Part 1
Psychodynamic Psychiatry: An Emerging Field

Psychodynamic Psychiatry and Psychoanalysis: Two Different Models

Richard C. Friedman, MD, César A. Alfonso, MD,
and Jennifer I. Downey, MD

MODERN PSYCHIATRY AVOIDS PSYCHOANALYTIC CONCEPTS

Psychoanalytic ideas, while useful in the treatment of the mentally ill, have largely been eliminated from modern psychiatry. The articles published in major psychiatric journals (excepting *Psychodynamic Psychiatry*) and the qualifications and interests of academic psychiatrists indicate that American psychiatry in 2015 is firmly bio-descriptive. The attempt to merge psychoanalytic and neurobiological thought in American medical schools during the three decades following World War II failed. Psychiatry seems to be reverting back to the state it was in prior to the discovery of the principles of psychoanalytic psychology by Freud.

This is unfortunate since many ideas that come from psychoanalytic psychology are useful in the treatment of mental illness. Perhaps the quietly anti-psychoanalytic tone of American psychiatry is at least in part a reaction to past rigidities of organized psychoanalysis. Ill will between psychoanalytic practitioners and bio-descriptive psychiatrists probably has been influential as well. We have attended meetings of psychiatric organizations, for example, in which a plenary speaker openly stated that she would "never" stand on the same podium as a psychoanalyst. Academic psychiatrists judged psychoanalysts to be arrogant, grandiose, insular, and anti-scientific.

On the other side of the spectrum, a speaker who declared psychoanalytic process to be inherently indescribable and who derided efforts to study it recently addressed a plenary meeting of the American Psychoanalytic Association. The audience, like-minded and enthusiastic, gave him a standing ovation (Hoffman, 2009). The notion that a putative therapeutic modality is unresearchable is profoundly anti-scientific. How do we know whether an intervention is helpful without studying outcome? How can we protect patients from being harmed without assessing behavioral change over time? How can we charge patients a fee for therapeutic services when no therapeutic progress or process can be objectively verified? Therapists who believe that their interventions are inherently beyond objective assessment should be viewed with caution by patients, clients, and their families.

PSYCHOANALYSIS, A DEPTH PSYCHOLOGY THAT APPLIES TO EVERYONE VS. PSYCHODYNAMIC PSYCHIATRY, A BRANCH OF MEDICINE

Freud believed that psychoanalysis was a depth psychology that included vast mental territory and that only a small segment of psychoanalysis was or should be devoted to its therapeutic application (S. Freud, 1927).

In "The Problem of Lay Analysis" he writes,

> For we do not consider it at all desirable for psychoanalysis to be swallowed up by medicine and to find its last resting place in a text-book of psychiatry under the heading "Methods of Treatment"… It deserves a better fate and it may be hoped will meet with one. As a depth-psychology, a theory of the mental unconscious, it can become indispensable to all the sciences which are concerned with the evolution of human civilization and its major institutions such as art, religion and the social order. (S. Freud, 1927, p. 83)

The distinction Freud made between psychoanalytic psychology and the segment of it that is applied in treatment is crucially important for understanding the differences between psychoanalysis and psychodynamic psychiatry. The latter emerging discipline is concerned with only part of general psychoanalytic theory, namely that part that is directly relevant to empirical science and/or therapeutic practice.

POSTMODERNISM, ENDORSED BY PSYCHOANALYSIS, REJECTED BY PSYCHODYNAMIC PSYCHIATRY

Psychodynamic psychiatry embraces standards of assessment and scientific relevance used in academic psychiatry and psychology. Interestingly, this is also true of a group of innovative and insightful psychoanalytic researchers who have emerged from *within* organized psychoanalysis. These individuals, however, do not represent the voice of organized psychoanalysis as a whole.

Psychodynamic psychiatry seeks to identify incorrect beliefs about basic scientific and clinical issues and to avoid building theory upon them. Organized psychoanalysis has no way of doing the same. Formed from many local institutes, organized psychoanalysis and its practitioners espouse different and often conflicting ideas about psychoanalytic theory and practice. Most are deemed acceptable. Few are explicitly rejected. All find their way into the numerous psychoanalytic journals that define the field as a whole. No scientific method serves to validate or invalidate psychoanalytic theories. For this reason, psychoanalysis gravitates naturally toward a postmodern perspective.

