# Innovative Educational Initiatives to Train Psychodynamic Psychiatrists in Underserved Areas of the World

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**KEYWORDS**

• Psychodynamic psychiatry • Psychotherapy • Transcultural psychiatry
• Psychiatric education • Low-income and middle-income countries

**KEY POINTS**

- Psychotherapy training is insufficient despite available standardized psychiatric residency curricula.
- Cultural adaptations of psychotherapy remain crucial and relevant in psychiatric training.
- Pedagogical innovations with international collaborations bridge educational gaps of psychodynamic psychiatrists in underserved countries.

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## INTRODUCTION

Although psychoanalysis is not commonly practiced in many areas of the world, psychodynamic perspectives and constructs enhance the standard of care of the more widely used supportive and cognitive-behavioral (CBT) psychotherapies. The multimodal integrative approach of balancing cognitive restructuring and correcting cognitive distortions, along with uncovering, interpretative, and supportive interventions, helps patients understand behavior and gain higher levels of functioning.

This article describes educational initiatives of the World Psychiatric Association (WPA) in collaboration with psychiatrists in Thailand, Indonesia, and Malaysia; and a psychotherapy training fellowship in Iran that emphasizes psychodynamic theory. Educators who are officers and members of the WPA sections (committees) on Psychoanalysis in Psychiatry and Education in Psychiatry and Psychotherapy, from Columbia University, Chulalongkorn University, the Royal College of Psychiatrists in Thailand, the Universitas Indonesia, University of Malaya, and the National University of Malaysia, designed a teaching and mentoring program to improve competency in psychodynamic psychotherapy.[1] The WPA project included a series of live workshops, followed by a semester of advanced psychotherapy courses using video conferencing and email moderated discussions, with the objective to train psychiatrists to become expert psychotherapists. Additionally, faculty development seminars were designed to engage course graduates to develop pedagogical skills. Also, a mentoring system was created to ensure self-sufficiency and enduring results. The Tehran University of Medical Sciences (TUMS) Psychotherapy Fellowship Program is also presented as an alternative advanced psychotherapy educational model that could be replicated in other countries.

Challenges affecting the implementation of educational models include limited psychiatric staffing resources, fulfilling public health needs, and considering cultural adaptations in psychotherapy training.

## PSYCHIATRIC STAFFING RESOURCES WORLDWIDE

Worldwide, psychiatric staffing resources are influenced by income disparities. Staffing is of essence to provide adequate clinical services, as well as allowing more flexibility for physicians to balance academia with clinical duties.[2] Currently, the psychiatry workforce rate in the world is 1.2 per 100,000 (psychiatrists per 100,000 population, with an SD of 6.07), although psychiatrists are vastly unequally distributed. Europe has 9.8 per 100,000 and the United States 15.2 per 100,000, whereas Africa has approximately 1800 psychiatrists to take care of a population of greater than 700 million (0.04/100,000). The 2 most populous countries in the world, China and India, have estimated rates of 1.53 per 100,000 and 0.3 per 100,000, respectively. The World Health Organization (WHO) Global Health Observatory (GHO) 2015 data[3] needs to be interpreted with caution because it tends to underreport.[4]

The World Bank classifies countries into 4 categories based on income. Using the gross national income (GNI) per capita as an economic indicator, low-income, lower middle-income, upper-middle-income, and high-income countries are defined as those with GNI per capita of $1005 or less, $1006 to $3955, $3956 to $12,235, and $12,236 or more, respectively. This article focuses on countries with low-income or lower-middle-income economies because 149 out of 195 countries in the world are in this category. In these countries, the workforce disparities are overwhelming because 10% of the global psychiatric labor force cares for two-thirds of the world population.[4]

It is customary for specific geographic subregions to be consolidated as cultural zones determined by economic or other sociocultural agreements or clusters, such as the Association of South East Asian Nations (ASEAN) or Latin America. Notably, the cultural diversity between the nations included in these zonal conglomerates and that clinical reality psychiatrists face in the subregions varies widely. **Table 1** examines the psychiatric workforce diversity in the ASEAN and Latin America regions.

