Medical Realities and Psychological Experience:  
*Bridging the Great Divide*

**Working in American Medicine: Reflections of a Psychoanalyst**

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*The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.* (Plato)

*It is much more important to know what sort of a patient has a disease than what sort of a disease a patient has.* (William Osler)

*The twenty thousand biomedical journals now published are increasing by six to seven per cent a year. To review ten journals in internal medicine, a physician must read about two hundred articles and seventy editorials a month.* (Manning and DeBakey)

I. Overview

Clinical psychologists within the U.S. have a well established presence within the health care system which includes medical centers, hospitals, specialty clinics and private practices. In these roles, and along with other mental health professionals, clinical psychologists assess the psychological aspects of medical illness.

The established theoretical orientation of most psychologists practicing in these realms is that of behavioral medicine, a perspective which is a combination of theories, therapies and techniques derived from the behaviorist and the cognitive behaviorist traditions. Out of this has come the discipline of health psychology, which mandates the improvement of health and the management of illness through voluntary control of behaviors.

Along with other psychoanalysts who work in a variety of roles within clinical medicine, and those who see individuals with physical disorders in their practices, I am a clinical psychologist who works with medical patients from the perspective of contemporary psychoanalysis. As such, I collaborate with physicians to provide psychological evaluation and treatment services. I consult with the medical staff and provide education and training to physicians and psychology post doctoral fellows. My understanding of patients with medical illness is organized around psychoanalytic concepts such as affect dysregulation, self structural vulnerability, attachment disruption, concretization of affect through somatization, pre-symbolic meaning, internal object representations, antidote functions, alexithymia, traumatic re-enactments, and a failure of desomatization, limited mentalization and reflexivity.
II. The Culture of Medicine and the Culture of Psychoanalysis

There continues to be a Cartesian dualism inherent in the practice of American medicine. In my experience, physicians do not usually consider psychological process based upon experience and context and how these factors influence physical disease. There is more of a focus upon psychological symptoms and symptom reduction. Hence, the concept of psychological assessment and intervention relies upon an essentialist, empirically grounded medical model of disease with specific etiology and evidence based practice.

For example, this sensibility can be seen in a textbook of pain medicine which recommends that a psychological evaluation focus upon the following areas: 1) Observable overt behavior; 2) Covert behavior; 3) Emotional/affective aspects of behavior and 4) Physiological response. The treatment is framed using the behaviorist concepts of positive/negative reinforcement (Doleys et al, 1998).

Many physicians with whom I have worked have told me that they did not enjoy their rotation in psychiatry because working with psychiatric patients was unpleasant. It is my impression that contemporary psychoanalysis is not commonly a part of many medical school curriculums. Many medical physicians do not understand the analytic attitude.

In lecturing to medical residents, fellows and staff physicians as well as those in private practice, I have often felt that I had to be careful with my use of psychoanalytic language and speak in terms of evidence based practice. Terms which psychoanalysts take for granted are unfamiliar to physicians. It is often difficult and challenging to face a room full of physicians while giving a psychoanalytically based lecture. There are few questions or comments. By comparison, when speaking to a room of psychoanalysts, I may not be able to finish the lecture due to being interrupted by comments.

A study of the distribution of physician faculty by primary specialty by the Association of American Medical Colleges revealed that out of 60,617 members, there were 4 psychoanalysts.¹

Physicians who practice medicine have had diverse experiences with personal psychotherapy. Some have had none at all. Some have had extensive treatment. Some have little respect for psychotherapy, others value place high value on it. Some physicians define psychotherapy as cognitive behavioral therapy while others do not know about differing theoretical orientations or types of practice. A few physicians have been involved with psychoanalytic treatment, understand it, have read books about it and apply some knowledge of it to their patients and respect the psychoanalytic domain.

I have frequently had the experience of a medical physician recounting to me an obscure fact about psychoanalysis as their reference point. “What was the final resolution of the

¹ www.aamc.org/data/facultyroster/usmsf97u/tab17.htm
controversy about Freud and the Seduction Theory that was uncovered by Jeffrey Masson” asked one oncologist. “I thought Freud was dead” an internist confided in me. A surgeon told me that he didn’t think psychoanalysis was relevant to the problems of the 21st century. “I was in psychoanalysis and I hated it” reported another physician.

Referrals are usually not for psychoanalysis as a specific treatment. Just recently, a physician in training called to ask if I did CBT because he felt that this was what his patient who was depressed required. Another told me his patient needed “stress management”. Still another sent a patient to me “because I cannot do anything more for her maybe you can”. Recently, a patient called me on referral from her physician who she said “thinks that I have no one to talk to”.

