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***“Psychoanalysis, Psychiatry and Medicine”***

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 Psychoanalysis does not have an obvious relationship to psychiatry or medicine. It is not particularly interested in psychiatric illnesses, but rather in how people adapt, how they cope with stress, including the stress of illness, and including the stress of psychiatric illnesses, rather than in the illnesses themselves. It is interested in the person’s mind, not his body or even his brain. Psychoanalysis began outside of psychiatry, and Freud, himself a neurologist, not a psychiatrist, never saw it as a part of psychiatry.

Freud’s only visit to the United States, in 1909, was hosted by psychologists, not psychiatrists. Jung, a psychiatrist, was invited to the same conference, and was better known than Freud by American psychiatrists. Unlike Freud he had worked with Bleuler in Zurich, had conducted empirical research employing his word association methods on schizophrenic patients, and had published in English. Soon after the conference Freud and Jung had a falling out, and Freud became annoyed with two leading American psychiatrists who were enthusiastic about psychoanalysis—Smith Ely Jelliffe and William Alanson White—who maintained strong ties to Jung. Freud disliked America and Americans, and he returned to Vienna to develop his new science, viewing American psychoanalysis as an embarrassment. He had little contact with American psychiatry, then or afterward

 The middle of the twentieth century brought major changes. Several American psychiatrists went to Vienna to study with and be analyzed by Freud. More important, many prominent European psychoanalysts fled central Europe and settled in the United States. Freud himself wanted psychoanalysis to be independent from psychiatry and not restricted to physicians. He dreaded that it might, some day, become a chapter in a textbook of psychiatry. His view prevailed in much of the world. However American psychoanalysts both native and immigrant were attracted by the prestige of psychiatry and medicine, and opposed his anti-medical and anti-psychiatric stance. For more than half a century they succeeded in excluding non-psychiatrists from the American Psychoanalytic Association and tying themselves to psychiatry and to medicine. They constituted an elite group whose status in American psychiatry, medicine and society was enhanced by the exclusion of non-psychiatrist analysts, an exclusion that only came to an end with a lawsuit filed by a group of psychologists that was not settled until 1988.

The success of psychoanalysis in the world of psychiatry was remarkable. For several decades it dominated American psychiatry. As psychoanalysis arrived on the scene, psychiatry had become increasingly alienated from the rest of medicine, and surprising though it seems to a contemporary reader, psychoanalysis was hailed as promising closer ties to medicine and science. Through its prominence in psychosomatic medicine it meant a return from rural asylums for the insane to the teaching wards of academic medical centers. It offered an intellectually fascinating theory that promised a new understanding of mental life that seemed far more scientific than that provided by the humane and perhaps clinically helpful but theoretically unimaginative “nondynamic” psychiatry. It provided a counterpart to the somewhat disreputable physical treatments of convulsive therapies and lobotomies that were frightening to the public. Perhaps most importantly, it arrived with a reputation for clinical efficacy. Non-psychiatrist physicians who had received brief psychiatric training with a psychoanalytic orientation and then placed in the front lines of World War II returned home with stories of great therapeutic success in treating traumatized soldiers. They were enthusiastic about their clinical experiences and wanted to train as psychiatrists and psychoanalysts. The result was that psychiatry, and particularly psychoanalytic psychiatry was increasingly accepted by the public and by general medicine, and psychoanalysis was increasingly influential in psychiatry.

 Psychiatry’s enthusiasm for psychoanalysis faded over the next few decades. The scientific hypotheses of psychosomatic medicine generated a body of respected empirical research; however, this research largely demonstrated that strong psychoanalytic “specificity” theories about somatic disorders were not confirmed. The theories of psychoanalysis were interesting, but they failed to generate a body of empirical research, were criticized for being unscientific, and came to be seen as an historic relics rather than scientific theories. Lobotomies and convulsive treatments were viewed with distaste but biologic psychiatry, beginning in the 1950s, replaced them with successive waves of psychopharmacologic treatments that were much more palatable and increasingly came tocompete with the psychotherapies and psychoanalysis for the same population of patients. Perhaps most importantly, the psychodynamic psychotherapies that seemed so effective in treating the self-limited traumatic syndromes of the battlefield were much less effective when applied to the chronic mentally ill, while it became clear that their efficacy in treating acute trauma had little do to with their psychoanalytic theoretical foundation. Psychoanalysis had seemed to promise a strategy for developing a scientific psychiatry, but it failed to deliver on that promise and the sociocultural factors that supported its role faded away.

