MEANING-MAKING IN A MEDICAL WORLD: THE ART OF TALK THERAPY, THE SCIENCE OF THE
BIOLOGICAL MODEL AND THE BOUNDARIES IN BETWEEN

By

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ABSTRACT OF THE DISSERTATION


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In this study, I interview psychiatrists and psychologists (N=40) in order to assess their feelings about the role of medication, talk-therapy, and diagnosis in practice; in general, I explore what practitioners feel is the best modality for treating patients. Though there is extensive research on psychiatric paradigms, on prescribing patterns and trends in the use of talk therapy, there is to date no comprehensive project that involves interviews with mental health practitioners - doctors who have become central figures in American culture. I address the assumption in the literature that the classic Freudian, psychodynamic, or psychoanalytic model is at odds with the biological, diagnostic or medical model that dominates psychiatry today. In the 1980s, psychiatry underwent a dramatic shift its approach to treatment; the once dominant psychodynamic model gave way to the biological model, which is characterized by treatment with medications, short visits with doctors, and which targets assumed underlying imbalances of chemicals in the brain. Until the 80s, patients generally engaged in long-term, in-depth talk-therapy with practitioners who believed their problems stemmed from trauma, psychological development and repression. Therefore, psychodynamic therapists believed that uncovering the meaning of patients’ symptoms using the “talking cure”
could relieve suffering. Today, there is little psychodynamic practice in the United States. Psychodynamically oriented practitioners are often accused of employing unscientific treatment methods. Most theorists suggest that the psychoanalytic and the biological model are irreconcilable in their assumptions about etiology and treatment approaches. Yet there are a handful of practitioners who choose to train in psychoanalysis to strengthen their talk therapy skills after medical training in psychiatry or graduate programs in psychology. Thus, practitioners negotiate the boundaries between the dynamic and biological paradigms. Given the major changes in the mental health field and the potential struggles for practitioners who work within multiple treatment modalities, I explore how the tensions between the psychodynamic and biological models affect psychiatrists and psychologists. In short, I explore whether and to what extent these potential clashes between these paradigms manifest in practice (and how practitioners avoid them in other cases).

By Dena T. Smith

Dedication

For Kyle, whom I know will be successful in whatever path he takes, and whom I hope will, most importantly, choose a destination that makes him happy and whole. For David, whose course was radically different than mine, but who is the only person to have been with me for (almost) the entire journey. And for my mom, whom I told nearly 20 years ago, at a party celebrating the completion of her own, that I would never write a dissertation – I guess I was wrong...just this one time.

Acknowledgements

In New York City, therapists are ubiquitous. Unlike street vendors, however, they do not stand beside shiny carts or tables covered with t-shirts or incense, but rather work in more covert spaces - in offices on the ground floors of brownstones, or in high rise apartment buildings. Though nearly hidden, shingles that read PhD, MD, PsyD, LCSW or MSW adorn the landscape of New York City’s (generally most affluent) neighborhoods. As you walk the halls of most apartment buildings in these areas it becomes clear that those titles often appear on buzzers, doors and mailboxes, and at the somewhat hidden side entrances of apartment buildings. Having grown up in New York, I paid little
attention to these indicators of a therapeutic culture, but am now fascinated by the extent to which the city is riddled with these markers of mental health practice. Between the hours of 7am and 10pm, behind closed doors, there is a nearly constant stream of patients discussing their lives with professionals trained and paid to listen to their stories, and to offer assistance to their often painful symptoms.

I have long been interested in the field of mental health and as an undergraduate struggled with the choice to continue my studies in sociology or psychology. My sociological imagination and affinity for the former won out over my early fascination with the latter, but I have worked to combine my sociological worldview with my interest in the mind and the field of mental health. As a sociologist who is also the child of a psychoanalyst, I have come to know the mental health profession as a Simmelian stranger; I am neither completely foreign nor truly a member of the group. Having a mother who is a psychologist led to many discussions pertaining to the practice of psychotherapy, a lifetime of observing the life of a practitioner, and to personal experiences in treatment that I am thankful for and have learned a great deal from. And yet I will always be an outsider in the sense that I do not treat patients, nor have I been trained to do so. Thus, I feel somewhat removed and objective, yet simultaneously immersed in the culture and knowledgeable beyond most researchers in my own field.

On a summer afternoon several years ago my mother and I collectively mulled over an advertisement we had seen earlier that day for a psychotropic medication, and reflected upon its meaning in the context of myriad similar ads we had seen the evening
before. After some time, our conversation turned toward Americans’ concepts of suffering: the genesis of ideas about what it means to suffer, how much suffering is acceptable and what the appropriate solutions to psychiatric (and other) problems are. We discussed the role of medication in alleviating suffering, whether or not medication and talk therapy even address the same kinds of problems, and whether psychodynamic psychotherapy is a dying art. The conversation resonated with me as I had recently begun a short project on the effects of direct-to-consumer advertising for psychotropic medications. Now, however, I was thinking more broadly. Where do these concepts about what it means to suffer come from? This, I thought, must underlie decisions as to whether we take seriously or reject these kinds of advertisements and if we ever make it into doctors’ offices hoping for a prescription. For guiding my intellectual inquiry toward this topic, and for my broader interest in the mental health field, I owe a great debt of gratitude to my mother.

Not long after that conversation about suffering, I browsed for work on psychiatrists’ perspectives on pain and suffering. I was disappointed to find very little. I searched more broadly for psychiatrists’ narratives of their own practice. A vast literature describing psychiatric ideologies, training and treatments appeared, but I was disheartened to find a complete lack of first-hand accounts of psychiatric practice. There was extensive and fantastic theory about the history and current state of psychiatry, but nothing about what practitioners think. There were a handful of interviews with psychiatrists, but the topics were very narrow, none systematic, and only one or two with practitioners beyond their training years. I contemplated the difficulties associated
with interviewing psychiatrists, but wondered how it could be that there is so little knowledge about how psychiatric principles are applied beyond medical school. And so, with an excitement I had not felt in quite some time, I decided this would be my next project. I would talk to psychiatrists (later I would also include psychologists) and ask them about their practice. Though my excitement about this topic is different today, directed at new goals, and propped up with a more expansive knowledge base, it is no less fervent than it was years ago.

For the next few years, mostly because psychiatrists are often a difficult group with whom to schedule appointments, I crisscrossed the New York City area, from the Upper East Side to the West, from Union Square to Westchester County, from Midtown East to Midtown West, from one waiting room to the next, from one end table strewn with New Yorker magazines to another. I became accustomed to listening to the hum of a white noise machine, patiently anticipating the creak of a door and the introduction to a new doctor. The handshakes became routine, but the awkward, sometimes uncomfortable experience of being a researcher in a patient’s world never felt as ordinary. Generally, these doctors open the door to people who sit in their leather recliners and describe the intimate details of their lives. Their waiting rooms are reserved for people who await a comforting, helpful ear. I, on the other hand, am not there to share my own stories, but to turn on its head the dynamic that is generally at play in these offices. I sit where patients sit and look to these doctors for assistance, but not the kind they are used to offering. Instead, I’m there to ask questions about their work, and to hear their opinions about their practice.
This role reversal prompts intrigue, sometimes a bit of excitement, occasionally skepticism, and on rare occasion, even a bit of antagonism. My motives and the purpose of my project always prompt indirect, if not more overt, cross-examination. Sociologists are often seen as critics of the medical model and this was a clear component of my interactions with some of my medically trained interviewees. Who I am as a person is also a general topic of interest – why sociology (as opposed to medicine or psychology), and how did I get interested in this topic? As a young woman who lives in New York, who is in academia and has an interest in therapeutic practice, I also represent to these doctors someone who usually comes to their office for quite different reasons. And yet for the most part I was welcomed, offered tea, coffee and water. On more than one occasion I was even offered to share a home-packed lunch, as it became clear that my interview was taking up their only free hour of the day, which they graciously offered to me. And at the end of these interviews doctors almost always wanted to know how the project was going and if they could help me find new contacts – many said they will continue to think about the themes of the interview and will be excited to see what comes of their contribution to the study.