The first line of treatment for psychological symptoms seen in medical practice is psychotropic medications. The legacy of the managed care system in health care is partially responsible for this reality. Another problem is that referrals may not be made until well into the medical treatment. One M.D. advised me that a particular patient had significant elements of a ‘Cluster B’ personality disorder and was not a good candidate for elective surgery until involved in psychotherapy.

Most importantly, even among insightful physicians who are knowledgeable about psychoanalytic treatment, time constraints are present. There is not enough time to incorporate a psychoanalytic formulation of a patient’s dynamics into the medical treatment.

When I consult with a patient referred to me by a medical physician. I gain an understanding about the contribution of the patient’s personality organization, unconscious functioning and developmental history. I seek to offer a formulation of how the medical disorder was influenced by these factors. I look at how the illness caused personality changes or provoked dormant existential issues. I outline psychoanalytic treatment, which would improve physical health and well being.

My success in developing a network of physicians who understand what I do and who refer to my practice is based upon my efforts at education and my track record of clinically improved outcomes with patients. This process has taken time to develop and it is an ongoing process.

A recent clinical example is illustrative. A high functioning and successful female lawyer was diagnosed with a pain disorder. She had been seen by a variety of physicians, given three provisional medical diagnoses and had had medication regimens and other treatments. Her pain levels remained high in spite of these treatment interventions. She was referred for psychological evaluation. It was noted that she had depression and anxiety. A psychoanalytically based evaluation revealed that the patient had seen politically motivated violence as a child in her country of origin had had subsequent marital domestic violence in the country of immigration and for the majority of her adult life, had had a pattern of poor stress management, overwork and emotional dysregulation.
With this patient it made sense that she had had a less than favorable outcome of surgery (the initial source of the pain) given her history, her defensive structure, her attachment style and her level of affect regulation. All of these I believed to be contributing to her pain perception. I was struck by how she had functioned with such a history. The failure of medical treatment made sense as the patient’s somatic complaints were being fueled by processes such as concretization, unregulated affect and unresolved trauma.

When I explained my findings to the referring physician, I realized that my understanding of this patient would be difficult to communicate. I struggled to summarize but the essentials were lost. My physician colleague, who I respected a lot, did not have the time or the understanding to fully comprehend what I was trying to explain. Had I used behaviorist language, I would have been more successful. My psychoanalytic formulation was reduced to saying that the patient would benefit from psychotherapy.

II. Historical Perspectives

In his 1927 paper on lay analysis, Ernest Jones reflected:

"Both the internal and external bonds between psycho-analysis and clinical medicine ... are fundamental in character, and they can be ignored only at considerable cost to psycho-analysis".

In his Presidential Address to the American Psychoanalytic Association (December 10, 1950), M. Ralph Kaufman, M.D., psychiatrist at Mt. Sinai Hospital and Professor of Psychiatry at Columbia University, said:

“Psychoanalysis is biologically based and body bound. Historically, its most intimate relationship has been as a medical discipline originating with Freud's intense desire for therapeutic procedures which might prove efficacious in the treatment of the neuroses.

Even though they speak timidly, more and more voices, among them distinguished ones, at least partially confirm Freud's teachings. It is striking that such substantiations come not only from psychiatrists, but from circles of internists, gynecologists, pediatricians, dermatologists, and so on. They state that many a problematic case in their field of specialization has become intelligible and accessible to therapy only because of psychoanalytic explanation. Consideration of unconscious psychic factors in the pathogenesis of disease seems to spread almost like an epidemic. Many distinguished physicians occupy themselves intensively with analytic therapy in organic disease. To be sure these are only promising beginnings, but their future significance cannot be denied. To medicine which has been segmented into all the specialties, psychoanalysis has been a benefactor for it reminds one, in every form of disease, to treat the patient as well as the disease.”

Further, “I can state that until Freud medicine has been taught as a purely natural science. One attended a health technical high school from which one graduated with much theoretical and practical knowledge, yet ignorant of the human psyche. But out in the world of medical practice the psychological factor in therapy is as important as the objective finding in the organ. I can imagine how much effort and pain might have been spared had I, as a student, been taught the art of dealing with transference and resistance. I envy the medical student of the near future who will be taught this. The humanization of the university course of study will become an absolute
necessity and it finally will come about.” In many medical schools this humanization is in the process of being realized.”

Nonetheless, beginning in the 1950s there was a shift away from psychoanalysis to systems theories and neurophysiology. The paradigm of unconscious intrapsychic conflicts elucidated by psychoanalytic methods was replaced by the paradigm of directly observed conscious and semi-conscious maladaptive behavior. This included an emphasis upon the stress response syndrome, bioconditioning, sleep deprivation, sensory overload, and biobehavioral management (Brown, 2000). Conscious voluntary control of somatic symptoms replaced the idea of understanding unconscious factors as a treatment goal. Behavioral change could have an impact on disease.