Sokal and Briemonet (1998) have characterized postmodernism as follows:

> Vast sectors of the humanities and the social sciences seem to have adopted a philosophy that we call for want of a better term "postmodernism," an intellectual current characterised by the more or less explicit rejection of the rationalist tradition of the Enlightenment, by theoretical discourses disconnected from any empirical test and by a cognitive and cultural relativism that regards science as nothing more than a "narration," a myth," or "social construction among others." (p. 1)

Taking the position that it is impossible to identify as invalid any ideas if one accepts postmodernism as a guiding philosophy, modern psychodynamic psychiatry rejects it as a way of understanding therapeutic interventions. Psychodynamic psychiatry relies on standard criteria used by academic psychology and psychiatry to assess validity, reliability, and the usefulness (or its opposite) of beliefs about behavior. This leaves psycho-

dynamic psychiatry more or less in the same position as clinical medicine.

Physicians make countless decisions on a day-to-day basis that cannot be completely supported by controlled studies. They form relationships with patients and try to maximize the likelihood of the patient following a sound, mutually agreed on treatment plan. They often operate in ambiguous therapeutic territory but use common sense and empiricism to whatever degree they can. They anchor their decisions in empirical knowledge to the degree that this is available. Psychodynamic psychiatry as a discipline adopts this approach. Organized psychoanalysis has not done so.

A qualification is necessary here. The fact that we compare psychodynamic psychiatry to medical practice does not suggest that we believe that only physicians should practice psychodynamic psychotherapy. We welcome the psychodynamically informed therapeutic practices of our nonmedical colleagues who must confront the same ambiguities and complexities.

The discipline of psychodynamic psychiatry is much more discrete and limited than psychoanalysis, the depth psychology. This bounded focus does come at a cost. In its largest sense psychoanalysis is best considered a branch of the humanities, and as such has greatly enriched modern thought.

THE IDENTITY OF PSYCHIATRISTS

Modern psychiatry has distanced itself from psychoanalysis—almost as if the latter had never existed. Unfortunately, a field that disavows its own past history is akin to an individual who disavows his or her family, cultural, and/or ethnic background. Amputation of the past comes at considerable cost. This is particularly salient since much psychodynamically oriented therapy, research, and theory is as empirically supported as psychopharmacological therapy, research, and theory (Lazar & Yeomans, 2014).

Organized psychiatry is indeed experiencing conflicts about what its appropriate social role and sense of identity should be. Should psychiatrists expect to spend their careers prescribing medications for patients whom they barely know, in an endless series of very brief interviews? The notion that they should, popular in certain quarters today, paints a professional role that is shrunken to Lilliputian proportions. Should psychiatrists be applied neurobiologists? If so, why is a psychiatric specialty needed at all? Perhaps, as some have suggested, psychiatry should simply be considered part of neurology. Should psychiatrists practice psychotherapy? If so, how should it be reimbursed?

Arguably, the most important schism in the field is between those who have a narrow view of psychiatry as medical specialty (i.e., physicians who use drugs to treat diseases) and those who have a broader bio-psycho-social view (i.e., physicians who understand and treat the people who are their patients and who are ill). This schism is reflected in disagreement about the proper role of the *DSM-5* (American Psychiatric Association, 2013).

Some psychiatrists believe that this manual appropriately characterizes the intellectual territory of modern psychiatry. This should influence the identity of psychiatrists and the ideal identity presented by teachers to psychiatrists in training. Other psychiatrists take a broader view. They recognize the need to make reliable symptom-based diagnoses but emphasize the need to conceptualize mental illness in ways that are not captured by the *DSM-5* (American Psychiatric Association, 2013). This includes the idea that subjectively constructed narratives of personal history are important in understanding an individual's motivation across all psychiatric disorders and combinations of disorders. This latter view is also

widely endorsed by non-medical mental health professionals. It is only by interviewing patients about their circumstances and past history that therapists can understand the *context within which their symptoms occur.*

DEFENSE MECHANISMS: USEFUL KNOWLEDGE FOR ALL PHYSICIANS

There is no question that psychiatrists must be conversant with psychopharmacology. They should be equally conversant with the psychological defenses, which probably influence psychopathology and therapeutics as much as drugs do (Cramer, 2006.)