These doctors allowed me into their offices, their clinics, and even invited me into their homes on several occasions. They shared with me their ideas about a profession that is for most of them part work and part soul, part profession and part worldview. And while I have examined their words critically and had personal reactions (both of fervent disagreement and genuine sympathy) to their assertions, it was clear that the desire to help patients and to use their training to alleviate pain and suffering
was never absent. I am now more than ever before certain that it is important to study psychiatry from the ground up in order to avoid the mistake of overlooking the people who do this work – people who care deeply about their patients, and find meaning in the work they do to help people understand themselves and ease suffering. Psychiatry is a profession and should be studied as such, but researchers should not ignore the fact that it is a profession that helps people and by treating their most personal problems. For sharing their ideas and their often overbooked and valuable time, I am grateful to each one of my interviewees. This was an enlightening, at times frustrating, yet ultimately truly extraordinary experience to be allowed this kind of insight into the world of private practice.

I would also like to thank my wonderful dissertation committee at Rutgers, chaired by Deborah Carr and including Allan Horwitz, Patrick Carr, Phaedra Daipha and, from The Graduate Center, Lynn Chancer. The idea for this project evolved over many years. The first meaningful words on the page appeared in Allan’s seminar on the Sociology of Mental illness, which shaped my thinking about the history of the psychiatric profession and helped me think critically about psychiatric paradigms. Without his course this project would never have taken shape. Over the years Allan has provided invaluable feedback on countless papers and versions of this project, and for that I am grateful.

I developed the interview guide for this study in a qualitative methodology seminar with Pat, who guided me from day one with structuring my questionnaire, spent hours with me coding transcripts and, perhaps most importantly, provided morale
boosters when I was in the thick of interviewing and transcribing. Debby, my chair and graduate advisor, offered tireless support throughout my graduate career, with everything from teaching to job talks. Her social psychology course that I took in my third year shaped my thinking on every project I worked on thereafter. Debby has read so many drafts of this project (and others) that it’s hard to tally, and with each revision her comments helped me to reframe, reorganize, and refuel for another round. As I move on in my career, I know I will take with me many pieces of advice Debby has offered me over the years. In particular, I am certain that one part of a conversation I had with her over the phone this past month will stick with me forever -- she reminded me that though capturing nuance may seem to make things messy, it is what makes a project interesting and worthwhile.

I’m also thankful to Lynn, who (along with several members of the psychoanalytic reading group in New York) read my work on the role of suffering in psychiatry many years ago and has offered advice and an interesting intellectual discussion ever since. I am indebted, as well, to Phaedra, who has been an amazing support and helped enormously with my interpretation of the data. She reminded me always that “writing is thinking,” a mantra she can be sure I will pass on to my own students. I would also like to thank Evitar Zerubavel, whose seminar on cognitive sociology shaped a great deal of my thinking for this project and every other I have worked on since my undergraduate years. I would also like to acknowledge Sarah Rosenfield for helping me re-discover an interest in studies of mental health that I had not felt since my undergrad years, as well as for her comments on early ideas for this
dissertation. I am also indebted to one of my oldest friends, Lila Barre, for her meticulous editing of this manuscript.

Finally, I am grateful to my undergraduate professors at Goucher College, who introduced me to sociology. I have continued to turn to them for advice in the last eight years, and am thankful to know I will be able to in the years to come. In particular, I am indebted to Jamie Mullaney, whose academic trajectory I seem to be fated to follow. Jamie helped me design my first qualitative research project, introduced me to cognitive sociology, led me to Rutgers, and brought me back to Goucher. For all of that, I am truly thankful. Janet Shope first sparked my interest in issues surrounding mental health in her seminar over a decade ago; I still recall the deep sense of injustice I felt when first discovering the way in which people with mental illness have been disenfranchised and stigmatized. For being exposed to the importance of the field of mental health within sociology, for inviting me to South Africa, and for leaving big shoes for me to fill in the next three years, I am forever grateful to Janet. And lastly, to Joan Burton, who first taught me what it means to have a sociological imagination, who candidly shared with me her perspectives on the field and the world more broadly, and whose dedication to mentoring has been hugely influential in all the work I have done in the last decade. I have recently come to realize just how influential these three wise women have been on my career and my thinking more broadly and feel lucky to have the opportunity to continue to learn from them in the years to come.
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INTRODUCTION

Culture of Psychiatry and Psychiatric Culture

“Theories of medicine are exemplified by the actions of doctors.”¹

Over the course of the 1980s, persons seeking help for the troubling, sometimes debilitating symptoms of mental illness became less likely to encounter the psychologically oriented talk-therapy that dominated American Psychiatry for most of the 20th Century. Instead, it became increasingly common for patients to be offered a diagnostically driven, biologically based treatment, which often resulted in the prescription of psychotropic medications. Though talk therapy still flourishes in certain places, among certain subpopulations, and for certain kinds of problems, its decline has continued into the 21st century with many scholars suggesting the imminent demise of in-depth talk therapies, at least within the field of psychiatry.

From 1996 to 2005 The National Ambulatory Medical Care survey, which assesses characteristics of medical practice, found that the number of “office-based” psychiatrists providing some kind of psychotherapy to patients had decreased dramatically during the survey period (Kaplan 2008:1). The study, published in the National Archives of General psychiatry, reports that “the number of psychiatrists who provided psychotherapy to all their patients declined from 19.1% in 1996-1997 to 10.8% in 2004-2005” and that “from 1996-2005 psychotherapy was provided in 5597 of 14,108

¹ Eric J. Cassell, New York Presbyteryian Hospital Physician and Professor of Public Health, Weill Cornell Medical Center (2004:vii).
office visits to psychiatrists lasting longer than 30 minutes, but the percentage of visits involving psychotherapy declined from 44.4% in 1996-1997 to 28.9% in 2005-2006” (idem). This decrease was less dramatic in certain populations: patients who pay out of pocket are more likely to receive psychotherapy than those using private insurance; patients with diagnosed personality disorders and low level depression are more likely to receive talk therapy than those with illnesses that are considered to be biologically based (like schizophrenia); patients seeking treatment in the northeast of the United States are more likely than those in other geographic locations to receive talk therapy; and African Americans, Hispanics, people under 25 years old, and those with public insurance (such as Medicaid) are less likely to receive psychotherapy. Further, managed care tends not to cover talk therapy, but will usually cover some 15-minute visits for medication management (Mojtabai and Olfson 2008). These are all structural barriers preventing the use of a “talking cure” in lieu of biologically based treatments.

In the chapters to come I show that the decrease in talk therapy and the increase in the use of medication-based treatments is because of a number of factors: patients seek talk therapy less than ever before; it is less likely that mental health practitioners will offer it to them (especially to those in the groups listed above), and it is more difficult to gain access to due to the constraints of managed care. The common mechanism that underlies these phenomena is that psychiatry underwent a dramatic about-face in the 1980s to become a field anchored by biological theories and medicinal treatment. This irrevocably altered the way psychiatrists define illness and see their patients’ troubles. This project focuses on the role of talk therapy and medical practice
in psychiatry today. Particularly, I explore whether the deep exploration of the psyche that once characterized American psychiatry has been washed away by the rise to prominence of biological treatments and to what extent these disparate models influence the practitioners who employ them.