**Table 1**
**Psychiatrists in Association of South East Asian Nations and Latin American countries**

| | GNI per Capita | Psychiatrists per 100,000 Population |
|---|---|---|
| Brunei | High | 6 |
| Cambodia | Lower-middle | 0.34[32] |
| Indonesia | Lower-middle | 0.29 |
| Laos | Lower-middle | 0.03 |
| Malaysia | Upper-middle | 0.8 |
| Myanmar | Lower-middle | 0.29 |
| Philippines | Lower-middle | 0.46 |
| Singapore | High | 3.48 |
| Thailand | Upper-middle | 0.87 |
| Vietnam | Lower-middle | 0.91 |

| | GNI per Capita | Psychiatrists per 100,000 Population |
|---|---|---|
| Argentina | High | 11.5 |
| Bolivia | Lower-middle | 0.82[32] |
| Brazil | Upper-middle | 3.49 |
| Chile | High | 4.66 |
| Colombia | Upper-middle | 2.53 |
| Costa Rica | Upper-middle | 0.98[32] |
| Cuba | Upper-middle | 2.08[32] |
| Dominican Republic | Upper-middle | 1.08 |
| Ecuador | Upper-middle | 1.09 |
| El Salvador | Lower-middle | 0.32[32] |
| Guatemala | Lower-middle | 0.29 |
| Haiti | Low-income | 0.07 |
| Honduras | Lower-middle | 0.38 |
| Mexico | Upper-middle | 0.67 |
| Nicaragua | Lower-middle | 0.65[32] |
| Panama | Upper-middle | 3.80 |
| Paraguay | Upper-middle | 2.00 |
| Peru | Upper-middle | 0.76 |
| Puerto Rico | High | 2.37[32] |
| Uruguay | High | 11.35[32] |
| Venezuela | Upper-middle | 0.7[32] |

*Data from* World Health Organization (WHO), World Psychiatric Association (WPA). Atlas: psychiatric education and training across the world 2005. Geneva (Switzerland): World Health Organization; 2005.

Regardless of psychiatric workforce general statistics, the provision of intensive psychotherapies is limited in most countries and formal psychoanalytic and psychodynamic psychotherapy training is rarely available outside of countries with high-income economies. This article examines creative ways to fulfill psychodynamic psychiatry competencies and offer training in underserved areas of the world.

## PSYCHOTHERAPY EDUCATION: COMPETENCY VERSUS PUBLIC HEALTH APPROACHES

### *Competency-Based Education*

Competency-based learning has come to be seen as a preferred training model because of its emphasis on the acquisition of practical, clinical skills (as opposed to traditional, theory-based training), though it has largely been implemented only in countries with high-income economies. This model assumes that psychiatrists should have expertise in treating a range of mental disorders, as well as possessing specific fundamental clinical skills.[5] In the United States, the Milestones Project, a joint initiative of the Accreditation Council of Graduate Medical Education and the American Board of Psychiatry and Neurology, provides a framework for the progressive assessment of trainees focusing on competencies that include psychotherapy and, specifically, psychodynamic psychotherapy.[6]

The competency-based learning model in countries with low-income and middle-income economies is difficult to implement.[4] Psychiatry residents in underserved areas struggle to provide ethical care to a high volume of patients while simultaneously attending to educational needs. In these scenarios, faculty members in busy hospitals and clinics teach best through clinical demonstrations rather than in the classroom. The apprenticeship model of 1-to-1 faculty–trainee clinical supervision is highly useful with respect to some clinical learning but may not produce desired outcomes if staffing resources are inadequate and if pressing service needs preclude protected educational experiences.

### *Public Health Emphasis*

In challenged geographic areas, psychiatrists engage in clinical management and consultation as active liaisons with primary care providers, and take on public health leadership responsibilities.[7] A public health emphasis may be more prudent in the clinical care of persons in countries with low-income and middle-income economies. An educational model that expands care from the individual to the community would be ethically appropriate to match resources with the high burden of disease.