Eysenck, (1952) asserted that research detailing the progression of mental problems concluded that a psychoanalytic outcomes were not substantiated by valid research. Cases of hysteria were later found to have actually had organic disease diagnoses (Brown, 2000). Internal medicine shifted to the “specific etiology” paradigm and psychological interventions were recast. Empirical clinical interventions gained importance.

A recent review of relevant textbooks reveals how psychoanalysis is portrayed:

1) “The “psychoanalytic tradition” in psychosomatic medicine is generally was most prominently represented by Franz Alexander and his now discarded ‘specificity theory’. Although Alexander foresaw and advocated a multifactoral model of illness in which psychological factors interacted with biological, environmental and social influences, the field of psychosomatic medicine has as yet to recover fully from the misconceptions that arose from the belief that specific constellations of intrapsychic conflicts resulted in specific type s of physical illness”. (Stoudemire, 1995).

2) “Psychodynamic approaches to psychotherapy that are relational in orientation can be especially helpful to clinicians working with pain patients, because they allow for the application of cognitive behavioral techniques without interfering with or minimizing the importance of exploring the meaning of a patient’s pain and suffering” (Grzesiak et al, 1996).

3) “This chapter’s purpose is to show how Freudian ideas were introduced to the world of pain and how they evolved and decayed. ... Not everyone in the fields of psychiatry or psychology accepts that the demolition has occurred ... This is ... because the essential work ... (has shown) the poverty of valid data and the poor results that have attended psychoanalytic practice (Merskey, 2000)”.  

4) “In a discussion of “Biopsychosocial Approaches to Pain”, the Canadians Asmundson and Wright (2004) primarily cite Freud and George Engle to conclude that “With few exceptions, the psychodynamic formulations have not fared well against empirical scrutiny ... Although incorrect, these assumptions can (and still often do) have a negative impact on opinions and general treatment of people who suffer from persistent pain conditions” (Asmundson and Wright, 2004)”.  

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Furthermore, not all psychoanalysts think that psychoanalysis should be a part of health care. Hyman (1999) has suggested that psychoanalysis does not belong in medicine at all. Health care is different than psychoanalysis in that:

1) It is concerned with symptoms not mental life
2) It pertains to pathology not psychodynamics
3) It seeks fundamental causes not subjective experience
4) It seeks the cure of illness not the experience of illness
5) It seeks to reduce the human condition to the biological
6) Its views mental illness not an objective fact
7) The diagnosis determines the treatment
8) It emphasizes outcome not process

III. Recent Developments

In response to a concern about the harmful effect on health of destructive behaviors and the role of psychological factors on chronic disease, the Institute of Medicine of the National Academy of Science convened The Committee on Behavioral and Social Sciences in Medical Education. The committee was given the charge to provide the National Institutes of Health and the Robert Wood Johnson Foundation with a critical analysis of the behavioral and social sciences in medical schools. A report was issued in March 2004 which concluded:

1) There was inadequate information available to sufficiently describe the curriculum content, teaching techniques and assessment methodologies in U.S. medical schools
2) It was recommended that there be the development of a new national behavioral and social science database used to provide education to medical students in these areas and extending through the four years of medical school.
3) The committee identified 26 topics in six domains which should be included in the proposed new medical school curriculum. The six domains identified were:
   a. Mind/body interactions in health and disease
   b. Patient behavior
   c. Physician role and behavior
   d. Physician/patient interactions
   e. Social and cultural issues in health care
   f. Health policy and economics
4) It was recommended that the National Board of Medical Examiners ensure that the behavioral and social sciences were adequately covered in their future exams

A discussion of this report in the APA Monitor on Psychology reported that Division 12 (Society of Clinical Psychology) has a section the Association of Medical School Psychologists, and that Division 38 (Health Psychology) members are active in medical education and that APA psychologists have been involved in the Association of Behavioral Science Medical Educators. In this review, psychoanalysis was not mentioned.
IV. What Do We Do?

What I have described is truly remarkable. In psychoanalysis, we have a theory and technique which is highly suited to the care of patients with medical illness. Let us not forget that psychoanalysis came into being in that context. At the same time we are confronted with a health care system which is unaware of what we know and practice.

The psychoanalytic paradigm was abandoned by American medicine, perhaps with good reason. It is now time for a rapprochement. The experiences of psychoanalytic clinicians support the relevance of our work in clinical medicine.

Perhaps the conclusions of the National Academy of Science have opened a door for the redevelopment of medical psychoanalysis. The domains cited by NAS of “mind/body interactions in health and disease” and “physician/patient interactions” are fertile areas. I suggest that it is time that the pendulum swings back from the far right where it now rests (as a reaction to the far left where it remained for decades following Freud) to the middle where a new school of thought can develop. To reintegrate psychoanalytic thinking into medical practice is a formidable task. But it is a task long overdue.
References