Medications are central to treatment in the biomedical model. We can see how prominent this paradigm is by looking at the increasing rate of diagnosis. The use of anti-depressants tripled between 1988 and 2000, and in the United States about 10% of women and 4% of men use psychotropic medicines in a given month (Pear 2004). It is a psychiatric orientation towards the diagnosis of illness using discrete symptoms and the dominance of biological thinking in psychiatry that propel these trends (see especially Horwitz and Wakefield 2007:6-8). At the heart of psychiatric treatment today (and a prerequisite to prescribing) is the diagnosis of illness using standardized protocol listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), a massive volume published by the American Psychiatric Association and used as the guidebook for psychiatrists in assessing their patients’ symptoms.

In short, psychiatry today is characterized primarily by the belief that mental illness is born from heritable, biological traits, consists of neurochemical imbalances, and should be treated with psychotropic medicines. For the most part, this perspective and the corresponding biological treatment are relatively unchallenged. And yet several recent studies that examine the effectiveness of psychotherapy using evidence-based practices show that talk therapy is effective (sometimes equally to medicines) for reducing symptoms and increasing quality of life (even if the mechanism and the extent
to which this is the case is somewhat unclear) (Busch 2009; Graf 2010; Leichsenring and Rabung 2008; Seligman 1995). In spite of this, talk therapy continues to decline and prescription rates continue to rise.

Myriad factors influenced the waning of psychotherapy and the increased reliance on medicinal treatments. The same forces keep the scales tipped toward the biological model; I explore many of these key influences in the chapters to come. The outcome is that, in a “typical week for 756 office-based practices, 59% of psychiatrists provided psychotherapy for some, but not all participants, 12.2% provided psychotherapy during all visits, and 28.4% did not provide psychotherapy during any visits” (Kaplan 2008:6). Where psychotherapy is not provided, biological treatments that involve the prescription of medications take its place. Further, when psychotherapy is provided, it is unlikely to be classic psychodynamic therapy involving deep exploration of the psyche – the kind of therapy characteristic of mid 20th Century American psychiatry. Today, even when non-biological treatment is provided, it is likely to be evidence-based; cognitive-behavioral therapy\(^2\) in particular and a range of problem-focused treatments are much more common than in-depth talking treatments like psychoanalysis (McWilliams 2000). This is mostly because psychiatry, and the mental health field at large (under the influence of the field of medicine and science more broadly) have been pushed to cease practice of any treatment that cannot be clearly tracked using objective

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\(^2\) Cognitive Behavioral Therapy is a short-term, usually twelve or thirteen-week program wherein therapists work with patients on restructuring the way they think in order to change their behavior. The idea behind CBT is cognitions cause symptoms and altering them changes the patients’ reaction to stimuli. CBT is symptom-focused and therefore traceable and considered to be evidence-based. It is highly active and involves exercises and homework assignments on the part of patients.
measures of efficacy. Further, because insurance companies are much less likely to reimburse patients for in-depth, long-term talk therapy when the option for more efficient medicinal treatments is available.

Regardless of treatment modality, psychiatrists are central figures in the American cultural landscape; the number of people seeking some form of psychiatric treatment has more than doubled since the early 1980s (Kessler et al 2003). Furedi (2004) describes a “normalisation of therapy,” citing the American Psychological Association report that, “by 1995, 46% of the American population had seen a mental health professional” (p.103). For depression, for instance, between 2001 and 2002 alone about 4% of the American population or about ten million people sought treatment just for depression (Kessler et al 2003); since the late 1980’s, the diagnosis of this condition has increased by 300% (Olfson et al 2000). Because of this, Americans have been described as living in an “Age of Melancholy,” (Blazer 2005) in which depression is a central psychiatric diagnosis and certainly a cultural focus. Horwitz and Wakefield (2007: 5) argue that there is a “ubiquity of depression”; contemporary psychiatric standards diagnose low-level sadness that would once have been considered a natural part of every-day life as depression. In general, the trend toward increasing diagnosis is clear across most mental disorders (save schizophrenia), though it is most marked for depression. Of course this also influences lay understandings of sadness and suffering more broadly.

What has been described as an “epidemic” of mental illness coupled with the view that these illnesses are biological in nature and should be treated as such, landed
psychiatry a central role in contemporary American culture. Thus the inflation in rates of disorder led to increases in biological treatments, all of which have the net effect of bolstering the legitimacy of the field of psychiatry and de-legitimating what are now seen to be less scientific modalities for treating psychological problems: in-depth talking treatments. The spread of managed care is a leading factor in keeping patients out of in-depth talk-therapy-based treatments. There is a low likelihood of reimbursement for any type of treatment that is not considered to be evidence-based. Biological treatment is thought therefore to be the “gold standard” for reimbursable care for mental illnesses today.

The statistics on mental illness also provide important insights into why studies of psychiatry as practice and what it entails are so important. Epidemiological studies, particularly those that show a dramatic increase in both depressive symptoms and Major Depressive Disorder (MDD) over the last several decades, lead to the inference that there is greater symptomatology - greater sadness, greater distress - than ever before. Yet this increase in illness is largely due to changes in the psychiatric definitions of these illnesses (see especially Horwitz 2002; Horwitz and Wakefield 2007). After all, a basic sociological argument explains that any phenomenon that so rapidly and radically increases (in this case the exponential rise in mental illness diagnoses) indicates a central role of social factors, rather than a change in the character of individuals (in this case biological functioning and neurochemistry). Increases in rates of depression are

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3 This is less of a concern in this project since my focus is on private practice where practitioners generally do not see patients with insurance that provides minimal coverage (if any at all).
likely caused by a combination of changes in diagnostic practices (Horwitz and Wakefield 2007) and other social factors as evidenced, for example, by studies that show much higher rates of depressive symptoms in low socioeconomic status groups (cf. Kessler et al. 2003; Link 2008; Link and Phelan 1995). It is also true that more recent epidemiological studies cast a wider net in assessing the unmet need for treatment that older studies missed when measuring treated populations alone, or when focusing solely on wealthier, less ethnically diverse populations that are exposed to fewer adverse social stressors. Regardless of whether there has been a “real” increase in disorder or if it is a result of the changing measurement of disorder and greater incentive among practitioners to give a formal diagnosis, millions of Americans are diagnosed with mental illnesses each year, making professionals who treat these conditions an ever more important population to investigate.

Why Study Psychiatrists? What this Dissertation Does

Mental health professionals are understudied despite their powerful influence on American society; hundreds of thousands of Americans come into contact with them each year. It is therefore imperative that we understand more about the world of mental health practice particularly from the perspective of practitioners since that is what patients encounter in treatment. In particular, because depression is the most common mental illness diagnosis today, and it is largely treated in outpatient, often private-practice settings, the practitioners who work in those settings are an important population of interest for sociologists of psychiatry and mental health more broadly. The
goal of this project is to explore thoughts about and the approach to treatment of a
group of psychiatrists and psychologists. Psychiatry in particular is an important field of
study as it is responsible for the prescribing of psychotropic medications and has
undergone drastic changes to its general methodology for treating patients in the last
three decades. For most of the 20\textsuperscript{th} Century psychiatric treatment was predominantly
dedicated to Freud’s talking cure, which involved very little medical intervention. In fact,
until the 1980s psychotropic medications were used very rarely and almost always for
severe symptoms such as the delusions and hallucinations that come along with
disorders like schizophrenia, bipolar disorder, and very severe forms of major
depression. Medicines have only been around since 1949, when Lithium emerged as a
treatment for bipolar disorder, or what was then referred to as Manic Depression, and
they were not widely used for less severe conditions until much later\textsuperscript{4} (Porter 1997:520).