Most public health–informed care delivery models, especially in low-income and middle-income countries, assume that psychiatrists have very limited time to provide direct clinical services and, instead, focus on oversight and administering resources. This is the model proposed by Patel[8,9] to best address the global burden of mental illness, based on successful public health initiatives around the world. Changing the historical role of the psychiatrist from that of direct caregiver to that of supervisor or consultant, while meeting some clinical needs, poses risks. Among those risks is the concern that a psychiatrist who practices very little, and who has had limited clinical experience, may be ill equipped to supervise, especially over time. The health teams in the public health model are to be composed of diverse workers who could deliver specific tasks under the guidance of or in collaboration with psychiatrists. Such interdisciplinary collaboration is certainly beneficial; however, when using this model in particular, most psychotherapeutic interventions are assigned to counselors with more limited training.[4]

### *A Combined Educational Approach*

The authors take the position that the competency-based and public health-minded pedagogical approaches can be combined to inform curricular and training model design, and that both aims can accommodate psychotherapy training and supervision of psychiatric residents, including in countries with low-income and middle-income economies. In such a combined model, psychotherapy training and, specifically, psychodynamic psychotherapy training are seen as informing the psychiatrist's understanding of systems and group dynamics (useful in serving as a team leader), as well as providing the psychiatrist with a sound clinical base from which to provide meaningful and expert guidance to team members. Also, the psychiatrist would take on the responsibility for the most complex cases, often providing care to those individuals directly. Primary care providers and other mental health clinicians would still carry the larger burden of care in these health systems.[4]

Some of the most complex cases include patients with multiple comorbidities, including the concurrent presence of severe personality disorder, together with patterns of impulsivity, heightened risk of self-harm, and frequent decompensation. These patients have been shown to benefit from psychodynamic psychotherapy[10–12] and, because they tend to be high users of services,[11] appropriate expert treatment by a well-trained psychiatrist may over the longer term realize significant cost-savings, as well as relieving suffering and improving quality of life. The literature suggests that pharmacotherapy in these patients is of limited benefit unless integrated with psychotherapy.[10,11] Research demonstrating that a psychotherapy dose effect is relevant for complex conditions supports this assertion.[11,13]

Although there are a variety of models with which providers can work, psychodynamic psychotherapy training has been shown to provide the best structure for safe and ethical practice. The authors maintain, with confidence, that psychodynamic training is essential because it affords practitioners the requisite skills to creatively adapt methodologies to the patient's circumstances while grounding the clinician in a framework that demands self-reflective awareness; attention to nuances of meaning and communication; and a profound, unwavering patient-centered focus. Because not all providers can be trained in psychodynamics, it is appropriate that the psychiatrist or team leader possess these skills.

The following sections describe examples of successful ongoing educational initiatives in diverse areas of the world, applying culturally informed models of collaborative care and competency-based approaches.

## CULTURAL ADAPTATION OF PSYCHOTHERAPY TRAINING

Cultural adaptation of psychotherapy training addresses change over time; or the dynamics of societal, political, and other environmental factors that may influence the values and belief systems of individuals intergenerationally.

Understanding the cultural factors of the generational gaps between students and supervisors enhances the teaching processes in psychiatry.[14] In underserved areas, the competency-based training approach, although cumbersome if the psychiatric workforce is inadequate, may be increasingly plausible because younger trainees are more comfortable multitasking and can focus attention better than their teachers; they are highly skilled with swiftly shifting mental sets and can incorporate technological advances in learning and clinical practice. Nevertheless, sharing the burden of patient care with other mental health professionals may be prudent in underserved areas to optimize the use of scarce resources.

