Many thoughtful writers, representing various points of view, have lamented the erosion of psychiatric training and practice that integrate biological and psychotherapeutic treatments. A prescription for reform is set forth by Hobson and Leonard, in *Out of Its Mind: Psychiatry in Crisis: A Call for Reform*. They paint a grim picture indeed of our profession. Drawing on neurobiology and their version of psychoanalytic psychotherapy, they propose an integrative model of reform and a treatment approach for which they coin the term “neurodynamics.”

My reading of this book coincides with the appearance in June 2002 of a lead article and commentaries on the place of psychoanalytic treatments in psychiatry in the *Archives of General Psychiatry*. The issues raised in these two discussions merit much attention on the part of anyone concerned with the future of psychiatry.

Hobson and Leonard write from a very personal perspective, one that reminds me of Boston’s old promotional slogan as The Hub of the Universe. Their view of history is somewhat different from mine. While psychoanalysis did dominate academic psychiatry in the 1950s, somatic treatments and locked wards were part of my clerkship experience at the Massachusetts Mental Health Center, a year or two prior to Dr. Hobson’s one-sided residency described in the book. As a novice medical student, I recall carrying a ward key that seemed at least half a foot long with very scary patients on the other side of the door. I witnessed the last insulin coma treatments, then being phased out because chlorpromazine trials were demonstrating the efficacy of medication. However, we had inscrutable case conferences with psychoanalytic giant Ives Hendricks, counterbalanced by eminently sensitive and clinically practical psychodynamic discussions with Leston Havens, who more than anyone else influenced my decision to go into psychiatry.

My choice of psychiatric residency at University Hospitals of Cleveland grew out of the awareness that the psychiatry department there had played a major role in the medical school curriculum reform at Western Reserve School of Medicine (later Case Western Reserve), integrating an organ-systems approach to biological medicine with humanism and practical application of psychoanalytic understanding. Here, too, psychotropic medication trials were beginning. I felt profoundly then, as I have ever since, that psychoanalysis and psychiatry must be intimately associated with biological approaches.

The present bifurcated situation, which Hobson and Leonard so vividly portray, is exquisitely painful to psychiatrists of my ilk. Severe funding cutbacks and relentless de-institutionalization in the public sector, and managed care strictures and strong financial incentives in the private sector, push psychiatrists into seeing severely ill patients for 15 minutes every few months. Primary care physicians dispense the preponderance of psychiatric medications with little training or clinical sophistication. When treatment is divided between psychiatric medication management and non-medical psychotherapy, there is usually very little communication between the clinicians treating the patient. Ancillary support services and programs for the severely ill are frequently minimal or nonexistent. More mentally ill people are housed in jails and prisons than in psychiatric hospitals. Hobson and Leonard document what is clearly a crisis and an atrocity, eloquently decried as a “wholesale collapse of our mental health system” by incoming APA president Paul Appelbaum in his inaugural speech in Philadelphia in May.

In their seminal chapter, “Neurodynamics: Toward a New Psychology” (pp. 223–246), Hobson and Leonard summarize the fundamental principles of an integrative psychology. They elaborate on each topical sentence quoted below, building on material developed earlier in the book.

- The mind arises from the brain.
- The mind is divided into functional compartments.
- Mental acts require coordination.
- The mind’s state depends on the brain’s chemistry.
- The conscious mind is limited.
- The conscious mind acts as a unit.

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Most brain activity is unconscious.
The conscious and unconscious minds are friends.
We need to be more critical about childhood memories.
Mental states lack fixed boundaries.
Both genes and experience are important.
Mental disorders involve structural brain problems.
Structural problems give rise to coordination problems
between systems of mental operation.
Brain chemistry mediates disordered states of mind.
Psychiatric drugs are not cure-alls.
Psychotherapy is no cure-all.
Drugs and therapy are mutually reinforcing.
Mental ills should be treated like chronic diseases.
Our ability to treat disorders of the mind is good.

As a practicing and teaching psychoanalyst, I find little to dispute in such theses, even though some of the background material suggests that the authors have little familiarity with the tremendous evolution of psychoanalytic thought since the days of Freud. For example, psychoanalysts are long past the early step of seeing the conscious mind and the unconscious mind as opposing entities, rather than seeing consciousness and unconsciousness as continuously shifting attributes, with repression sometimes intervening as an unconscious defense to prevent awareness. Analysts have moved beyond looking only at the inner workings of the mind while ignoring the interplay of inner conflict and sense of self with the field of relationships with other persons. I see little need to coin a new term, neurodynamics, but that is inconsequential compared to the fundamental principles of an integrative psychology.

