

I'm a Psychoanalyst—and Here's Why I Love It

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Some of you might be surprised to see an entire issue of *The Carlat Psychiatry Report* devoted to psychoanalysis. Do psychiatrists still practice it? Does it actually work?

To paraphrase Mark Twain, the demise of psychoanalysis has been greatly exaggerated. I am an early-career psychiatrist, trained in a mainstream residency, and I prescribe medication to the majority of my patients. Yet, about 10% of my practice is psychoanalytic—

and I believe that these patients are benefiting tremendously from this very intensive type of therapy.

In this article, I'll discuss the current status of psychoanalysis, some of the evidence for its efficacy, and why I've found it so useful for my patients.

A brief description

Psychoanalysis was developed by Sigmund Freud and colleagues in Vienna in the 1890s. As practiced today, psychoanalytic technique focuses on the unconscious basis of feelings and behaviors. The main theory is that emotional distress and dysfunctional behavior are often caused by unconscious feelings and memories that patients try to suppress, especially those that involve internal conflict. These feelings leak out in various ways, despite psychological defense mechanisms patients use to prevent this.

Psychodynamic therapy and psychoanalysis are similar. Both ascribe to the above theory of the mind, but a psychodynamic therapist will typically meet with a patient 1–2 times per week, sit face to face, and converse with the patient. A psychoanalyst will meet with the patient more

frequently (3–5 times a week) and for a longer time period (4–5 years). The patient lies on a couch and “free associates,” saying whatever comes to mind, including fantasies, dreams, and thoughts about the analyst, while the analyst sits out of view behind the couch, primarily listening, but occasionally interpreting the patient’s comments.

Theoretically, psychoanalysis works by altering self-defeating patterns, and it does so by helping patients get to know their own minds, especially the unconscious processes that produce difficulties in relationships and work.

The analyst finds clues to these unconscious feelings by listening for links between a patient’s associations; noting slips of the tongue; interpreting dreams; using the associations and countertransference reactions in the analyst’s own mind; and focusing on the transference, meaning the reenacting of a past relationship in the context of the therapy session.

Over time, the analyst presents all this data to the patient in the form of comments, or “interpretations.” If all goes well, the complicating patterns of the patient’s life come to light, and the patient is able to alter them. This process often requires the patient to mourn the loss of familiar ways of interacting with the world, and to replace rigid thinking and a harsh self-image with a gentler perspective, modeled by the analyst.

Psychoanalysis today: Who practices it, and what’s the evidence?

Psychoanalysis is widely practiced by psychiatrists, psychologists, and social workers. There are 3,500 active members of the American Psychoanalytic Association (APSA), 65% of whom are psychiatrists, and there are many more practicing analysts who were trained by U.S. institutes not affiliated with APSA.

Like any psychotherapy, the effectiveness of psychoanalysis is not easy to evaluate. This is largely because randomized clinical trials (RCTs) require a control group with which to compare the active treatment. In drug trials, you can assign some patients to the drug and others to a placebo sugar pill. In therapy trials, finding a believable placebo condition is much more challenging than in medication trials. This is especially true of psychoanalysis, because the treatment is more intensive and longer lasting than other psychotherapies.

The most recent meta-analysis of psychoanalytic research looked at 14 studies, which enrolled a total of 603 patients, with the number of patients in each study varying from 17 to 92.

Psychoanalysis was defined as at least 2 sessions per week, with the patient lying on the couch. In these studies, the duration of analysis ranged from 2.5 to 6.5 years. Only one of these studies was an RCT that included a control group. The other 13 were pre/post cohort studies, meaning that all patients were assigned to the same treatment (psychoanalysis) and researchers compared their symptoms before treatment with symptoms after treatment.

In terms of results, the good news for psychoanalysis was that the overall effect size was 1.27, which indicates robust symptom improvement. The bad news was that the methodology of these studies was variable, limiting confidence in the results. Different studies enrolled different diagnoses, different symptom measurements were used, and, as mentioned, there was only one study that met the gold standard of randomizing patients to a control group (De Maat S et al, *Harv Rev Psychiatry* 2013;21(3):107– 137).

While there is much work to be done in proving the merits of psychoanalysis, at least we can say that these studies are consistent with the notion that this classical treatment—couch, silent doctor, and all—might be effective. And that certainly mirrors my own clinical experience.

Analytic training

During my psychiatric residency, I quickly realized that the more deeply I understood my patients, the more I could help them, and the more interesting the work was to me.

As a PGY-3, I had two supervisors who were analysts, and I was fascinated by how they thought about patients with respect to developmental trauma, unconscious motivations, and conflicts. It was vastly more complex than the DSM assessments I had become accustomed to. After attending the annual meeting of the APSaA and hearing actual analytic cases presented, I knew I would eventually become an analyst.