Psychiatry educators need to pay close attention to cultural factors associated with disease onset, illness course, and psychotherapy treatment outcomes. The biopsychosocial model postulates that the biomedical paradigm constricts clinical care, and exploration of psychosocial aspects is essential to be fully therapeutic.[15] Psychosocial determinants affect the therapeutic alliance, treatment adherence, treatment response, and prognosis.[16,17] Important psychosocial determinants in psychodynamic psychotherapy treatments include

- Understanding of illness
- Willingness to seek and accept treatment (ambivalence, contemplation, precontemplation)
- Shared attributes
- Learned attitudes
- Belief systems
- Value systems.

Societal and family views and attitudes about illness influence the psychotherapy discourse through transferences, enactments, and parallel processes.

Cultural sensitivity needs to take place beyond identifying relatively rare and exotic culture-bound syndromes, or encouraging trainees to mechanically construct cultural formulations. Although language affinity between clinician and patient promotes attunement, other factors are equally important. Determinants of cultural attunement include identifying

- Nuanced symbolic meaning that may be alien to the clinicians' way of thinking
- Idiosyncratic ways of communicating distress
- Idioms of distress that are culturally sanctioned or encouraged, such as a propensity toward either somatization or psychologizing, without fluid expression of affect.

Although, in the authors' collective experience, cultural similarities tend to outweigh differences, trainees need to understand the cultural makeup of each individual patient. The psychodynamic techniques of detailed inquiry and neutral curiosity[18] are helpful in constructing a careful anamnesis; however, this needs to occur without excessive countertransferential enthusiasm that could derail the process.

Of importance in psychotherapy training is exploration of cultural aspects of religion and spirituality in clinical care. It is challenging to incorporate cultural heritage data and the associated symbolism when making psychotherapeutic interpretations. Some basic knowledge of social sciences, such as philosophy, theology, and anthropology, could inform medical education and postgraduate training. Rather than assuming that spiritual advisers or community elders will contaminate the treatment space, psychotherapists should encourage synchronized efforts toward a common therapeutic goal. Creating liaisons with clergy, religious leaders, and organizations should be encouraged rather than discouraged, in the same way that collaborative models of care are inclusive of other health professionals.[4] Similarly, learning to be sensitive and neutral to historical and political development of different nations and ethnic groups, and their taboo themes could facilitate the development of the therapeutic alliance in transcultural treatments.

To adequately promote mental health, one needs to attend to the multiple dimensions of stigma as it relates to mental disorders in diverse populations. Other relevant cultural issues that permeate psychodynamic treatments include

- Attention to migration
- Traumatic displacement because of political turmoil

- The pandemic of intimate partner violence
- Victimization of children.

Learning to adequately liaise and advocate with social and protective services contextualizes psychotherapy treatments while protecting basic human rights.

## TECHNOLOGY IN THE SERVICE OF BRIDGING EDUCATIONAL GAPS

Because incorporating technological advances in everyday life has taken on a life of its own, using the Internet in the practice of intensive psychotherapies is now widely accepted, despite pitfalls and legitimate concerns about protecting confidentiality. Similarly, Internet-based videoconferencing has been effectively used to bridge educational gaps in geographically compromised and underserved areas.[19]

The most successful distance learning enterprise is the China America Psychoanalytic Alliance (CAPA) educational programs, offering advanced psychodynamic psychotherapy courses, supervision, and personal psychotherapy to clinicians in China, mostly through secure Internet-based video with episodic site visits. More than 200 students have graduated from CAPA courses since its inception in 2008, and more than 150 volunteer faculty members from the Americas and Europe actively serve as educators.[20]

Other successful educational programs that are, at least in part, Internet-based include international collaborations between the University of Colorado School of Medicine and the University of Health Sciences Cambodia,[21] the Hamad Medical City Program in Qatar and Cornell University,[22] and the University of Toronto and Addis Ababa University in Ethiopia.[23] The following section details an innovative WPA intersectional program implemented in 3 ASEAN countries.