In the June Archives, Gabbard, Gunderson, and Fonagy address the research basis for psychoanalytic treatments and outline a proposal for enhanced awareness of and training in psychoanalytic research, and for more robust studies of the efficacy and effectiveness of psychoanalytic treatments. A fundamental predicate is fostering the openness of psychoanalysts to scientific methodology that may challenge or confirm assumptions that have long been developed by case study, theoretical elaboration, and consensus. A daunting challenge is studying psychoanalysis as a treatment that takes place over 5 years on average, is subtle and far reaching in unforeseen explorations, and is open to many variables. A suitable control group is hard to imagine. Short-term psychodynamic psychotherapy is much easier to research.

In companion commentaries, Kernberg incisively critiques the reasoning and proposals of Gabbard et al. Wallerstein points out the need to go beyond outcome measures of symptoms and behavioral change to the “more thoroughgoing and enduring personality reconstruction, with greater proof against future adverse environmental vicissitude” that is “espoused” as the therapeutic goal of intensive psychoanalytic treatment. He also advocates the use of process research as well as outcome studies.

Auchincloss goes farther yet to state her belief that “outcome research will demonstrate that there are many patients who can be helped only by clinicians with a firm grounding in both brain-centered psychiatry and sophisticated psychoanalytic psychotherapy.” She states that “the most important reason for deepening our understanding of the psychoanalytic psychotherapies through systematic investigation is the opportunity to learn not only that the treatment works, but how the mind works.”

Venturing more into the interactive dimensions of mind and brain, she cites studies demonstrating that “(1) the human brain develops in the context of an interpersonal matrix that is crucial for its structure formation, and (2) the brain retains some measure of plasticity so that experience changes brain structure and function in the adult as well as in the developing child.”

How will these thoughtful and incisive writings influence me as a practicing psychiatrist and psychoanalyst, seeing a range of patients in psychoanalysis as well as various, individualized adaptations of psychoanalytic psychotherapy? How will it change what I do each day in my office? Probably not a great deal, because I have long taken an integrated, biopsychosocial approach to the treatment of my patients, and I have refused to compromise with the managed care invasion of the doctor-patient relationship. I work in a private practice setting in a full-service medical building with referral relationships with many other physicians. I encourage young psychiatrists to overcome their fear of independent practice; they are much needed there and can earn a decent living while enjoying their work. On behalf of our colleagues who dedicate their working lives to the severely ill in the public system and those who chafe under managed care or organized system production goals of four “med checks” an hour, I join with other leaders of the American Psychiatric Association in efforts to influence decision-makers in business and government to interrupt the vicious downward spiral of both public and private mental health care systems.

The theoretical models I think about privately as I work with patients continuously evolve. My mind oscillates between thoughts about concepts such as psychic conflict, self and other, transference and counter-transference, the patient’s unique history, the evidence of dynamic changes in brain function, and the effect of med-
ication on neurotransmitter systems. I consider whether reducing distressing symptoms with medication is facilitating the psychotherapy, and whether the psychotherapy is enhancing medication compliance (the case for integrated treatment has recently been beautifully addressed by Gabbard and Kay\textsuperscript{10}).

These are the working models that provide a rationale for my own interventions, but they do not determine the form in which they are expressed. I would no more say to a patient, “Your amygdala is not working effectively with your prefrontal cortex,” than I would say, “Your rageful id is not sufficiently controlled by your ego and is in sadistically self-punitive league with your superego.”

Psychoanalysis has long taught us to listen to the patient, to encourage associative connections to unfold freely, to let the associations to dreams lead us into unsuspected corners of the mind, to pay close attention to what patients bring into our working relationships and what this evokes in us, and to share our thoughts with patients as closely as we can manage to their field of understanding, rather than in our own shifting theoretical terms. While genes and the vicissitudes of life have continuously reshaped the brain of each of us, this is only the beginning. Our intense personal experiences, not to speak of the tremendous scope of evolution of human culture over the past several millennia, profoundly affect our mental function and subjective experiences and understanding. Sometimes only intensive work over years can change the way we think, feel, and behave.

Within our heads we have unique information systems, in which the hardware influences the software and the software can modify the hardware. These are two faces of a unity, the self. The marvel of it never ceases. Whatever we call it, an underlying synthesis of science and humanism is the core of effective psychiatric work with patients.

References

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