Before its decline, psychoanalysis came to dominate academic psychiatry as well as clinical psychiatry. Psychiatry was entering its golden age in academic medicine, and psychoanalysis was already at the peak of its golden age in psychiatry. However they were not quite in phase with each other, and as academic psychiatry gained increasing status, its dominant theme shifted first to social psychiatry and then to biological psychiatry and neuroscience, while the influence of psychoanalysis waned.

 Psychoanalysis seemed much more relevant to psychiatric practice and education than to psychiatric research. In the 1950s, American academic psychiatry was dominated by its educational mission. Beginning the 1960s, as academic psychiatry matured and moved closer to other fields of academic medicine, its became more like them as its research mission became increasingly prominent. Success was no longer measured by student enthusiasm or recruitment into the field, but rather by research support and publications. Psychiatric research made immense strides, largely biologic research—first psychopharmacology, and later neuroscience, genetics and brain imaging. Psychological research, and particularly research in psychotherapy was much less prominent, and in psychoanalysis almost nonexistent. As academic psychiatry developed its scientific base its new leaders were more likely to be neuroscientists or biologic psychiatrists than psychoanalysts.

 Psychoanalysis itself was changing simultaneously, independently of, and largely unrelated to the developments in psychiatry. Freud’s death in 1939 ended an era in which there was a single accepted criterion for what was truly “psychoanalytic” and initiated a period of pluralism that continues to this day. Freud’s early theories had been strongly biologic; they speculated about what was going on in the patient’s mind and brain and emphasized constitutional determinants of behavior, innate drives that somehow led to mental events. His theories were also, of course, psychological, mentalist, but even these were formulated in ways that were comfortable to those familiar with the positivist scientific thinking of the day, and suggest the possibility of eventual neurobiologic reductionism. Freud believed that his method led to the discovery of previously existing although unconscious and therefore undetectable psychological phenomena, and that exposing them to the patient’s consciousness would be curative. He had himself tried to construct neurobiological models of his psychology, but even though he eventually gave these up, this was not because he thought that they were inherently inappropriate, but rather because he thought that they were premature. The necessary neuroscientific knowledge base did not exist at the end of the nineteenth century. However he had no doubt that mental life would someday be understood as the reflection of underlying neurobiologic processes. With today’s neuroscience he would probably be an enthusiastic fan of “neuropsychoanalysis” and eager to make another attempt at his project for developing a scientific brain-based psychology. He did not want psychoanalysis to be a branch of psychiatry, but was quite comfortable seeing it as biological, and ultimately reducible to the functioning of the nervous system.

 Why didn’t American academic psychiatry, during its period of psychoanalytic leadership and its growing interest in research, develop a program of psychoanalytic research? Psychoanalysts were eager to be seen as scientific, and they cast their early theories in the language of science. However they failed to develop a true scientific methodology and had little interest in testing their theories or in attempting to invalidate them. In fact, most of the theories that they embraced were not based on psychoanalytic data, but rather were borrowed from contiguous disciplines—initially neuroscience and cultural anthropology, later developmental psychology and linguistics. Psychoanalysts neither developed nor tested them, and in fact didn’t treat them as scientific theories at all. Rather they used them as tools in the clinical process of searching for meanings, as sources of metaphor. The analytic process came to be seen more and more as an interpretive endeavor, developing new meanings, rather than searching for previously existing but unrecognized facts. The analyst and the patient co-constructed narratives, rather than uncovering forgotten memories. Psychoanalysis moved closer to the humanities rather than the sciences, and much as its practitioners admired science, borrowed its concepts, and aspired to be seen as scientists, their daily work and their intellectual interests moved them away from science, medicine and psychiatry, and toward hermeneutics. The goal was understanding, not explanation.