Today, however, most psychiatric illnesses are treated in evidence-based
practice and often with medication, which is a radical alteration from the psychiatry of
the mid 1900s where theories of the mind and long-term talk-therapy reigned supreme.
Gerald Maxmen, author of the popular book \textit{The New Psychiatrists} neatly explains the
transition: “…the old psychiatry derives from theory, the new psychiatry from fact” (Kirk
and Kutchins 1992:31). That psychiatry today relies so heavily on medical treatment yet
treats much greater numbers of patients with less severe illness than ever before is an
important and even somewhat ironic practice given that medicines were traditionally
reserved for the most severe conditions like schizophrenia and bipolar disorder.

\textsuperscript{4} An exception is tranquilizers for anxiety that were prescribed regularly in the 1950s
and 1960s.
While we know a great deal about the history of the Freudian model and the biological takeover of psychiatry, most of the information we have is gathered from knowledge of structural changes in theory and practice, from prescribing patterns, and from anecdotal accounts of treatment experiences from the perspective of both patients and practitioners. In order to fully understand psychiatric treatment and theory, I contend that we must start from the ground up, with the doctors who know these paradigms most intimately and employ their principles in daily practice. Therefore in this project I interview forty psychiatrists and psychologists in order to ascertain basic information about their practices and the role of medical treatment and talk therapy in their work. Some of my interviewees were medically trained, while others were schooled in Freudian theory. Some are biologically oriented practitioners and others adhere closely to an in-depth talk therapy model. Still, some of my interviewees can be more aptly be characterized as hybrid practitioners who straddle the line between the psychodynamic and biological perspectives.

The Trends in Psychiatric Practice

The literature on psychiatry suggests that training in predominantly biologically oriented hospitals has minimized what was once presumed to be an indelible Freudian mark on the psychiatric landscape (Hale 1995; Horwitz 2002; Shorter 1998). Scholars have further suggested that this biological model is an opposing force to the *Freudian*, *psychoanalytic*, or *psychodynamic* practice that was dominant in the field just thirty years ago (idem). The medical model undoubtedly holds the most prominent place in
psychiatry today, but some suggest that deep roots in the dynamic tradition still influence psychiatric practice. What is most clear in the literature is that alliances to either psychotherapeutic practice or biological practice influence psychiatrists’ treatment preferences. In 2008 Mojtabai and Olfson found:

...that psychiatrists who strongly favor psychotherapy tend to prescribe medications for only slightly more than half of their patients, and a growing number of psychiatrists who prescribe medications for the large majority of patients appear to shun delivery of formal psychotherapy altogether. A key challenge facing future psychiatrists will largely involve maintaining their professional role as integrators of the biological and psychosocial perspectives. (Kaplan 2008:7)

This challenge is not for future psychiatrists alone, but for those who practice both talk therapy and prescribe medications today. In noting the forces that have driven psychiatrists to practice less talk therapy (namely the shift to the biological model, the increased availability of medications, managed care, and split care, in which psychiatrists prescribe medicines and psychologists practice psychotherapy), Eric Plakun, chair of the American Psychiatric Association’s committee on psychotherapy by psychiatrists, notes that “It really is a loss to our patients if they aren’t getting psychotherapy...psychiatrists are in a unique position to provide psychotherapy because they really have the medical training that allows them to integrate medication and therapy, mind and body” (Kaplan 2008: 8). Despite this perspective the role of talk therapy in psychiatry has dwindled and many psychiatrists today have strictly medical practices and do not practice any talk therapy at all.

In her ethnography of psychiatric training programs, anthropologist T.M. Luhrmann (2001) informs us that “what residents actually learn is to do what they have
to do: admit, diagnose, and medicate patients, and – less pressing these days, see them in psychotherapy” (p.30). Psychiatry residents themselves perceive that, for many reasons I will soon explore, “it’s easier to be a competent psychopharmacologist than it is to be a competent psychotherapist” (p.81). Since the widespread use of psychotropic medications, it has been the case that the perceived efficacy and efficiency of psychopharmacological treatments influences psychiatry residents who think that talk therapy is much more difficult to learn and to do well. This is a reality that psychoanalysis is up against – one that has significant consequences for the type of treatment practitioners are likely to offer and patients are, therefore, likely to receive. In the following chapter I describe a range of structural influences that make it much more difficult (and much less likely) that patients will receive anything other than biological treatment for mental illness.

In this dissertation I use a qualitative approach to examine the trend of medicalization (Conrad and Schneider 1992) and the role of the medical model in psychiatric and psychological practice. Insight into how psychiatrists and psychologists think about treatment, medicines, prescribing patterns, and the etiology of psychiatric conditions can inform an understanding of these important macro-level shifts. For instance, we know that the pharmaceutical industry, managed care and new biological trends in psychiatry contribute to high rates of prescription for a range of psychotropic medications, but we know relatively little about the rationale for the use of medication (or for talk therapy for that matter) that psychiatrists employ on a daily basis when thinking about particular patients with particular troubles. We lack information about
the opinions of the people who treat these conditions and how they think about illness and their patients.

In Freidson’s (1970) seminal work on professional dominance in medical care, he proposes that “the question for the sociology of medicine is how men are molded into physicians so as to be able to perform the healing role and what influences their performance once they play the role...” (p.15) and that “it is in the realities of practice rather than in the classroom that we find the empirical materials for clarifying and articulating the actual rather than the imputed or hoped-for nature of the professional role” (p.19). While there exists a small body of work on the training of psychiatrists, as in T.M. Luhrmann’s (2001) ethnographic study of residents, there is very little information about what happens to psychiatrists once they are in private practice, in offices away from the gaze of supervisors, once their role as psychiatrists has crystallized and they have truly settled in as seasoned professionals.

I follow historian Elizabeth Lunbeck (1994) who urges scholars to “…locate the sources of psychiatry’s cultural authority not in institutions but in the discipline’s conceptual apparatuses” and specifically that “…the discipline’s authority [should] instead be located in the spread of the psychiatric perspective that has little to do with institutional power” (p.4). Though it is not a focus of my project, the power built into the institutional structure of psychiatric training is certainly an important factor worthy of much greater investigation than I can offer here. The dominance of the biological model certainly rests on the power of certain professionals and interest groups to maintain it, just as was the case with the psychoanalytic model in its heyday. Those in positions of
power control medical institutions and there simply are not psychoanalysts in control of many hospitals across the country today. However, the cultural authority of the discipline largely hinges on the diffusion of psychiatric thinking from doctors to the general population. It is partly for this reason that theorists such as Thomas Szasz and Michel Foucault were so concerned with psychiatric diagnosis. For Szasz (1975), the socially constructed nature of these illness categories led to misdiagnosis, over-diagnosis, and the legitimation of a professional that he though could no more accurately classify mental illness than someone seeing it for the first time. For Foucault (1965), the medical system grants practitioners too much power and treats patients as if they are peripheral in their own illness experience.

I contend that an investigation of how practitioners think about illness (and therefore are likely to influence their patients’ thinking) is crucial because a bottom-up approach allows insight into the institutionalized training system (medical schools, hospitals and clinics where psychiatrists learn how to be doctors and work in their field) that maintains the power of the profession. Though not everyone with symptoms is in treatment and many (even people with severe symptoms) will never see a mental health professional, laypeople are still affected by the psychiatric model that seeps into American culture more broadly⁵. In the words of Luhrmann (2001) “...It is particularly

⁵ Many people with symptoms of mental illness will never come into contact with anyone in the mental health field. And yet psychiatric definitions of what constitutes illness are still likely to affect millions of Americans through media representations, the education system (largely responsible for sending children for testing for illnesses such as ADHD), lay diagnosis by friends and family members, and especially self-diagnosis.
important to understand how psychiatrists look at illnesses and thus how we understand them (psychiatric knowledge seeps into popular culture like the dye from a red shirt in hot water)” (p.20).