As an example, consider the mental mechanism of *denial*, which operates in non-patients and patients alike—"I light up a Lucky Strike whenever I feel like it. Other people might get cancer, but I won't. I've always been lucky." Patients with diverse diagnoses and in fact millions of people who have never seen a psychiatrist and never even heard of psychoanalysis use denial in their daily lives.

During the decades when psychoanalytic ideas were freely expressed and applied in American psychiatry, many clinically useful concepts were put forth. These may have had less to do with the practice of psychoanalysis as a therapeutic technique than the application of depth psychology to routine psychopathological disorders seen in office practice and the general community. They made it easier to treat patients with mental disorders because psychiatrists were better able to understand their motivations. This was true despite the fact that the disorders were diverse and complex and their etiologies were usually obscure.

Military psychiatrists, for example, have been well aware of this. During WWII psychiatrists with a psychoanalytic perspective were able to be helpful to their patients in a way that those who relied entirely on biodescriptive paradigms could not be (Bion, 1961). A "psychoanalytic perspective" as we use it here does not refer to the practice of treating patients with four or five weekly sessions on the couch, analyzing dreams and encouraging free associations. On the contrary, military psychiatrists saw patients wherever was convenient. The duration of treatment was dictated by practical necessities. The goal was restoration of function and diminution of suffering (Lewis & Engle, 1954). The therapists were flexible, interactive, and relational. Their "psychoanalytic perspective" usually consisted of an awareness of depth psychology and the importance of the personal narrative as discussed by Freud and his followers. Subsequent generations of military psychiatrists and others who specialized in understanding and treating psychic trauma have had similar experience.

Sophistication about denial is part of the effective practice of medicine according to the Hippocratic oath and certainly is not restricted to psychiatrists or psychoanalysts. At any given time physicians and psychotherapists of all disciplines can summon up dramatic examples of denial in their daily practices. Experienced physicians wisely understand that the beliefs expressed by a patient in denial are not entirely motivated by feelings and thoughts that are in the patient's conscious mind. The range of defenses that a patient uses may well influence the degree to which he or she cooperates in a treatment plan (Cramer, 2006; Vaillant, 1994).

Freud described a handful of basic defense mechanisms, all relevant to the treatment of psychiatrically disturbed patients (S. Freud, 1926). His daughter, Anna Freud, discussed these in more detail and spelled out their role in psychological functioning (A. Freud, 1936). The defenses are unconsciously motivated in response to an inner signal of anxiety. They function in diverse ways to keep the person's sense of self stabilized by diverting the attention of the conscious mind from psychological conflict. Sometimes these defensive processes are

adaptive, sometimes maladaptive (Perry & Cooper, 1989). They may directly influence the therapist–patient relationship and the patient's willingness to participate in any form of treatment, including pharmacological treatment.

Another defense commonly seen in general psychiatric and medical practice is *identification*. Identification, an unconscious psychological process, does not necessarily connote psychopathology. Children routinely identify with caretakers, for example, and students, with teachers. Identification may, however, become part of psychological symptoms and syndromes. Internists and family physicians are aware that pain without known organic cause can occur as a result of identification with a caretaker or other loved person following the death of that individual. In such instances, identification becomes part of a complex grief reaction. This is but one of many examples of the relation between identification and psychopathology.

The entire subject area of conversion reactions and somatization is based on knowledge of awareness of maladaptive defenses expressed as a result of unconscious conflict. This issue also illustrates how complex modern psychiatry actually is. For example, there is no drug that adequately treats conversion reactions, whereas a psychodynamically informed approach is often effective (Kaplan, 2014).

Assessment of defensive style does not depend on whether a given patient is to be treated with psychodynamically oriented psychotherapy or not. Such assessment should be carried out as a *routine* part of the psychiatric diagnostic interview in similar fashion as discussion of the patient's history of past psychiatric illness.

