What Is Medical about Psychoanalysis—and What Is Psychoanalytic about Medicine?

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Despite the birth of psychoanalysis in neurology, modern psychoanalysis and modern medicine seem to have drifted apart. The author explores how and why this has taken place and what its effects may be. Yet the core principles of both medicine and psychoanalysis remain intertwined and vital to both, and the future holds the promise of new possibilities. As American medicine and American psychoanalysis both confront critical stages in their existence, both professions would be well advised to be mindful of their common foundations in science and the ethical, professional bond with the patient. (*Journal of Psychiatric Practice* **2014;20:291–293**)

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Psychoanalysis entered the world as a medical science. After publishing papers on cerebral palsy and cocaine and studying hysteria with Charcot and Breuer, Sigmund Freud evolved a method of exploring the unconscious workings of the mind by allowing patients to talk. Free association and dream analysis facilitated a wealth of scientific exploration that built a working model of mental operations. As the method developed, it also helped patients overcome neurotic inhibitions and painful symptoms. As more was learned and the model became more complex, psychoanalytic treatment became longer and more adaptable to deal with various constellations of symptoms, behavior, and distress. Over 110 years later, psychoanalysis continues to be a rich source of evolving knowledge about human mental life.

Most of the early psychoanalysts were physicians, but other professionals were also drawn to the field and made substantial contributions—for example, Erik Erikson and Freud's own daughter, Anna. In Europe, the field was open to training by medical and non-medical candidates alike. In the United States, psychoanalysis became closely allied to psychiatry and at one point was even proposed as a subspecialty with its own board exam and certification. After the Second World War, psychiatry departments and hospital services across the nation were founded by medical schools and headed by psychiatric psychoanalysts. Psychoanalytically informed work with patients with severe mental disorders and those with medical illness provided a new and promising approach. Private practice began to flourish, as did psychoanalytic institutes. The department in Cleveland in which I serve was one example.[1] Douglas Bond was invited to establish a division within the department of medicine to bring psychoanalytic expertise to Western Reserve University School of Medicine. A few years later, the medical school radically changed its curriculum to incorporate patient care from the very beginning; psychoanalysts helped to design the new curriculum and worked in the student clinics. Pediatricians working with child psychoanalysts radically changed the rules to allow parents to stay in the hospital with their sick children, which subsequently became standard practice throughout pediatrics.

With very few exceptions, non-physicians were excluded from psychoanalytic training in the American Psychoanalytic Association (APsaA), which is the regional association of the International Psychoanalytical Association. This situation naturally led to widespread resentment and frustration among psychologists, social workers, and other mental health professionals who shared the same excitement and sense of discovery about psychoanalysis as did psychiatrists. They established their own training programs, journals, and record of accomplishment in psychoanalytic studies. In 1988, a landmark lawsuit by the American Psychological Association against APsaA was settled in favor of the plaintiffs, and the doors of APsaA institutes were opened to non-medical mental health professionals. With this opening of the gates, selected academics in the humanities and other non-medical fields were trained in APsaA institutes, either to enrich their academic studies or to conduct psychoanalysis after receiving basic training in mental

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health care skills. The result was an influx of talented people with the skills and perspectives of social work, clinical psychology, counseling, and the humanities or other academic fields.

Meanwhile, psychiatry became deeply involved in neurobiology and psychopharmacology and drifted away from an emphasis on psychotherapy. Heads of departments were no longer likely to be psychoanalysts, but rather were prominent scientists in biological fields who often devalued psychoanalysis. The community psychiatry movement also produced clinically oriented leaders who were concerned with the underserved, severely mentally ill and the strained community resources for their care. Fewer physicians have become psychoanalysts in recent years, so that the largest proportion of psychoanalytic trainees has become non-medical.

Psychodynamic psychotherapy had already evolved over the past century as an application of psychoanalytic principles to more focused and limited work with patients. Other schools of psychotherapy, particularly cognitive-behavioral therapy (CBT) and interpersonal psychotherapy, have also emerged as more short-term treatments that are focused on diagnoses from the *Diagnostic and Statistical Manual of Mental Disorders* and that could be manualized and more easily studied. Efficacy studies have found that all of the shorter term therapies are about equivalent in relieving symptoms. However, psychoanalysis has remained an important approach for treating more deep-seated and complex disorders. Modifications of psychoanalytic therapy have proven their efficacy in controlled trials for conditions such as anxiety disorders and borderline personality disorder.

The amount of psychotherapy done by psychiatrists has significantly diminished. In 2008, Mojtabai and Olfson reported that, over a 10-year period from 1996 to 2004/2005, the percentage of psychiatrist office visits involving provision of psychotherapy declined from 44% to 29%.[2] A confluence of forces seems evident in this development. Psychiatric residencies must cover a vast store of knowledge of neurobiology and psychopharmacology as well as many other non-psychological areas. Although residency programs are required to train residents to a level of competence in psychodynamic therapy, CBT, and supportive therapy, evidence strongly suggests that this training and experience are far less extensive than in the past.[3,4] Much of the training in any psychotherapeutic method is done by non-physicians and hence does not model psychotherapy as part of what a psychiatrist does. After graduation, early career psychiatrists are pressured by educational debts to work in salaried positions where they are used to provide medication management, while non-medical professionals provide whatever psychotherapy is allowed.[5] Third party reimbursement and aggressive management techniques offer substantial inducements to psychiatrists at any level of practice to see multiple patients per hour at higher fee levels for medication management.