The effects of the cultural dissemination of the biological model in psychiatry are not yet entirely clear, though we can see the influence of psychiatry in the extent to which the language and basic concepts of the model that was dominant until the 1980s (the Freudian model) remain a part of the American consciousness. Terms like transference, repression, and ideas about subconscious thought, and the importance of dreams have been absorbed into American culture (though often misinterpreted), and are not likely to disappear. However, there is mounting evidence that biological notions of psychiatric troubles have also inserted themselves into cultural conceptions of illness, suffering and therefore notions of normality. It is clear - at least through advertisements for medications and a public discourse about illness that involves imbalances of chemicals like serotonin, dopamine, and norepinephrine, and certainly because of the significant percentages of Americans taking medications to alter these chemicals each year - that biological psychiatry has made its way into the discourse about mental illness.

This dissertation seeks to answer the following central questions: What role do talk-therapy and medication play in psychiatric practice today? Are what I term meaning-making principles that were once so central to psychiatric practice still influential or has their use really become peripheral to this predominantly medical field? I use the term meaning-making to refer to the practitioners’ deep understanding of
patients’ life histories and psyches that is central to the psychodynamic approach. This is important since it is the element claimed by historians and cultural theorists of psychiatry to have been lost in the paradigm shift towards the medical model (see especially Kleinman 1988). I assume, however, that psychiatrists do not adhere uniformly to the medical model. The dichotomous description of the psychodynamic and biological approaches that commonly appears in historical texts is also overstated – though it may be much more stark at the theoretical level it is unclear what actually happens in practice, when at least some practitioners bridge the divide between these models, often because they seek any possible option to help their struggling patients. This is why the term meaning-making will help to locate where practitioners lie on a continuum, between only using medications and short consultations versus in-depth talk therapy.

An examination of practice from the perspective of the practitioners who employ these psychiatric models is a necessary albeit absent area of investigation. Psychiatrists are the gatekeepers of diagnosis and prescription. They learn, employ, and propagate these ideas through practice and through mentoring new generations of doctors, and yet we know so little about their thought process and their action behind the closed doors. Information about the practical application of psychiatric models is sparse, and few studies address psychiatric practice from the proverbial trenches\(^6\). Researchers

\(^6\) Klitzman (1995), Light (1980), Shepherd (1982), Rudnytsky (2000), and Linde (2010) each investigate psychiatric practice, though none of these studies involve systematic interviews – they provide either personal accounts or interviews with a handful of renowned practitioners. Luhrmann’s (2001) work with psychiatric residents is one of the
interested in the practice of psychiatry both within psychiatry and outside the medical field very rarely talk to psychiatrists themselves, and have yet to investigate how the use of the medical model plays out in everyday practice. Sociological studies of private psychiatric practice are absent from the literature. Prior studies address the organization of healthcare, the cognitive processes of practitioners, professional socialization, and what happens in hospital settings, but this is the first sociological study of these trends in the context of psychiatric practice. In starting from the bottom-up, I investigate the result of shifting macro-social demands on psychiatric and psychoanalytic practice at the micro level.

A Note on My Approach: Mental Health Practice from the Ground

It is not my intention to advocate or disparage either of these models, but to examine the influence of treatment paradigms on the thinking and practice of the psychiatrists and psychologists participating in my study. Both the biological and psychodynamic models have contributed to the understanding and treatment of psychological distress (and both have likewise caused different kinds of harm). In particular, the psychodynamic model offered a way to understand psychological development, childhood development, the psyche, the self, and responses to trauma.

only studies that explore psychiatric training through a non-psychiatric lens, but she does not systematically interview practitioners. Whooley (2010) interviews psychiatrists about their practice, but focuses largely on issues surrounding The Diagnostic and Statistical Manual of Mental Disorders, a crucial, but certainly not the only important issue on which psychiatrists should be questioned. Finally, each of these studies excludes other kinds of mental health practitioners, such as psychologists, who, I contend, are an important comparison group.
Because of psychoanalytic thinking, art, literature, theater, and the way we think about human beings more broadly was altered irrevocably.

The biological model has allowed doctors to treat the symptoms of debilitating and painful conditions in ways psychiatrists not that long ago only wished was possible. Antipsychotic, mood stabilizing, antidepressant, and antianxiety drugs have offered new hope to people who once would have had only talk therapy as an option, many of whom had been failed by or were too sick to participate in psychodynamically oriented treatments. The rates of symptom relief from major mental illnesses by way of medication are unparalleled by any other form of treatment. For instance, the World Health Organization reported in 2001 that “70% of [people diagnosed with major depression] who take antidepressant drugs responded, and a relapse following initial treatment can be significantly reduced with a combination of antidepressants and psychotherapy” (Blazer 2005:3). It is for this reason that Blazer, a staunch critic of the disappearance of meaning-making in psychiatry today, acknowledges being “…thankful that we do not live in an age of hopelessness, at least from the perspective of psychiatry” (p.3). In spite of the benefits the movement toward the biological model is critiqued largely, not because of what it does, but because it eclipses other modes of treatment, an issue that runs though the literature on contemporary psychiatry as well as the narratives of the doctors in this project. That critique is important for an understanding of the influence of paradigms on treatment (Smith 2010) but it is not my focus here.
A Note on Terminology: Medicalization

When I use the term *medical* I do not intend to isolate psychoanalytic practice as non-medical. Though skeptical of doctors’ motivations, Freud considered psychoanalysis to be a branch of medicine and was optimistic that there would someday be observable markers for mental illness just as there are for cancer or diabetes. Rather, I intend to highlight the shift in medical training from a paradigm in which doctors sought a deeper understanding of patients (a practice in both physical medicine as well as psychiatry until the late 1970s) to one in which shorter visits and more surface-level scrutiny of symptoms has become the norm. I use medical to mean *medicalized* (Conrad and Schneider 1992). To say that something is medicalized, then, is not a critique of the practice of medicine, but rather a way of understanding the extent to which the medical field, other non-medically trained practitioners, and laypersons alike come to see a given phenomenon.

For instance, the rapid increase in the diagnosis of ADHD or Attention Deficit Hyperactivity Disorder over the course of the 1990s has been described as the “medicalization of misbehavior” (Searight and McLaren 1998), in which what was once seen as bad behavior came to be seen as a medical phenomenon in need of medical treatment (see Conrad and Schneider 1992 for a detailed history). Uncovering the

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7 Even though Freud became an advocate of lay analysis (the practice of psychoanalysis by non-MDs) (exemplified by his training of Theodor Reik, which I explain in more depth in the following chapter), he also staunchly believed that psychiatric symptoms were manifestations of brain functioning. Of course, the two claims are not necessarily mutually exclusive, given that one is about the etiology of illness and the other about treatment. Modern medical practice views etiology and treatment as one and the same, but for Freud this was not always the case.
process by which ADHD came to be medicalized involves a discussion of the
claimsmakers, as well as the structural and cultural factors that ushered in medical
concepts of certain behaviors as disordered rather than simply disruptive.
Medicalization theories are not meant, for instance, to say that medical treatment for
ADHD is bad or unhelpful, but to point out a phenomenon in which it came to be seen
as a medical problem. How did this happen? Who and what propelled this shift? And
who has been critical (if anyone) of the process?

Biological thinking and treatment dominate psychiatry today, and there is little
dissent. To be sure, there is some concern over the loss of psychoanalytic principles that
anchored the field until relatively recently. For instance, prominent psychoanalyst Nancy
McWilliams (2009) describes disheartening encounters with psychiatric residents, who
lament the loss of training in dynamic theory and the ability to spend quality time with
their patients:

Whereas it used to be assumed that we treat whole persons and try to develop a
relationship that makes them safe enough to expose to us the complex
developmental, defensive, and contextual origins of their suffering, it is now
assumed that we should identify their discrete ‘disorder,’ treat it with a
manualized protocol, and consider our work done if the patient’s overt
symptoms are temporarily eliminated. (p.81)

In psychiatry, however, only faint voices support the psychodynamic approach over the
medical, and psychoanalysts, oft accused of treating patients via non-scientific practice
that resembles much more an art than a science, have been pushed to track the efficacy of their treatments.