 Freud wanted to develop an objective science of human subjectivity, and he viewed the psychoanalyst as a neutral observer of the patient’s words and acts, data from which might be inferred the patient’s inner experience. Contemporary psychoanalysts are not as confident in the analyst’s neutrality or objectivity, and increasingly see the analyst’s interpretations as reflecting the analyst’s own inner subjectivity, while relying on the analyst’s countertransference as an important contributor to the data. This shift, from the patient’s words and acts to the analyst’s experience and reactions, moves psychoanalysis even further from the rest of psychiatry, medicine and Popperian science.

 I have mentioned the strong psychoanalytic interest in the theories and discoveries of adjacent sciences, if not in their methods. There has also been pressure within the psychoanalytic community for research on the treatment itself—its effectiveness, its indications, and so on. However this pressure has largely come from those concerned with public health, health policy and economics. Clinical psychoanalysts have shown little interest in this kind of endeavor—the studies required would be long, expensive and difficult, and relate to the sciences of biostatistics and evaluation of treatment outcome, not to those of interest to psychoanalysis. Clinicians anticipated little from the results that would enrich their daily work. They had no doubt that their treatment worked, and had more confidence in the wisdom of their elders than in systematic empirical studies that explicated whether or how it worked. Studies of its effectiveness might be of interest to skeptics or to those concerned with public policy, but not to practicing psychoanalysts. Clinical psychoanalysts want to enrich their repertoire of potential interpretations, not to learn what percentage of their patients might be expected to improve by what percent on scales of psychopathology.

 However, there is another reason that a research tradition in psychoanalysis has not developed, one that I believe is more important and has little to do with the potential value of empirical research but is embedded in the social structure of the profession. Most professional education occurs in university settings, and university cultures have a strong commitment to research. Faculty advancement depends on research productivity, and academic leaders are selected for their research, not their clinical or educational excellence. Psychoanalysis is different and virtually unique. Freud was suspicious of universities; he feared that they would attack and destroy his fragile creation, and psychoanalysis developed and largely continues outside of them. Psychoanalytic education is conducted in freestanding institutes, collections of practitioners with no full-time faculty, often meeting only at nights or on weekends, devoted to study and teaching, but with little interest, time or reward for research, and indeed often regard research activity with suspicion. Kernberg has compared these institutes to trade schools or seminaries. The result is that psychoanalytic research is almost, although not quite, an oxymoron.

Nevertheless, this is not to say that psychiatric research has had no impact on psychoanalysis, or psychoanalytic research impact on psychiatry, only that the impact has been largely sociocultural rather than scientific. Psychoanalysts have been wary or unenthusiastic about psychopharmacology but surprisingly interested in brain imaging. It is as though they finally see a strategy for fulfilling Freud’s goal of finding the neurobiologic basis of mind. Studies of brain function related to mental events, or changes in brain function before and after psychotherapy, are popular. There are societies and journals of “neuropsychoanalysis” with, for reasons I have explained, “old fashioned” or “classical” analysts being enthusiastic, while “modern,” “relational,” “interpersonal” or “hermeneutic” analysts viewing them as a step backward.

