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# Proving the Impact of Psychoanalysis on Daily Psychiatric Practice: Structured Programs and Clinical Guidance

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## Introduction

Let me begin by briefly outlining my professional background so that you might be better able to follow my argument. Of course, I am a psychoanalyst, member of the German psychoanalytic association DPV and of the Swiss society of psychoanalysis SGPsa and, thus, I am a member of the IPA. I am a psychiatrist as well and a university lecturer at Basel University. For almost 8 years now, I have been the head of a psychiatric institution, the psychiatric in- and outpatient hospital of the Swiss county Baselland . The institution offers a comprehensive psychiatric service for 239 in-patients and around 50 patients at three day hospitals; in addition, there is a huge outpatient department. Previously, I worked full-time as a tenured professor for psychotherapy at Basel University. My motivation to leave the university and to take on the extra responsibility of such a large non-university unit was to find out how far I could go in applying psychoanalysis to ALL sectors of psychiatric care. For the last 20 years, I have also been in charge of the postgraduate teaching for psychiatric residents in the whole area of the north-west of Switzerland, which I have initiated and for which I have – together with many coworkers – developed a curriculum.

Let me start now with the proper talk.

As the title of my talk suggests, I’ll talk about two forms of teaching:

1. the formal teaching for residents and how psychoanalysis can be and should be implemented in it;
2. the informal and everyday (sort of) bedside teaching, the teaching that is implied in a psychoanalysis-based approach to psychiatric patients

## Part 1: formal teaching

1.1. Training course **P**sychotherapeutic **B**asic **T**ools (PBT)

The PBT is a teaching program for residents at the beginning of their psychiatric career. In psychiatric postgraduate clinical training, residents work directly with patients from the first day onward; in medical school, they have gained a rough knowledge concerning psychiatric disorders generally – or at least they should have. Perhaps, they had a few courses on doctor-patient relationship. Postgraduate education in Switzerland provides no instruction in specific psychotherapy before the third year of postgraduate training. Prior to that, residents will not have had any specific teaching in psychotherapeutic methods. But they will have to talk to patients although they haven’t yet chosen the therapeutic approach they want to specialize in.

The training course on psychotherapeutic basic tools, the PBT, wants to alert residents to the concepts of working in and working with the therapeutic relationship. It is a supra-institutional training course. The participating residents come from psychiatric institutions that are members of the regional board of the network for advanced psychiatric education. Students are being taught in groups of 16 – 18 residents; there are two trainers in each group. Residents from the same hospital are mostly allotted to different groups. The classes are four hours long and the groups meet for one afternoon each month for a year. The timetable is divided into 2 parts: first, there is a theoretical input; after a short break, a practical exercise takes place. All residents have to bring a videotape of an interview with a patient, which they have personally led, to the class at least once. The interview should roughly correspond to the theoretical topic that has been introduced in the first part of the session. We have established didactical rules for how best to work with the interviews; at first, all participants watch the video sequence, which should not last too long. Then, alternatives to the interventions, which the presenting resident showed in the video, are deliberated. If the group decides that an alternative interpretation or commentary would have been more appropriate, a role-play will happen next. This allows the participants to get an impression of how the therapist’s contribution may shape the interaction positively or negatively. Throughout the year, the participants follow the steps of an imaginary patient through the psychiatric institutions and treatment forms, starting with admission to the hospital, covering suicidal crises, interactions with partner or family of origin, to psychosocial re-integration and other issues. Whenever possible, the same group stays together for the duration of the course, so that residents who work in different institutions can come to know each other, and so that the tutors might be able to use the evolving group dynamics for didactical purposes.

The first three meetings introduce the participants to the concept of the therapeutic relationship including aspects of transference and countertransference. This will be the perspective from which all the steps in the therapy with the imaginary patient are evaluated. And this is also where psychoanalysis comes in, because it is psychoanalysis that allows best to reflect on the therapeutic relationship. In PBT, psychoanalysis is not taught directly, but it is used as an instrument to help the residents take their (countertransferential) affects seriously, to watch the patient carefully and to be open-minded, that is to use one’s free floating attention, and in the end to be able to define the unconscious relational patterns connected to the patient’s symptomatology. The residents that take part in the training course learn how important it is to reflect on the therapeutic relationship and how helpful psychodynamic concepts can be for becoming aware of the patient’s verbal and non-verbal expressions and one’s own affective and spontaneous reactions to the patient. Thereby, they learn that psychoanalytic concepts may be helpful for the encounter with a patient in a psychotic crisis or with a patient in an early stage of dementia, that is: in all circumstances of the day-to-day clinical business.

In 2005 and anew in 2009, we have written and edited textbooks that serve as a manual for the training course.[[1]](#footnote-1) They cover all topics that should be treated throughout the course and describe to the tutors how to proceed didactically.