It is not just psychiatry or medicine at large, but patients too who are part of a larger culture in which medicalization has become the norm. Furedi (2004) explains that “since the 1980s, opposition to medicalisation has been minimal. This period has also seen an unprecedented level of the medicalisation of social experience” (p.101). Rather than resisting medical labels, as in the anti-psychiatry movement of the 1960s, or rejecting labels, as in the fight to remove homosexuality from the language of disorder in the 1970s, the 1980s ushered in the seeking of medical diagnosis by laypeople; even feminists who had previously lobbied against the disordering of the female experience pushed for the diagnosis of premenstrual syndrome (PMS), new mothers syndrome, and battered women’s syndrome (Furedi 2004:101).

Much of the push for medicalization since the 1980’s has been an attempt to de-stigmatize these conditions and remove the blame from those who were labeled, for instance, with depression, bipolar disorder, or PMS (now PMDD). If these are medical problems then the blame for not pulling oneself up by one’s bootstraps and shaking off

8 For instance: Leichsenring and Rabung (2008) report on the effectiveness of psychoanalytic treatment, defending this therapeutic tradition; they show that the few studies that track patient progress in psychodynamic therapies clearly demonstrate symptom reduction. Recent research (c.f. Busch 2009; Graf 2010) shows that some psychoanalytic treatments are both traceable and effective. New, manualized, short-term (24 session, 12-week) psychoanalytically informed treatments for panic disorder show that talk-therapy can provide symptom alleviation for anxiety disorders. This kind of research combats the notion that psychoanalytic treatment is unscientific and that it is incapable of efficient symptom reduction.
a depression or controlling one’s wild spending, drinking, and sexual promiscuity during a bipolar episode does not fall on the character of the patient, but on the illness.

In particular, childhood mental disorders have been a focus of medicalization as their conceptualization as medical conditions removes some of the blame that had previously fallen to bad parenting or neglect. In sum, medicine at large, psychiatry, other mental health professionals and laypersons alike largely consider mental illness to be a medical phenomenon and only a handful of dissenting voices, mostly in the social sciences, challenge this assumption. There are many reasons why this is the case: doctors genuinely seek the best treatment possible for illness and many of the most hopeful potentialities for a cure are in brain functioning and neuroscience; pharmaceutical companies are powerful institutions that convince (often with less than valid studies) (c.f. Healy 2004) the American public and professionals who prescribe these medicines that their drugs are effective; talking treatments have been discredited as subjective, unscientific, and unpredictable; there are many barriers to patients’ abilities to afford and find the time for in-depth talk therapy; practitioners have financial constraints against training and practicing psychodynamic treatment; the biological conceptualization of mental illness has removed some of the stigma from these conditions – if symptoms are inherited, they are not the fault of the person experiencing them – and this is especially appealing to parents whose children have been diagnosed with mental disorders. In sum, this propensity on the part of doctors and laypersons alike to disorder symptoms and to diagnose illness drives medicalization and is a significant factor in many of the practices we shall see throughout this dissertation.
Theoretical Framework

This project seeks primarily to advance a sociology of psychiatry and is, therefore, largely situated in the socio-historical literature on psychiatric treatment, particularly that which discusses the revolution in thinking about mental illness. However, the data presented here also provides an insight into how professionals think about their work and others in their field, as well as how they resolve tensions that arise because of socialization into particular ideological camps within professional communities. In that sense, this is also a study in the power of the medical fields to professionalize its practitioners in particular ways. Further, this study addresses the role of standards and technology in practice and how the differing concepts of appropriate practice influence intra and inter-professional tensions, conflicts, and their resolutions. In this section, I provide a brief background on these literatures before delving into chapter one, where I explore the socio-history of the field of psychiatry and psychoanalysis in particular.

Professional Worldviews

Though I do not focus explicitly on training in this project, it is important to note that my interviewees each have particular perspectives on their field, as well as the mind, the body, and the treatment of problems that arise therein because of what Fleck (1935) defines as “thought communities” which he explains as “a community of persons mutually exchanging ideas or maintaining intellectual interaction.” Thought communities provide “thought styles” which direct the perception of members of the group, and are a “‘carrier’ for the historical development of any field of thought, as well
as for the given stock of knowledge and level of culture” (p.39). Thought styles focus our attention (p.99), much like what Zerubavel (1997:31) calls sociomental lenses, which filter how and what we see of the world. These lenses come from membership in particular optical communities that have particular optical traditions (33) that teach members to observe and classify everything - events, people, actions, emotions, and much more – in particular ways. Thus, Bowker and Star (2000:287) report that “…categories are historically situated artifacts and, like all artifacts, are learned as part of membership in communities of practice.” Though classification is not a central focus of this project, it is important to note that the differences in how illness is seen in the psychodynamic and biological paradigms is intricately connected to the different classification systems in each of the models.

Schemas or “abstract cognitive structures that represent organized knowledge about a given concept or type of stimulus” are similarly indoctrinating (Howard 1995:93). Schemas organize our thinking about people (including ourselves), places, objects, and experiences; they help us “perceive the social scene” (Schuman 1995:82). In training programs, supervisors and textbooks provide practitioners with a model for understanding illness and treating patients that becomes difficult to see beyond and can even be restricting. Doctors tend to rigidly adhere to treatment schemas long after they leave residency and internship programs, which, we shall see, helps to explain why psychoanalytic training is so difficult for doctors who are previously trained in the biomedical approach to treatment.
Goodwin’s (1994) notion of a “professional vision” likewise explores the idea that “...the ability to see relevant entities is not lodged in the individual mind, but instead within a community of competent practitioners” which he describes not only as a cognitive endeavor, but one that is negotiated in professional action (p.626). The biological and dynamic models, which can be seen as communities with treatment traditions, each come with their own lenses or styles of perception and associated action. Similarly, Friedland & Alford (1991) describe "institutional logics," which they explain as sets "of material practices and symbolic constructions" that constitute an institutional order's "organizing principles" and are "available to organizations and individuals to elaborate” (p.248-249). Further, professional paradigms come with what Boltanski and Thevenot call *modes of justification* (1991) or discourses that are linked to particular institutions and dictate certain orientations toward action and assessment. In this case, biological and dynamic practitioners maintain different discourses and therefore distinctive practices because of their socialization into different modes of justification from training in different kinds of institutional settings.

I also follow Bruner (1990) who describes the "schematizing power of institutions" (p.58), which helps explain why cognitions that come from powerful institutions can seem so automatic and ingrained. They arise with little thought, which I show in the later chapters of this project when I investigate the ways in which practitioners are able to manage tensions between competing treatment paradigms using remarkably similar reasoning. In other words, the biological and psychodynamic perspectives in psychiatry and psychology do not arise spontaneously in practitioners,
but are the result of being trained in the former to see illness as arising from biological malfunctioning and in the latter from psychic conflict and repression. This is confirmed by T.M Luhrmann (2001) who explains that “in both of these approaches, the biomedical and the psychodynamic, what one learns to do affects the way one sees” (p.83). Whether a psychiatrist sees a patient’s problems as stemming from neurotransmitters or neuroses is largely dependent on how they are taught to see said patient. As we will see in the following chapter, it has historically been unlikely for biological and psychodynamically oriented practitioners to work collaboratively, and even more unlikely that a doctor would be trained in both paradigms.