## WORLD PSYCHIATRIC ASSOCIATION PSYCHODYNAMIC PSYCHOTHERAPY TRAINING PILOT PROGRAMS IN THE ASSOCIATION OF SOUTH EAST ASIAN NATIONS COUNTRIES

The aforementioned WPA sections identified a need to provide mentorship and facilitate career development in addition to offering workshops and symposia at regional conferences and world congresses. Psychiatrists, particularly from underserved areas, have a strong interest in learning psychodynamic psychotherapy. In Southeast Asia, young psychiatrists approached WPA speakers at regional conferences and asked for curricular guidance collaborations while clearly stating that clinical workshops were their preferred educational method for improving competency. As a result of this feedback, full-day workshops illustrating the relevance of psychodynamic thinking in a variety of clinical settings were piloted in Bangkok, Jakarta, and Surabaya beginning in 2012. An identical workshop was replicated in Kuala Lumpur during their national psychiatric conference in 2013.[24]

After preliminary planning in Bangkok in 2012, a pilot follow-up course was codesigned by colleagues from the Royal College of Psychiatrists of Thailand jointly with WPA section members, with the goal to train a select group of academic early-career Thai psychiatrists to improve their psychodynamic psychotherapy knowledgebase and gain confidence as clinical supervisors. The success of this course led to replication of the initiative in neighboring Malaysia and Indonesia. Over a period of 5 years, the WPA and national organizations in 3 ASEAN countries agreed to collaborate on a more comprehensive educational project. **Fig. 1** summarizes the 5-tiered pedagogical intervention now near completion.[1,25]

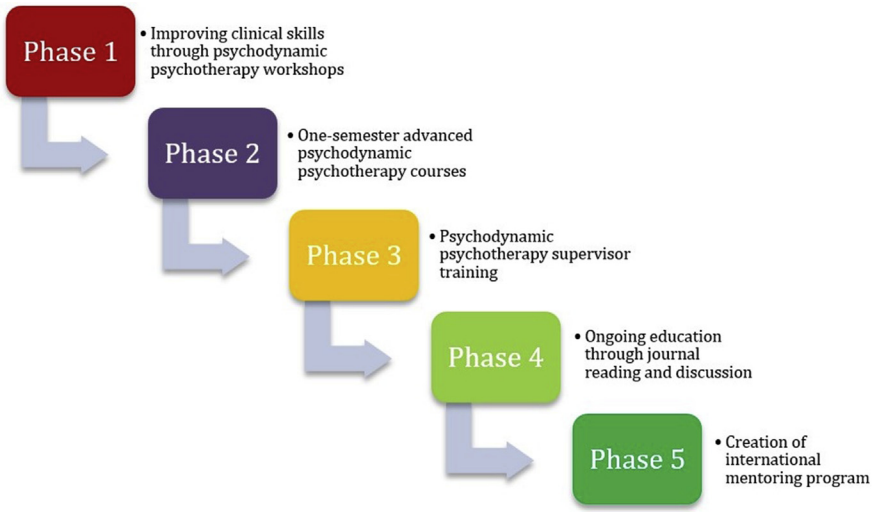


**Fig. 1.** Five-tiered pedagogical intervention.

### *Phase 1: Workshops to Improve Clinical Skills*

Between 2012 and 2014, Alfonso, Zakaria, Aida Adlan, Kalayasiri, Elvira, and Lukman orchestrated multiple full-day advanced psychodynamic psychotherapy workshops in national meetings conducted by the Indonesian Psychiatric Association Psychotherapy Section in Jakarta and Surabaya, the Malaysian Psychiatric Association in Kuala Lumpur, and the Royal College of Psychiatrists of Thailand in Bangkok. WPA section chairs Tasman, Nahum, Botbol, Bennani, and WPA committee members Ammon and Onofrio were supportive of these efforts, because Asian countries at the time were underrepresented in the respective WPA sections.