For a psychiatrist to provide the intensive and sustained psychotherapy essential to ameliorate more pervasive disorders requires a financial sacrifice. Fortunately, the professional satisfactions of doing this work help compensate for the financial disadvantage, as does the freedom to practice effectively under conditions that respect privacy and the therapeutic process.

In this array of centrifugal forces, what is medical about modern psychoanalysis? Psychoanalysis, like medicine, brings scientific methodology to bear on the subjective experience of the human mind, while not losing touch with the humanistic vision of the doctor-patient relationship. In the psychoanalytic therapies, work with that subjective experience takes place within an intense relationship of two people protected by professional ethics and expertise. From the beginning, psychoanalysts have been mindful of the fact that inner mental life is a phenomenon of brain activity. In recent decades, neurobiologists have discovered that the brain is a dynamic and plastic organ that is constantly adapting, repairing, and renewing itself through neurogenesis and revision of neuronal interconnections. They have found the psychoanalytic model useful as an analogue of the interplay of functions of different specialized areas of the brain. Neurophysiologist Eric Kandel cited psychoanalysis as a science that has contributed extensively to the study of the inseparable mind and brain, but he challenged psychoanalysis to engage in empirical research in conjunction with cognitive psychology and neurobiology for an integrative theory of mind.[6] Revising significant, long-standing neuronal patterns requires repeated experience over months or years. A major meta-analysis found that intensive, long-term psychodynamic psychotherapy achieved superior results with seriously ill patients with complex, multiple psychiatric disorders; gains are sustained or even augmented on long-term follow-up after the treatment is over.[7]

Since Freud, psychoanalysts have recognized the genetic and neurochemical roots of many mental dis-

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orders, and most now acknowledge the value of psychotropic medications when used judiciously in a biopsychosocial framework of care. Psychoanalytic therapies and medications may be provided concurrently, and physician analysts prescribe them when appropriate. The interplay of mind and body often results in significant physical symptoms or impairments. Analysts recognize these and advise patients to get needed medical care from relevant providers while in the process of addressing them in therapy—which often entails working with the patient's resistance to facing and dealing with the problem.

If one asks what is psychoanalytic about modern medicine, the same polarity exists: medicine has its roots in the humanistic statements of the Hippocratic Oath, defining the ethical basis of the doctor-patient relationship even as it emphasizes fidelity to the scientific knowledge of its time about various procedures. Healing begins in the relationship with the physician, and being attuned to the subtleties of mental and emotional processes in any patient contributes to both diagnosis and management of treatment. Basic psychoanalytic knowledge—often taken for granted without noticing its source—contributes to that attunement.

The polarities I have been describing came to mind recently as my wife and I attended the fifty-fifth reunion of the Harvard medical school class of 1959. Most of the 150 or so graduates went on to highly accomplished, leadership careers in science, patient care, and medical education. Twenty-two became psychiatrists, eight of them psychoanalysts. A forum of classmates addressed the rapidly occurring changes in the health care system: the Affordable Care Act, electronic medical records, integrated medical practice homes that include mental health care, parity of payment and utilization management for mental health services, and a mounting assault on fee-for-service financing of care (about which classmates' opinions were sharply divided!). From our classmates in academic medicine came alarming statistics showing that financing for hospitals from grants and public funding has diminished markedly while medical practice plans have become a dominant source of revenue. Health reform threatens drastic cutbacks in provider payments, an alarming prospect for academic medical centers.

An overarching concern that emerged from leaders in all specialties was the erosion of the doctor-patient relationship. Time with patients is sacrificed to productivity and revenue needs. Filling in checkboxes and distracting irrelevant details on electronic record screens disrupts eye contact, rapport, and the attuned listening that medical school preceptors, including psychoanalysts, help future physicians in all specialties acquire. The satisfaction of relating to patients on a human level fades away, while the modern physician expertly administers the finest technology. This troubled everyone at the class reunion and has led to some lengthy tirades on the class listserv.

Are these the jaded and pessimistic predictions that groups of superannuated physicians have been making since time began? Perhaps to a degree—but this was a bunch of really smart academic doctors, many of whom are still involved in forward-looking, influential leadership positions. Their concerns were about how such complex changes would work out from many angles, but a prominent issue was the effect on the fundamental doctor-patient relationship. As always, I was heartened when I got back to the psychiatric residents I teach. They are hopeful and enthusiastic about being well rounded psychiatrists, but they are at risk. I hope those who are building the new systems can keep alive the spirit that was and is so important to me as a psychoanalytic psychiatrist and physician.

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