CONCLUSION

The historical roots of the schism between psychiatry and psychoanalysis were present at the very beginning of the psychoanalytic movement. Eugin Bleuler, one of the most prominent psychiatrists of his time and director of the Eergholzi hospital in Switzerland was originally enthusiastic about Freud's discoveries. He studied with Freud and introduced psychoanalytic ideas in his discussion of schizophrenia (Bleuler, 1950). Bleuler rapidly became disenchanted with Freud's insistence on the role of infantile sexuality in the etiology of neurosis, however. Like Breuer, Freud's first collaborator, Bleuler found Freud's rigidity and inability to tolerate alternative ideas unacceptable. He distanced himself from psychoanalysis and in so doing brought to a halt an early effort to integrate psychiatric understanding and treatment of the psychoses with psychoanalytic psychology (Breger, 2000).

Decades later, psychiatrists again made energetic but ultimately unsuccessful efforts to integrate psychoanalytic and psychiatric thought. In the United States it is probably fair to say that a passionate romance developed between the two fields from about 1945 or so until the early 1980s. Sadly, the passionate romance between psychiatry and psychoanalysis ended in divorce. As matrimonial lawyers and mental health professionals know, however, not all divorces are alike. Some divorces are acrimonious and some are not. Sometimes divorced partners actually remain friends.

Psychiatry needs to move along its own path, heavily influenced by psychoanalytic ideas that have proven useful in the treatment of the mentally ill. The organizational inadequacies and painful feelings that have

led to the wholesale rejection of psychoanalytic ideas should and must be dealt with more adaptively in the future than is presently the case.

Biological reductionism on the part of psychiatrists has been paralleled by antiscientific dogmatism on the part of some psychoanalysts resulting in a schism that is not in the best interests of either discipline. More important, ongoing professional conflict like this is not in the best interests of the troubled and mentally ill individuals treated by mental health professionals of all disciplines, who are influenced by our professional disagreements.

The practical problems to insure that integration occurs are daunting. Departments of psychiatry often lack adequately informed faculty, for example. Telemedicine offers a partial but not entirely adequate solution to this problem. Hopefully, clinical and educational needs will inevitably lead to innovative approaches to re-integrate psychodynamic ideas into the mainstream of psychiatric thought. Were this to happen, the struggling new discipline of psychodynamic psychiatry would be recognized and given a home in academic departments of psychiatry and psychology. In order for this to occur, however, there would have to be widespread enthusiasm for paradigms that integrate biological, psychological, and social influences on behavior. Whether this happens or not remains to be seen.

REFERENCES

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: Author.

Bion, W. R. (1961). *Experiences in groups*. London: Tavistock.

Bleuler, E. (1950). *Dementia Praecox or the group of schizophrenias*. J. Zinkin (Ed. & Trans.). New York: International Universities Press.

Breger, L. (2000). *Freud: Darkness in the midst of vision*. New York: Wiley.

Cramer, P. (2006). *Protecting the self: Defense mechanisms in action*. New York: Guilford.

Freud, A. (1936). *The ego and the mechanisms of defense*. London: Hogarth Press and Institute of Psycho-Analysis.

Freud, S. (1926). *Inhibitions symptoms and anxiety*. New York: Norton.

Freud, S. (1927). The question of lay analysis. In J. Strachey (Ed. & Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 20, pp. 251-258). London: Hogarth Press.

Hoffman, I. (2009). Double thinking our way to "scientific" legitimacy. The destruction of human experience. Plenary Address. *Journal of the American Psychoanalytic Association, 57*, 1043-1069.

Kaplan, M. J. (2014). A psychodynamic perspective on treatment of patients with conversion and other somatoform disorders. *Psychodynamic Psychiatry, 42*(4), 593-617.

Lazar, S. G., & Yeomans, F. E. (Eds.). (2014). Special issue: Psychotherapy, the Affordable Care Act and mental health parity: Obstacles to implementation. *Psychodynamic Psychiatry*, 42(3).

Lewis, N. D. C., & Engle, B. (1954). *Wartime psychiatry*. London: Oxford University Press.

Perry, J. C., & Cooper, S. H. (1989). An empirical study of defense mechanisms. *Archives of General Psychiatry*, 46(5), 444-452.

Sokkal, A., & Briemont, J. (1998). *Fashionable nonsense: Postmodern intellectuals' abuse of science*. New York: Picador.

Vaillant, G. E. (1994). Ego mechanisms of defense and personality psychopathology. *Journal of Abnormal Psychology, 103*, 44-50.