Each workshop attracted approximately 35 to 50 participants; 260 participants attended the workshop in Kuala Lumpur. Local psychiatrists selected by host psychiatric societies ran these workshops and the modules were chosen according to the experts' areas of interest, with emphasis on application of psychodynamic thinking and clinical correlations in a variety of clinical settings. The local psychiatrists were invited to become active members of WPA sections or study groups on completion of the activities.[1]

### *Phase 2: 1-Semester Advanced Psychodynamic Psychotherapy Courses*

Subsequently, for each of the 3 countries, a 1-semester follow-up advanced online psychodynamic psychotherapy course was designed and conducted sequentially over 2 years, in which 8 participants were chosen through a competitive application and selection process by the national societies. The course had a core curriculum of 40 selected articles and textbook chapters and was conducted mostly in a virtual classroom (90-minute class every other week through videoconference) in which peer and thematic supervision took place. A moderated email listserve discussion forum was established, as well as on-site learning at the end of the semester. The end of semester lesson was conducted in conjunction with the corresponding national psychiatric society meetings. The courses were held in 2014, 2015, and 2016, in Thailand, Malaysia, and Indonesia, respectively. Each course had 2 to 3 coteachers: César Alfonso (United States), Rasmon Kalayasiri (Thailand), Hazli Zakaria and Aida

Syarinaz Adlan (Malaysia), and Petrin Redayani Lukman and Sylvia Detri Elvira (Indonesia). In addition, the coteachers chose student-coordinators: Natchanan Charatcharungkiat (Thailand), Najwa Hanim Rosli (Malaysia), and Rizky Aniza Winanda (Indonesia).

The classes in this course were clinically focused in a case-conference style, in which each student was responsible for providing a written and oral presentation of a psychotherapy case, doing psychodynamic formulations, and preparing questions for discussion. Readings based on the core curriculum were matched based on the clinical relevance of individual cases, and students were required to critique theory and technique. To ensure engagement, classes were conducted bilingually in each respective country, while the student-coordinator served as the translator and maintained English as the common language. Patient confidentiality was protected by requesting informed consent, omitting identifying information, encrypting files, and using secure videoconferencing technologies.[1]

### *Phase 3: Training Psychodynamic Psychotherapy Supervisors*

WPA intersectional leaders collaborated in designing full-day workshops aimed at improving supervision skills that took place in Indonesia and Malaysia. The first WPA intersectional workshop on psychodynamic psychotherapy supervision was in Malang, East Java, Indonesia, in March, 2017; the second was in Kuching, Sarawak, Malaysia, in July, 2017. These workshops were attended by a total of 75 participants, all psychiatrists engaged as intensive psychotherapy supervisors in academic medical centers. The workshops were also designed to further train the graduates of the phase 2 WPA psychodynamic psychotherapy programs to embrace their supervision responsibilities with mastery.

The supervision workshops combined small-group exercises and discussion, and brief lectures followed by interactive discussions. An interactive exercise examined the fine line between clinical supervision and psychotherapy of a supervisee, how to navigate between 1 dimension and the other, and under what circumstances one could integrate them in countries where residents have little or no access to their personal or training psychotherapy.

A workshop lecture module focused on describing psychodynamic psychotherapy competencies and ways to translate theory into technique through apprenticeship, including observation, collaboration, and assessment. Two videotapes were shown illustrating in vivo psychodynamic psychotherapy supervision, which highlighted how to teach theory and technique. Indonesian and Malaysian supervisors prepared these videos, which were conducted in Bahasa Indonesia with English subtitles and bilingually in Bahasa Melayu and English.

One workshop module focused in detail on the management of parallel processes in supervision, understanding enactments and projective counteridentification. Another module examined supervision as a process of progressive development, achieving mastery by moving along a continuum of milestones that progress from high motivation, inexperience, and high anxiety in beginners; fluctuating confidence and motivation with discouragement when facing impasses at midlevel; and security, consistency in attunement, serenity, and humility in advanced practice.[26]

A small-group exercise that followed focused on helping peers and trainees explore countertransferences in a systematic way, including erotic feelings and emotional states of boredom, rescue fantasies, rage, inadequacy, and sadness.