Today, however, because there is such little training in dynamic therapy (or any talk-therapy) in psychiatry residencies, if a psychiatrist wants in-depth talk therapy to be a central part of her practice, she needs additional, postdoctoral training. This means that a majority of the practitioners who wind up in psychoanalytic training programs, which requires an additional five years of schooling and necessitates that practitioners participate in an analysis themselves, have in fact been medically trained. In short, if a psychiatrist becomes an analyst, she must then contend with being trained in two different treatment paradigms, one that advocates long-term, intensive therapy, and another that upholds the notion that medication is the most appropriate response to psychiatric symptoms. Thus, in the narratives of psychoanalysts, especially those who are first trained as psychiatrists, we should be able to see whether these different lenses are mutually exclusive and whether they create tensions for practitioners who have one foot in each camp.
We should expect, however, that the doctor identity will be the most salient even though there are other parts of psychiatrists’ professional identity, because the medical model reigns supreme when it comes to treating mental illness, and particularly because it is the primary socialization for these doctors trained in both the psychodynamic and biological perspectives. It should, in a sense, monopolize the practitioner’s professional (and even personal) identity. As a master professional status, I assume everything else will be subsumed under this one, salient role; if it is truly a master status and such a powerful lens and identity category that it dominates all others, medical-doctoriness or the role as psychiatrist should make it difficult to see beyond this model.

Also crucial in the socialization of professionals are colleagues who are a source of on-the-job socialization and re-socialization. The way in which psychiatrists and psychologists come to see and therefore treat patients is fueled by the influence of colleagues and, in particular, pressures to conform to the medical model. In their study of the ideologies disseminated in psychiatric training, Strauss et al (1981) suggest that “...while a number of institutional conditions may affect professional fate...interaction with other ideology-bearing professionals is critical...For the advancement of most professionals, other professionals are the critical publics” (p.369). When it comes to which lens psychiatrists are more likely to see through, it is professionals – both supervisors and peers - who influence doctors in training and even more seasoned professionals. Further, they explain that “experiences at specific institutions can...cause genuine turning points in careers...the careers that carry people into an institution may
carry them out again in quite different channels” (p.371). For the practitioners in my sample who have training in more than one treatment paradigm this is certainly the case. Once it is complete, those who go through a secondary professional socialization in psychoanalytic training look quite different.

**Professional Competition**

The influence of the discipline is beautifully summarized by the historian Charles Rosenberg in his description of the intimate relationship between biochemistry and medicine:

> It is the discipline that ultimately shapes the scholar’s vocational identity, the confraternity, of his acknowledged peers defines the scholar’s aspirations, sets appropriate problems, and provides the intellectual tools with which to address them; finally it is the discipline that rewards intellectual achievement. At the same time his disciplinary identity helps structure the scholar or scientist’s relationship to a particular institutional context. His professional life becomes then a compromise defined by the sometimes consistent and sometimes conflicting demands of his discipline and the conditions of his employment. (Kohler 1982: 2)

Rosenberg explains that multiple factors influence the discipline’s effect on identity. In developing a vocational identity, and particularly one that is different from other practitioners’, it is professional socialization that establishes feelings of competition between, for instance, biological and psychoanalytically oriented psychiatrists and between psychiatrists and psychodynamic psychologists.

The institutional competition is manifest in the tensions individual doctors experience. I therefore approach the psychodynamic and biological models with
Abbott’s (1988) ecological theory of professions always in mind. I assume that “a fundamental fact of professional life [is] interprofessional competition. Control of knowledge and its application means dominating outsiders who attack that control….jurisdictional boundaries are perpetually in dispute, both in local practice and in national claims” (p.2). Whether or not these paradigms are used together in practice, there are still power struggles over which should be more dominant, with the biological currently winning out nationally. Psychoanalysts, who were once the most powerful mental health practitioners, must accept that this is neither the case today nor is it likely to be any time in the near future. Though I do not look at systems of professions, I examine how these forces of domination (in this case the biological model of psychiatry) are maintained in practice. Further, I show that intra-professional competition is also an important factor as psychoanalysts argue amongst themselves about how to incorporate medical principles into treatment. In this study these forces are represented by the tensions the practitioners experience between psychiatric paradigms. Overt power struggles and competition are not the focus of this analysis.

Practitioners who have allegiances to particular theoretical and practical approaches to their work maintain and propagate psychiatric paradigms. I borrow from Strauss et al. (1981) the notion that the biological and psychodynamic paradigms are deeply rooted in ideologies, the clash between and the complementary aspects of which can help us understand how professionals deal with tension and avoid them in their daily work. Just as the psychiatrists in my sample must find ways to assuage these potential or actual tensions so too must, for instance, soldiers fighting for wars they do
not support, academics who favor teaching, but work at Universities that favor research, and clerks for managed care insurance companies who favor universal healthcare. In each of these cases it is useful to know why professionals might need to manage these tensions and how they may be able to rationalize them enough to be functional employees.

Creating Certainty in an Uncertain Profession

Medicine is an uncertain profession. Cassell (2004) describes “...the hallmark of clinicians” as “their ability to tolerate uncertainty” (p.214). Patients present with troubling, sometimes painful symptoms, and doctors are responsible for accurately identifying their source and for finding a treatment and hopefully a solution to it. Renee Fox (1980) pointed to medicine’s inherent uncertainty, which is precisely what makes evidence-based medicine so important for doctors and even more so for psychiatrists, who do not have the same objective measures as those in, say, cardiology or oncology. There are very few markers of disease in psychiatry and even when illness is successfully identified, psychiatrists and other mental health specialists only have treatments; there is very little evidence that a cure for any mental disorder will be found in the future.

T.M. Luhrmann (2001) explains that there is no discernable entity to be treated in psychiatry: “...unlike the case with, for instance, cholera...” she says “there is no medical test for a specific disease pathology for any major psychiatric illness. You cannot know whether there really is an underlying ‘disease’ in psychiatric illness” (p.20). She continues: “in medicine...diagnosis gives a doctor control because it tells him how he
might be able to help a patient” (p.45). Diagnosis is, therefore, even more important for psychiatrists in the absence of any other “scientific” marker of illness and it is only possible because of standards, a concept central to the sociology of science. Timmermans and Berg (2003) describe standards as “...a measure established by authority, customs, or general consent to be used as a point of reference” (p.24). In particular, psychiatrists rely on what they describe as terminological standards, which “...ensure stability of meaning over different sites and time, and are essential to the aggregation of individual health care data into larger wholes” (p.25). DSM is the arbiter of these standards, the source of reliability in psychiatric diagnosis. DSM works to control what Zerubavel (1997) calls “optical diversity” or the possibility that different clinicians, coming from different backgrounds, with different training, might perceive their patients’ symptoms in different ways (p.31). In other words, DSM was meant to be something of a “boundary object,” or “...objects which inhabit multiple worlds simultaneously and which must meet the demands of each one” with the purpose of creating standards across paradigms (Star and Greisemer 1989:408). However, DSM has yielded mixed results in terms of its unifying effect on psychiatric and psychological practice; on one hand it creates a standard model for identifying and classifying illness, yet on the other, because it is not the result of what Star and Greisemer (idem) call “shared work” or “intersectional” perspectives, but rather the brainchild of a committee of lauded biological psychiatrists, DSM is seen as oppressive, restrictive, and is often condemned as the source of all that is wrong with psychiatry today.
In spite of the critiques, DSM retains its power as the central classificatory system in part because there is no way to physically see mental illness. The legitimacy of the psychiatric diagnosis is entirely dependent on the identification of symptoms and the diagnosis of an illness based on these standards -- on the consistent perception of certain symptom clusters as illness even in the absence of a visual, tangible lesion. Unlike with an arterial blockage that indicates the need for a cardiovascular procedure or a cancerous tumor that indicates the necessity of a surgical procedure, there is nothing visible about mental illness. Therefore, psychiatric diagnosis rests solely on very specific sets of criteria in lieu of a “real” marker. Especially given the fear that different psychiatrists might see different symptoms in patients and identify them as different conditions, diagnostic criteria are strictly adhered to. This was commonly the case in early psychiatry and led to anti-psychiatry movement critiques such as Rosenhan’s (1973) study of the mislabeling of psychiatric inpatients that led to unnecessary hospitalization.

