Psychodynamic Practice

A. Douglas Logue, MD ©

As everyone knows, psychoanalysis and general psychiatry have grown apart, beginning with DSM-III. That split was fostered by the growth of neurochemistry and neurobiology and the increasing research into and development of psychiatric medications, drugs. Originally, back in the early seventies, some psychoanalytic groups, certainly the Baltimore Institute and myself, were alarmed by the loss of concepts such as neurosis and visited Columbia in NYC about the changes. At the time we won a bit of a battle with regard to psychoanalytic concepts, but it was transient.

Psychiatric residencies changed strikingly. Essentially disappearing were the teaching of stages of ego development, object relations, and the vast sophisticated literature, particularly about schizophrenia and neurosis. Sophistication unbelievably lost. But more importantly, the interactional style between patient and treater morphed. The latter became a symptom oriented data collector and diagnostician and the concept of a cooperative effort between patient and practitioner aimed toward the discovery of symptom causes was basically lost. That is not to say that case diagnosis lacks medical sophistication, quite the contrary. Picking up inherent problems between meds and physiology can be very impressive and very smart. General psychiatry feels closer to internal medicine.

These perspectives have increasingly struck me over the last two years, as I have practiced locum tenens hospital-based general psychiatry, on psychiatric in-patient units, on general and specialty hospital wards, as well as EDs, ICUs, and also OPDs.

A large number of the midlevel practitioners, specifically PA-Cs (certified physician assistants) and ARNPs (advanced registered nurse practitioners), are very hungry for psychodynamic practice knowledge, theory, and experience. These practitioners want two things: a more sophisticated style of relating to patients, and diagnostic expertise coming from psychoanalytic experience. They want to sit in on evaluations with a psychoanalytic psychiatrist, to learn. The same is true of a number of psychiatrists. The age of primarily medications has reached its pinnacle and everyone knows the problems.

While it is certainly apparent to me and my psychoanalytic spouse, that there are quite a number of psychoanalysts in the U.S. who are quite aware of this problem and have published extensively about it, I haven't seen any practical solutions. What are needed are practical psychoanalytic institute outreach programs. To give an example: at a quite sophisticated Hopkins-level Florida hospital, I was asked about possible psychiatric improvements. I tried to answer about the introduction of psychoanalytic education, without using the term since it is currently still off-putting. But if the nearby psychoanalytic institute were to to offer consultations and teaching, even if by psychoanalytic students, this would get the process started. Structural changes should be implemented by the American.

A parallel problem is the request by patients being discharged for sophisticated, psychoanalytically oriented therapists. There are nil over the broad U.S. This becomes especially poignant when the patients or their families are wealthy, and still have nowhere to go.

Psychoanalysis and general psychiatry have been mainly on different planets. This is an opportunity for psychoanalysis to get back into the mainstream - in practice.