Finally, a workshop module traced the developmental progression of how supervisors help advance supervisees from inexperience to expertise, ego-supportively, by becoming self-objects and therapeutic role models. Workshop participants in this

way learned how the transition from supervisors to mentors and peers brings about full circle the ultimate aim of clinical supervision.[1,27,28]

### *Phase 4: On-Going Education Through Review of Journal Readings*

In the fall of 2017, graduates from the advanced course took charge of coordinating continuing education. Warut Aunjitsakul and Kanthee Anantapong, psychiatrists from Prince of Songkla University Thailand, coorganized of a 1-year psychotherapy journal club list serve for all 30 graduates and coteachers from the online courses. Activities of this phase include in-depth review of 12 recent articles published in the scientific journal *Psychodynamic Psychiatry*, in which an article is discussed every month over email list serve; journal article authors and editors are invited to mentor and participate in the discussions.[1]

### *Phase 5: Creating an International Mentoring Program*

Course graduates and coteachers are also organizing an International Mentoring Association of Psychodynamic Psychiatrists, with the aim of advancing intensive psychotherapy practice through regional scientific meetings led by course graduates, and encouraging publications through collaborative efforts with WPA intersectional members serving as mentors and senior authors. This core group of mentors, teachers, and graduates is becoming a network of psychodynamic psychotherapy expert practitioners and supervisors.[1]

Although the long-term impact of this initiative is yet to be measured, since the inception of the pilot program, 15 graduates and all coteachers have actively participated in WPA-sponsored intersectional workshops and symposia in Hong Kong, China; Taipei, Taiwan; Berlin, Germany; and Florence, Italy, over the last triennium. They have published 3 articles in peer-reviewed journals, including *Psychodynamic Psychiatry*, the *ASEAN Journal of Psychiatry*, the *British Journal of Psychiatry International*, and contributed in 2 chapters to the upcoming edition of the book *Advances in Psychiatry*.[1,4,17,29,30]

In terms of overall program feedback, students appreciate the innovative educational approach that emphasizes group cohesion, as well as incorporating theory into practice. Difficulties such as complexity of the core curriculum and short deadline periods can be overcome by extending the course duration to allow additional time to discuss readings and increased coteacher presence during individual learning, while also providing sample video clips of experts conducting psychodynamic psychotherapy sessions.

Despite the perceived difficulty in providing psychodynamic training in countries with scarce resources, academics can make the most of current innovations in pedagogical methods by engaging in international collaborations with emphasis on mentorship and sensible cultural adaptations. With a directive of empowering and inspiring local talent, this educational model can perhaps be replicated in other underserved regions where psychotherapy training is suboptimal.

## PSYCHODYNAMIC PSYCHOTHERAPY FELLOWSHIPS: THE TEHRAN UNIVERSITY OF MEDICAL SCIENCES MODEL

The Islamic Republic of Iran is located in Western Asia with an estimated population of 80 million as of 2017. Persia (Iran) has a rich medical history dating back millennia, as well as a strong psychiatric community with a psychotherapy tradition. Avicenna and Zakaraiyya al-Razi promoted the role of speech medicine and soul treatment as adjunctive to somatic treatments. The psychiatric workforce in Iran is mostly limited

to the larger cities of Tehran, Isfahan, Mashhad, and Shiraz, where most of the 1700 Iranian psychiatrists practice in combined inpatient and outpatient settings. One of Iran's 14 university-based psychiatry residency training programs is the TUMS program, with 65 residents and 6 psychotherapy fellows. Political and economic sanctions imposed against Iran dating from 1979 resulted in marginalization and international seclusion from the academic community. Recently, some of the sanctions have eased and international participation in conferences, as well as videoconferencing, is beginning to reestablish Iranian psychiatry into the mainstream. The authors would like to highlight the psychotherapy fellowship program in TUMS for its comprehensiveness, attention to erudition, and clinical relevance.[4,31]