 To a lesser extent, there has even been an impact of the small world of psychoanalytic research on contemporary psychiatry. I will cite three examples. First, in the last few decades psychoanalysis has been particularly interested in serious personality disorders, impaired patients who are not seen as psychotic and are seen as possible candidates for psychoanalytic psychotherapy. The concept of borderline personality was developed by psychoanalysts, several “evidence-based” treatments have been developed and even tested by psychoanalytic groups, and the phenomenology, course and outcome have all been studied by psychoanalysts. Finally, the DSM-5 conducted field trials that demonstrated the high interrater reliability of this diagnostic category, much higher in fact than the reliability of major depressive disorder. For a psychoanalytically conceived and defined entity to become a respected member of DSM-5 is the ultimate sign of recognition of American psychiatry. Second, studies of the effectiveness of all psychiatric treatments have routinely been based on the relief of core symptoms at treatment termination or shortly thereafter. The psychoanalytic research community has argued that this is too narrow a scope—patients suffer from many problems other than their core symptoms, their work, their play, and their families suffer as well, and their life trajectories are altered. Also, the termination of treatment provides all too brief a period of follow-up to assess treatment outcome—the critical question is not whether a symptom can be relieved at the end of a course of treatment, but whether the course of the patient’s life can be improved. The psychiatric research community has accepted these critiques, and broader outcome measures and longer-term follow-up are more and more accepted. Finally, the psychoanalytic interest in infancy and childhood, the parent-infant relationship and early development has spilled over and awakened a broad psychiatric interest in early development and the possibility of a preventive psychiatry. The direct observation of infants largely grew out of the importance of the hypothesized experience of infants in psychoanalytic theory.

 Several aspects of the psychoanalytic paradigm are particularly critical for its relationship to medicine and psychiatry. First, its insistence on strict psychic determinism is in conflict with a major trend in contemporary psychiatry. Our growing understanding of neurobiology and of the genetic and biochemical correlates of psychiatric disorders have led to an increasing interest in understanding mental states as determined by brain states, rather than by preceding mental states. Of course, this interest is nothing new. Freud, discussing melancholic depression in 1915 wrote, “What is probably a somatic factor, and one which cannot be explained psychogenically, makes itself visible in the regular amelioration in the condition that takes place toward evening.” Nevertheless, analysts try to understand meanings, while many modern psychiatrists are increasingly interested in understanding not only the form of mental life—such as diurnal variation in mood, but even the content, such as sexual, aggressive, or suicidal wishes, as secondary to neural events. Clearly, these are not logically different positions as much as different perspectives and approaches, but different they are. However, this difference is far more fateful for the relationship of psychoanalysis to psychiatry than to medicine. For, while neurobiologic reductionism has been popular in understanding psychopathology and psychiatric disorders, it has had little impact on our view of nonpathologic adaptation or the clinical process. When we want to understand how a medical patient is coping with a myocardial infarct, or a surgical patient is anticipating a thoracotomy, or simply how someone is talking to a physician, what he is revealing and what he is concealing, we want to know his thoughts, feelings, wishes, and fears, not his serotonin receptor status or his threshold for kindling.

 A second critical aspect of the paradigm, already suggested in the discussion of psychic determinism, is the psychoanalytic insistence on the continuity between normality and pathology. Freud’s reconceptualization of hysteria did far more than enrich our understanding of a specific type of pathology; it provided a new paradigm for considering mental states, including both those that had been regarded as pathologic and others that had not, and thus it radically altered the conceptual relationship between the clinical pathologic syndromes of psychiatry and normality. Freud believed that hysterical patients were fundamentally normal and that the psychological mechanisms leading to their symptoms were normal mechanisms that could be recognized in anyone. The distinction between a hysterical patient and any other normal individual was of quantity, not quality, or at most was based on the social appraisal of a surface differentiation that overlay a hidden, deeper commonality. Anyone was capable of constructing a hysterical symptom, and such symptoms could be traced to universal themes and structures in mental life. Psychoanalysis was the tool for translating the apparently pathologic phenotype that seemed to be qualitatively different from normal to deeper mental life that had created it. Furthermore, the deeper mental life that was first discovered in the treatment of neurotic patients was not only characteristic of the normal mind as well, but actually it became the key for unlocking the secrets of normal psychological development. In 1895, Freud wrote that he intended “to extract from psychopathology a yield for normal psychology. It is in fact impossible to form a satisfactory general view of neuro-psychotic disorders unless they can be linked to clear hypotheses upon normal psychical process.” The focus of interest shifted from studying the various categories of pathology and the characteristics that differentiated each from the others to studying the universal mechanisms of all behavior, whether clinical syndrome or mundane experience, with the recognition that normality and pathology were expressions of the same fundamental processes, and the individuals were neither one nor the other, but rather both.

