapy.

Today I'd like to address another topic—the relevance of training in *psychodynamic psychotherapy* for all of us and for our younger colleagues. This is not to de-value psychoanalysis. I am a graduate of a psychoanalytic institute myself and serve on the faculty of a psychoanalytic institute. I give thanks every day for the training I received at my institute in very intensive exploratory treatment.

But this kind of training, this kind of treatment, has become a luxury. And psychodynamic psychotherapy—both training and the clinical work itself—must be preserved. Recently the editors (Rick Friedman, Cesar Alfonso, and myself) of the Academy's journal, *Psychodynamic Psychiatry*, wrote an editorial about contemporary psychodynamic psychiatry. The article notes a number of ways psychodynamic psychiatry is different from classical psychoanalysis. I'm going to summarize some of it here. This is what we said:

1) Modern psychodynamic psychiatry has a positive attitude toward neuroscience and psychobiology.

2) Psychodynamic psychiatry has a positive attitude toward research

3) Psychodynamic psychiatry has a positive attitude toward academic psychology and psychiatry.

4) Psychodynamic psychiatry takes a critical view of Freud's contributions. This means that in the roughly 125 years since Freud began his work, some of his ideas have not held up to closer examination though others are as relevant today as they were then.

5) Psychodynamic psychiatry has a positive attitude toward psychopharmacology

6) Psychodynamic psychiatry has a positive attitude toward descriptive psychiatry.

7) Psychodynamic psychiatry emphasizes diagnostic assessment more than it emphasizes any specific type of treatment.

In that editorial we wrote, "It is astonishing, even shocking, that American psychiatry is in serious danger of throwing out the "baby" (viable and useful ideas that originally came from psychoanalysis) with the "bathwater" (psychoanalytic dogmatism). Most ideas accepted by modern psychodynamic psychiatry and psychology rest on a sound empirically validated foundation."

I have the warmest feelings for the Academy with the many personal and professional friendships, shared experiences, and the shared professional identity that it offers. This is the pleasure of being a member of this small, friendly organization. But

our Academy is not just a wonderful place to be affiliative with like-minded colleagues. It is our task to work together to do what we can to preserve psychoanalytic psychology and psychodynamic psychiatry. We can do that by talking about it at our meetings, publishing about it, and teaching it to our residents and candidates. We also must look out to the larger world of health care and make sure that access to psychodynamically sophisticated care survives for mentally ill people who need it.

We have no time to argue over the small differences between schools of psychoanalytic thought. We must unite to preserve and develop the important knowledge that psychoanalysis and psychodynamic psychiatry have given us. We must do our best to insure that all psychiatrists finishing training know how to perform a psychodynamically informed assessment and that they are able to recognize those individuals who need psychodynamic psychotherapy even if they cannot because of time constraints themselves perform it. Just as we advocate for individuals whose illness cries out for medication as part of the treatment approach, so must we advocate for patients who need a psychodynamically informed approach in order to get well.

I look forward to working with you over these next two years to advocate for our patients and our field in all the ways that we can.

References:

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