The TUMS psychotherapy fellowship is competitive and uncompromising. The fellowship emphasizes accepting trainees from diverse parts of Iran to equip them with the skills of becoming psychotherapy residency training supervisors. Through the 18-month program, early career psychiatrists or psychiatry residency graduates are allowed to learn through observation, assistance with and independent practice of psychodynamic psychotherapy, CBT, group psychotherapy, family therapy, spiritual psychotherapy, and supportive psychotherapy. In addition, enrollees work in treatment settings such as inpatient and outpatient psychiatric services (for 17 months), in conjunction with the psychosomatic medicine service (100 hours), child and adolescent psychiatry clinic (200 hours), addiction study center (100 hours), and a 1-month elective setting. San'ati developed a single-gender group therapy model that suits the Iranian socio-cultural context and is included in this fellowship program.[4,31]

At the end of the fellowship, trainees complete a total of

- 400 individual psychodynamic sessions
- 220 CBT sessions
- 70 schema therapy sessions
- 70 psychodynamic group psychotherapy sessions
- 42 CBT group psychotherapy sessions
- 60 family therapy sessions
- 1-month equivalency of spiritual therapies or 12 step-groups
- 24 sex therapy sessions
- 30 psychoeducation sessions.

The TUMS model uses didactic sources through 12 books (10 in English and 2 in Farsi) and 3 core journals: *International Journal of Psychoanalysis*, *American Journal of Psychotherapy*, and *International Journal of Psychotherapy*. The curriculum is flexible and individual teachers assign supplemental readings, with a high volume of reading materials covered in the span of the 18-month period. Trainees rely on primary sources with less dependence on textbooks, such as studying works by Freud, Klein, Fairbairn, Winnicott, Balint, Hartmann, Mahler, Jacobson, Spitz, Kernberg, Sandler, Mitchell, Lacan, Bowlby, and Adler, when they are studying psychodynamic psychiatry and learning the historical context of the development of other psychotherapies. The psychotherapy fellows also have responsibilities to teach medical and psychology students, as well as residents. In vivo observation and supervision are performed through 1-way mirror rooms or video camera recordings. Assessment of the program includes measurements of trainee satisfaction and feedback, level of satisfaction from faculty at universities that employ the graduates, and standardized faculty evaluations.[4,31]

Overall, The TUMS psychotherapy fellowship can be portrayed as an international model for rigorous training of advanced level psychiatry residents who are expected to take on teaching and supervisory responsibilities. San'ati and Moinalghorabaei,

both UK-trained physicians, are teaching and training younger psychiatrists to become psychotherapy supervisors with emphasis on a high standard of care through combined and integrative psychotherapy methods. San'ati and Moinalghorabaei are psychoanalytically trained and place emphasis in teaching psychodynamic theories. As psychodynamic psychiatrists and educators, they encourage transtheoretical thinking and integrative practices, and help their trainees navigate with comfort as they become proficient with different psychotherapy modalities.[4,31]

## SUMMARY

Although it may seem paradoxic that psychiatrists in underserved areas in low-income and middle-income countries are enthusiastic about learning psychodynamic theory and pursue training to advance intensive psychotherapy skills, on further reflection one realizes that the depth and breadth of psychodynamic training can serve organizing purposes by increasing the clinician's ego strength. A psychodynamic perspective also helps psychiatrists navigate through the complexity of imperfect systems with challenging public health needs. International collaborations that capitalize on principles of mentoring by providing self-object experiences are welcome and effective, especially under the umbrella of reputable organizations such as the WPA. Teachers, supervisors, and mentors are in a unique position to provide mirroring, idealizing, and twinship self-object experiences in an ego-supportive academic environment. The authors emphatically recommend maximizing the use of Internet technologies to bridge learning gaps. The authors favor condensed didactic interventions that highlight clinical relevance and correlation rather than the conventional, theory-heavy, lengthy postgraduate programs endorsed by psychoanalytic institutes in existence for more than a century in high-income countries. If the latter, conventional, Eurocentric model is preferred, the authors recommend shorter versions of integrated fellowship training templates such as the TUMS program. Finally, it is important to be mindful that all innovative didactic interventions should have as an aim to be self-sustaining, by training students to develop their own teaching and supervisory skills.

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