 The fundamental distinction underlying nineteenth century medicine, that between normal and pathologic, had been replaced by the fundamental distinction that defines the domain of psychoanalysis, between meaningful and meaningless. The same mechanisms that had first been discovered in such bold relief in the neurotic conditions formerly considered to be pathologic were studied in every area of behavior. Wishes, fears, defenses, conflicts were characteristic of what had been regarded as pathology, but more important, they were characteristic of the human condition. Freud repeatedly emphasized that “psychoanalytic research finds no fundamental, but only quantitative, distinctions between normal and neurotic life,” that “there is no fundamental difference, but only one of degree, between the mental life of normal people, of neurotics, and of psychotics.”

 The corollary of these two aspects of psychoanalysis is that although it was developed as a treatment for mental disorders, unlike most other treatments in psychiatry, from its very beginning it was seen as relevant to normal psychology, and I would add particularly normal psychology under stress, conflict, or strong emotion. Indeed, the late Charles Brenner defined it as the study of the “mind in conflict.” Further, while its relevance to the major disorders that concern contemporary psychiatry has been questioned, it’s relevance to less severe aspects of personality disturbance or normal adaptation is largely unquestioned. Paradoxically, psychoanalysis today may be more relevant to medicine than to psychiatry, just as lifestyle and non-psychopathologic behavior patterns may explain more of the variance in the etiology of medical than of psychiatric disorders.

 A third and final aspect of psychoanalysis critical for its relationship to medicine and psychiatry stems from its clinical method rather than its theory. Psychoanalysts are extraordinarily interested in the details of their patients’ experiences. They spend hundreds of hours with a single patient, listening to every word and searching for nonverbal clues to feelings and hidden thoughts. As a result they have become students of the clinical process, interviewing and communication. This procedure is an important basic science for all medical practice.

 Today, psychoanalysis as a therapy is one treatment in psychiatry. It represents an important theme in psychiatric education, but for most students it provides a context for learning about human behavior and basic clinical skills, rather than a treatment that will be central to their future professional work. Patients with major psychiatric disorders are likely to seek help elsewhere, but psychoanalysis has had a steadily increasing role in the treatment of those individuals whose lives are limited by character pathology.

 Psychoanalysis is a theory of mental functioning, one of mind and person, rather than brain and organism, or individual and culture. Its data consist of experiences observed introspectively or empathically and communicated largely verbally or symbolically. It is a theory about the experiential world of man, its origins, development, structure, and potential for change. In this regard, it relates to the most unique of man’s biologic characteristics—his capacity for symbol use and symbol creation and for an organized experience of himself in the universe. Because psychoanalytic theory has been linked to a clinical treatment, it has largely emphasized those aspects of man’s symbolic functioning that can interfere with his adaptation. Symbols can interfere with the most basic of biological processes. Other species kill in aggression, mate with lust, flee in terror, but man may kill for love, feel more anxiety than lust while mating, and flee from sexual pleasure. The symbolic structure of these behaviors, and the human interactions that may modify them, are the concerns of psychoanalysis. This concern has led to a special interest in early development, the origins of experiences concerning bodily needs, and the mental derivatives of these experiences in later adaptation.

 As a result, psychoanalysis provides a framework for considering the experiences of patients, their response to stress and disease, and the alternate possibilities for integrating these factors into their lives. If there are diseases in which the patient’s symbolic experience of himself in the world becomes part of his problem, and if a human interaction with a concerned other person could facilitate a change in that experience, then the psychoanalytic paradigm has a role in the understanding of that patient. It is particularly valuable in considering the sequelae of deviant developmental situations and, therefore, is of value in understanding adaptations to social and physical trauma, as well as primary psychopathology and its course.