## 1.2. Operational Psychodynamic Diagnosis (OPD)

The next step towards introducing psychoanalysis into psychiatric care and to teach psychoanalysis to psychiatric residents is training through the OPD system. Operationalized Psychodynamic Diagnosis (OPD) is a multiaxial diagnostic and classification system, which is based on psychodynamic principles[[2]](#footnote-2). It is analogous to those systems that are based on other principles such as DSM-IV and ICD-10. The OPD is based on five axes: I = experience of illness and prerequisites for treatment, II = interpersonal relations, III = conflict, IV = structure, and V = mental and psychosomatic disorders (in line with Chapter V (F) of the ICD-10). After an initial interview that lasts 1–2 hours, the clinician (or researcher) can evaluate the patient’s psychodynamics according to these axes and enter them in the checklists and evaluation forms provided. The OPD-2 has been further developed from a purely diagnostic system into a system that includes a set of tools and procedures for treatment planning and for measuring change. It can be used to determine the appropriate main focuses of treatment and develop appropriate treatment strategies as well.

OPD is very useful for teaching psychodynamic principles to a resident. What he or she will find there is a complex but well defined set of psychodynamic terms that have been found to be reliable and valid. Even though the majority of the terms are truly psychodynamic, they are operationalized, that is: made manageable for the beginner who is not – as yet – trained in psychoanalysis. The young doctor is well acquainted with operationalized diagnostic criteria; the methodology in which the OPD system proceeds is thus familiar to him or her. This makes it easier for him or her to access and then accept the system.

OPD is taught in specialized training seminars that have a specific structure, and all training centers exert identical standards. Compared to the PBT, OPD is far more advanced in psychodynamics; that is the reason OPD can serve as a second step. In my psychiatric center, I offer OPD seminars every six months; in between, small groups meet regularly under the supervision of an external OPD expert to discuss clinical cases through an OPD perspective.

All psychodynamic diagnostics have a severe disadvantage: they need time – and time is money when psychiatric hospitals are confronted with significant budgetary and monetary cuts – as they are in Switzerland and Germany. Hence, there might not be enough time in clinical practice for including these diagnostics, and using OPD might interfere with the necessities and pressures of daily practice in psychiatry, especially in acute situations. That is the reason we have tried to find a formula allowing OPD to be implemented step-by-step together with a group of OPD co-workers.[[3]](#footnote-3) In many occasions, the resident might not need the whole array of diagnostic tools. On admission of a patient to the hospital, for instance, only axis I (one) might be needed. With the help of axis I, the resident can explore the accessibility of the patient to psychodynamic treatment, find out about the patient’s therapeutic preferences und his or her personal illness concept and decide how to proceed with psychodynamic diagnostics. In other circumstances, it might be best to apply the axis IV structural diagnosis in order to define prominent structural deficiencies. This allows for an early intervention to help the patient improve their affect intolerance or control of impulses.

## Part 2: Informal Training

So far, structured and formalized training tools have been highlighted. They are important, but they are not exhaustive. The vivid routine of integrating a psychodynamic approach into daily business is the most important. It is only then that psychodynamics are “normalized” and really a part of the psychiatric education. I will now present a few examples for how this integration can be achieved:

## 2.1.Conjoint Therapy Planning

Most inpatient treatments are short term therapies. The patients will stay in the hospital for no longer than a few weeks. It is thus advisable to limit the therapeutic aims and focus on the most urgent issues. These include psychopharmacological care, social rehabilitation, organization of after-care etc. From a psychodynamic point of view, the formulation of a focus can be helpful for defining and delineating the main psychotherapeutic aims. The focus serves as an integrating formula, which links the different therapeutic approaches by defining a common and shared central aspect; as a result, the focus enables coordination of the team’s work. What is needed then is a team conference on the patient’s ward with all members of the staff, where they can communicate the results of their individual assessments. These results can then be evaluated and, finally, used to attain a focus formulation that summarizes the patient’s main object relations and their conflictual or structural concerns and helps to find the appropriate therapeutic approach. Again, the OPD system may serve as a conceptual background for the focus formulation, but other psychodynamic approaches may be just as useful. Thus, the residents and the other team members become aware of the advantages of a psychodynamic approach: it guides them to a conjoint therapeutic team process; it helps them to better understand the patient’s object relations, to define the central conflict or the personality organization of the patient, and to use the diagnostics as a starting point for the appropriate and fitting therapeutic measures.