But after residency, I opted to take a break from training, and so I took a job on an inpatient unit with a private practice on the side. The inpatient work was demoralizing: admit, medicate, discharge, repeat—exactly the opposite of trying to understand the patient better. The turning point came when I was sitting with a private patient one day and realized that my therapy skills were not adequate for her needs. I began my analytic training the following autumn.

I enrolled in the New York Psychoanalytic Institute, which follows the tripartite training model of didactics, clinical work, and a personal analysis. I attended 6 hours of classes per week,

including theory, technique, and continuing case conferences, for 4 years. Over the 7 years until I graduated, I treated a total of 4 analytic “control” cases, each 4 times per week, with 1 hour of supervision per week, per patient.

In addition, I participated in required training analysis for myself, 4 times per week. If all this sounds like a lot of time, it was, especially while working. Between tuition (roughly \$5,000 per year), paying my analyst (I don’t even want to go there), taking on low-fee cases, and losing work time to transit, it was also a lot of money.

Pearls from supervision

I learned many things from supervision, but here are some of the main pearls that stand out.

If it seems reasonable, say it. Early in training, I thought a lot about what to say and not say, and whether the patient was “ready to hear” (ie, could tolerate hearing) what I was thinking. I struggled with this until one of my supervisors told me, “Don’t worry so much. If you’re thinking it, be tactful, but say it. If the patient has trouble tolerating it, that’s something else to analyze. It is all part of the proverbial grist for the mill.”

Body language is key. Another supervisor reminded me to pay attention to the patient’s body language, as well as my own. For example, he noticed himself removing his glasses with a particular patient, or leaving certain mail out with another—both physical manifestations of countertransference, or his feelings towards the patient.

Self-revelation can be productive. There have been times I’ve said things to patients about myself that felt impulsive to me, such as revealing where I’m going on vacation. I used to assume these were errors in technique, and I would give a lot of thought to why I had made them, and studiously try to avoid making them again. But when I discussed some of these with one supervisor, she said, “Your ‘error’ is probably an indication that you were picking up on something the patient is having difficulty communicating, and if you analyze it, it will probably help you and the patient discover something that was otherwise inaccessible.”

Getting analyzed

My personal analysis was the most grueling of the 3 components of training. Psychoanalysis produces a regressed state in the patient. There’s something about lying on the couch, not facing the analyst, day after day, that brings up primitive thoughts and sensitivities, and turns mature, responsible adults into fragile children, like a return to the cradle. This is good for the

analysis, because it facilitates access to the unconscious, but after each session, you need to put yourself back together and act like a grownup, even though you're not feeling like one. In the face of this vulnerable experience, analytic trainees tend to bond with each other for support, which helps to develop our identities as analysts. I found that being in analysis helped me empathize with my patients' feelings about being patients, and it also gave me firsthand knowledge of how an experienced analyst thinks and works.

Life as an analyst

I graduated from analytic training four years ago. I now have a small private practice in Manhattan's Greenwich Village, with an office that contains an analytic couch, which new patients often point at and ask, "Do you really do that? Like in Woody Allen movies?"

Early in my analytic training, I enjoyed doing psychotherapy more than psychoanalysis. I felt that not seeing the patient's face left me with one less source of data. But gradually, I began to feel more comfortable and competent, and better able to tolerate the intensity of the analytic relationship, which is much greater than that of conventional psychotherapy. By "intensity," I mean the feeling I have when working as an analyst of being such a powerful part of the patient's internal life. I consider this a huge responsibility, and during sessions I listen carefully to everything the patient says or does not say. And while listening, I also let my thoughts wander, paying close attention to them, because this is another way to recognize the patient's unconscious at work. In psychoanalytic jargon, this is called using the "analyzing instrument." For an example of this process, see the case "Anger, Anxiety, and Pain: A Description of an Analytic Session" on page 5 in this issue.

Unfortunately, I do far less analysis than I'd like. Most of my patients start seeing me in some form of psychotherapy. I suggest analysis to those who I deem appropriate, but very few make the switch. The logistics of coming to sessions 4–5 times per week are difficult, and analysis is expensive, even with the sliding scale I offer. I do not take insurance, and very few companies offer out-of-network coverage.

While psychoanalysis is a small part of my practice, the skills I learned enrich all my work with patients. My ability to listen and discern meaning has made me more astute at recognizing symptoms, and thereby a better psychopharmacologist as well as therapist. I also have the intellectual stimulation and community of my analytic institute, where I teach, attend lectures,

and am active on various committees. So far, I don't feel burned out, as many doctors do. Frankly, I think my job is fun.

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