 In the nineteen-forties and fifties, many psychoanalysts believed that their potential contribution to medicine rested on the importance of psychological determinants of physical disorders, and the field of psychosomatic medicine grew up around psychoanalytic ideas. This area of inquiry has been fertile, but it has largely led away from psychoanalysis. Mental experience is relevant to medical pathophysiology, but the more we have learned about the mechanisms of transduction, the neuroendocrine, and neuroimmunologic systems, the less relevant the study of unconscious fantasies and mental conflict has become. However, at the same time, the clinical concepts of transference and resistance and the technical study of the interview have become even more important to physicians. Psychoanalysis has relatively little role in understanding medical diseases; it has immense value in understanding patients’ adaptations to those diseases, how and why they respond in the way they do, the illnesses that result from those responses, and the kinds of intervention that can be useful. Psychoanalysis helps doctors treat patients who have diseases.

 Again, Freud anticipated this issue as early as 1918. “Medical…training has been quite rightly criticized…for…failing…to explain to [the student] the significance of mental factors…in illnesses and their treatment…This will not only show itself in his lack of interest in the most absorbing problems of human life…but will also render him unskillful in his treatment of…patients…Psycho-analysis…more than any other system, is fitted for teaching psychology to the medical student…In America, according to the best of my information, it has already been recognized that psycho-analysis has made successful inroads into this unexplored region of psychiatry. Many medical schools in that country, accordingly, have already organized courses of psycho-analysis as an introduction to psychiatry.” Of course, that was in 1918. A century later medicine had passed through a period in which it seemed less interested in illness and more interested in disease; psychoanalysis had an extended flirtation with psychiatry and retreated to a significant, but restricted position as one among several psychiatric treatments, and medicine’s renewed interest in the experience of illness is matched by psychoanalysis’s renewed recognition of its unique contribution to the understanding of normal adaptation to life stress.

 If medicine and medical education have a need, and psychoanalysis has a potential solution, what is the problem? There are complex and interesting reasons for the stigma associated with psychoanalysis in the world of medicine, unconscious attitudes toward mental illness and sexuality, the inappropriate extension of clinical approaches to personal relationships, and others. However, I shall close by discussing one that is both important and, I believe, remediable. Medicine has become increasingly science-based, and psychoanalysis has not developed a strategy for sustained scientific research. Psychoanalysis is unusual in that it has placed far greater emphasis on preserving knowledge and training practitioners than on developing new knowledge, particularly when contrasted with other clinical or health professions. This fact is related to the unusual social structure of psychoanalysis, which consists of several loosely affiliated networks of mostly freestanding institutes with members who are primarily self-employed practitioners outside of the institute, and who are only secondarily part-time members of the institute itself. These institutes’ primary function is training, and most of them have only minimal relation with other educational or research institutions or with other scientists or scholars. Systematic encouragement of research and ongoing inquiry is decidedly secondary to their mission of training and clinical practice. A small number of institutes are affiliated with universities, but even these have essentially the same structure as the freestanding ones, and have few or no members whose primary identity is their university-institute role rather than clinician-supervisor. This structure produces the almost unique separation of training from research and the immense emphasis on training peculiar to psychoanalysis. Here again I believe the theme can be traced back to Freud, but this time as villain rather than hero. Freud was mistrustful of universities. He had been wounded by personal rejection in his pursuit of academic advancement, and he was fearful that his new discipline would be smothered by institutional prejudice. He wrote in 1918, “It is clear that the psychoanalyst can dispense entirely with the University without any loss to himself.” Perhaps psychoanalysis needed this protection in 1918, but by 2015 it was clear that it had paid a heavy price. The institutes that developed outside of universities were interested in teaching, but not in research. This attitude has made psychoanalysis out of step with most of modern medicine. However, there are signs that this barrier can and will be removed. The second century of psychoanalysis will be marked by its transformation to a science-based profession, and medical education and practice, as well as psychoanalysis itself, will be enriched as a result.