## 2.2. Crisis conference

In the psychiatric hospital of which I am in charge, we have introduced a special conference in urgent crises, which we call “crisis conference”. All partners involved in the inpatient’s therapy are entitled to call for such a crisis conference. The conference must be established within 48 hours and it includes the resident, the senior psychiatrist, the consultant, members of the nursing team, the physiotherapist, maybe the sports therapist – whoever was involved in the patient’s treatment. As the clinical director, I take part as well and chair the conference. The crisis conference is convened only in moments of a real crisis and imminent danger. Typical triggers are a permanent suicidal proneness that interferes with dismissal from the hospital, a homicide threat, an elderly patient’s wish to be let go and allowed to die etc. In most instances, the team already knows the solution to their problem; they merely need someone to help straighten out their ideas, to contain their fears and countertransference blockades and to support their therapeutic plans emotionally but also legally – thus, they need help to establish or re-establish a symbolic order which was threatened to be disturbed by the patient’s psychic disorder. I wouldn’t be able to lead the crisis conference without my psychoanalytic abilities – by letting the members of the crisis conference take part in my psychodynamically guided considerations, I can serve as a teacher and therefore as a role model and a good guide to psychoanalysis.

## 2.3. Supervision of the Team and of the Institution as a Whole

The best training in psychoanalysis for the resident is to sense – as it were - a psychodynamic atmosphere within the institution, to feel that the personal resonance, the affects in the therapist, the conflicts between members of the staff etc. all are seen as potentially relevant to the therapeutic outcome. To learn that these factors are not discarded as merely disturbing or private, but that they are taken in earnest so that time and money can be invested into the working-out of countertransference reactions either on an individual or on a team level, to understand mirroring phenomena where conflicts of the severely disturbed patient are projected unto the team members, to reflect on a team’s working ability, e.g. on the formation of “basic assumptions” in the team due to institutional problems.

If psychoanalysis is allowed so far into the institution, there will have to be psychodynamic supervisions that can work with the dynamic factors mentioned above. This means that the teams need a psychodynamically trained supervisor who is able to work with the affective processes during therapies and in the team. Even as a unit, the institution itself may be submitted to an institutional supervision on a psychoanalytic basis – for many years, we had a group analyst and institutional counselor who came once every semester to moderate large groups consisting of all levels of the institutional hierarchy. Thus, in the end, the resident notices that psychoanalysis may be at the center of a psychiatric institution.

## Concluding Remarks

Instead of presenting a summary of my talk, I would like to present 12 rules for teaching psychoanalysis to psychiatric residents. These rules might sound basic and naïve at first; but I don’t think they are – they help prevent mistakes in introducing psychoanalysis in psychiatric care:

1. Don’t take too much for granted concerning residents’ knowledge and experience – they have much less experience and knowledge than you might think!
2. Don’t be too theoretical!
3. Don’t expect that residents will greet quotations from Freud texts (or other psychoanalytic authors) with awe just because you think they are tremendous!
4. Don’t try to lead residents to a new (and somewhat remote) area of psychiatry they are not acquainted with; rather help them to explore their own field of work and start from there!
5. Be useful for residents! Show them how useful psychoanalysis can be for solving their daily clinical problems.
6. Provide a “transitional supervisory space” from the start and encourage the trainees to present their cases with all affects and conflicts.
7. Don’t devaluate the common psychiatric forms of treatment – and don’t introduce psychoanalysis as a (superior) alternative! Rather connect your psychoanalytic approach with the usual psychiatric procedures!
8. Be – on the other hand - explicit in stating that you are convinced that psychoanalysis should not confine itself to the psychoanalytic cure proper but is very useful for application in psychiatry.
9. Let the residents have an idea about your therapeutic practice – show them self-made videos, let them be present when you interview patients.
10. Be careful in choosing your didactical approach; be modern, use modern media; let them participate actively!
11. Be credible by allowing psychoanalytic reasoning into all levels of the institution, including organizational matters. Don’t relegate psychodynamics to a small and well fenced-off area but let it be an important factor throughout the entire organization.
12. Try to find psychoanalysts who are ready to serve as senior psychiatrists, consultants, clinical directors –this is the most difficult thing to do, in my experience: there are still not enough psychoanalysts ready to devote themselves to psychiatric care. But you’ll never be able to establish psychoanalysis alone, you need a team!

1. Küchenhoff Joachim, Mahrer Klemperer Regine (2009) Psychotherapy in Psychiatric Daily Care [book in German]. Schattauer Stuttgart [↑](#footnote-ref-1)
2. OPD Task Force (ed.) Operationalized Psychodynamic Diagnosis OPD-2

   Manual of Diagnosis and Treatment Planning. Hogrefe Publishing [↑](#footnote-ref-2)
3. Sammet I, Himmighoffen H, Brücker J, Dreher C, Olshausen Küchenhoff C, Wilmers F, Wolf A, Zell P, Küchenhoff J. (2012) OPD in the hospital: an algorithm for structuring the diagnostic process with the Operationalized Psychodynamic Diagnostics OPD-2. [Article in German]. Z Psychosom Med Psychother. 2012;58(3):282-98. [↑](#footnote-ref-3)