In other words, in order to be considered a science or a true medical field, psychiatry desperately needed a “gold standard” (Timmermans and Berg 2003) or at least conventional norms of classification (Zerubavel 1997: 54) to which doctors could point, much like doctors of the body can point to high cholesterol or broken bones. In the 1980s DSM provided this possibility to psychiatry, as I describe in more detail in the chapters to follow. Of course, this was not an entirely successful endeavor, as Whooley (2010) shows when he describes the extent to which psychiatrists use “workarounds” to avoid using DSM in proscribed ways.
What Standards Offer - The Role of Technology in Reducing Uncertainty

In adhering to medical standards (and often in distancing themselves from the murkiness of psychoanalysis) psychiatrists model themselves on hard-science and legitimize both their profession and their own identity as doctors. Timmermans and Berg (2003) explain the general goal of the standard in the following way:

...standards create configurations of instruments and people, and in the process redefine what these groups, individuals, devices, and eventually, health care are about. In this view, standardization is, paradoxically, a dynamic process of change. The implementation of clinical practice guidelines or novel nomenclatures generates action and creates new forms of like. (p.23)

Identifying and examining the role of standards highlights how a field has changed. In psychiatry standards were few and far between before DSM III. The standards that did exist were poorly enforced, if at all. The standardization of psychiatric practice acted as a conduit from the meaning-making oriented psychotherapy to the evidence-based biological model. Part of the goal of this project, then, is to look at the standards and what they change, how they change, and for whom they change things.

Atkinson (1984) describes a "training for certainty" in which physicians “learn to view the science underlying medicine as ‘established 'facts' and soluble 'puzzles.' From this perspective, patients' problems are always the result of identifiable diseases, and, therefore, once the ‘correct’ identification has been made, treatment and related recommendations automatically and predictably follow” (Gerrity et al. 1992:1027-28). It is DSM that allows the clinician to do this, especially early in her career. Light (1980), too, describes schools of thought, as an “ideological resolution of uncertainty.”
Socialization into a psychiatric school of thought or learning to see with a particular sociomental lens provides psychiatrists with proscribed ways to manage the inevitable uncertainty of a profession that involves treating emotions and psychological functioning.

Given that DSM plays a key role in the ability to reduce uncertainty, I consider it a form of technology in the sense championed by Timmermans and Berg (2003), who argue that technology-in-practice should be a key area of focus for sociologists. They contend that sociologists should be “…looking at technologies as central mediators in the construction and reproduction of novel worlds…” (108). Because so much of the story of psychiatry over the last century involves the introduction of new technologies (medication and DSM) it is particularly important to understand the connection between medication usage and the emergence and dominance of the biological model. This is very much linked to professional identity; especially for psychiatrists for whom medicine is the treatment, their professional identity is intimately connected to their ability to prescribe. For all three groups of my interviewees, DSM, which is the embodiment of the new technology in psychiatry, is an important standard by which symptoms are gauged and by which treatment is geared. Any of study of psychiatry that disregards the importance of DSM ignores a key factor in the construction of the psychiatrist and the maintenance of the psychiatric worldview.

In looking at technology-in-practice, this project also provides insight into the relationship between diagnosis and treatment, something Mol and Elsman (1996) dissect. Diagnosis is particularly important for a discipline that has been continuously
considered on the fringes of and even less important and less rigorous than medicine at large. I follow Mol and Elsman’s claim that, “Studying the content of medical discussions and techniques instead of the interests behind them gives new insights into…” practice (627), though I investigate private practice, rather than hospital settings, as Mol and Elsman do. The interests of medicine at large are crucial to identify and they intertwine with practice, but happens in doctors’ offices and how doctors themselves think about their own profession and their treatment practices is of equal importance. Further, an investigation of practice can uncover a wealth of information about trends in medicine; for instance, in psychiatrists’ narratives, decisions about whether to medicate patients can provide insight into prescribing patterns, and descriptions of navigating diagnostic codes can help us understand the effect of structural forces such as managed care on the physicians’ autonomy.

In sum, the reliance on disease and the movement away from looking at the person more holistically control uncertainty, manage it, and make it less likely to ever affect practice. In particular, Cassell (2004:217) explains that, “in practice, uncertainty can be put out of mind in several ways.” One way, he explains, “deindividuates” patients to “make them more like the textbook cases (idem). This, too, helps to explain why DSM is so important. Put another way, Cassell explains that “uncertainty makes doctors turn away from knowing the patient – turn toward what is seemingly knowable” (idem). Psychiatry is a field wrought with uncertainty, which pushes doctors toward the medical model. This appears to increase the scientificity and certainty of what they see in their
patients. But this tends to blind doctors to everything other than symptomatology (Smith, 2010), a critique of DSM we shall see in chapters to come.

Routine Practice: Resolving Uncertainty, Maintaining Autonomy and Constructing Expertise

Standardization is quite helpful for organizing doctors’ thinking, and particularly for decision-making. However, it also causes many problems in a field comprised of doctors who struggle to maintain their autonomy in practice. Further, for doctors who are socialized into both the medical and diagnostic worlds, the standardization of the medical model may be hard to integrate into a practice that involves talk therapy, particularly psychodynamically oriented talk therapy. So how is it that practitioners resolve these conflicts? They use what Berg (1992) calls routines of medical practice to create new forms of standardization and to avoid the conflicts that could arise at the boundary between the biological and psychodynamic approaches. Berg (1992) describes the necessity of routines as key to medical practice; they are “…the micro-sociological correlative of the concept 'paradigm” (171). In other words, we can see these psychiatric paradigms playing out by identifying routines of practice. Berg further explains that routines demarcate:

...a set of actions which is repetitively carried out with a certain 'automatism': habitually, without explicitly reflecting on or legitimating the actions involved. In the medical problem solving process, routines are of major importance. The type of questions a physician asks, the way she asks them, the kind of examination she performs, the interpretation of the answers and the results, the completion of insurance forms: all these actions are routinely performed. (P.170)
As a result of professional socialization these routines become available to psychiatrists and psychologists. Berg describes the necessity of routines in the context of medical practice. Among other services, routines “facilitate medical action: the physician is not continuously deliberating on the steps she should take next” (idem). In order to practice without incident, and to avoid the experience of tensions stemming from having been trained in both the biological and medical paradigms, the biodynamic group relies heavily on these routines. Since they come from organizations (what Berg calls organizational routines) and develop in interaction with other practitioners (which makes them shared and even more powerful), routines often feel automatic.

Employing routines also aids psychiatrists in performing what Gieryn (1983) calls boundary work, which serves in this case to separate biological psychiatry from softer, less scientific forms of practice and ultimately to monopolize the field. Psychologists also perform boundary work when they describe the prescription of medications by psychiatrists as a practice different from their own -- as a different kind of science. They demarcate their world of talk therapy as being something different than the work of psychiatrists, who are outside the boundaries of their brand of treatment. The recent push in psychoanalysis to prove the efficacy of the talking cure is also a form of boundary work in which talk therapists seek to demarcate their own scientific practice. Though psychoanalysis is likely never to be the dominant paradigm for treatment in psychiatry ever again, it is the primary model for psychodynamically trained psychologists who perform this boundary work as a way of claiming prestige for their practice, pushing back against the monopoly of biological treatment, and of coming to
terms with having to operate to a certain extent within the medical model as it is a central part of the mental health field today.

Though standards and routines are functional, psychiatrists (and to a lesser extent psychologists) struggle to maintain their autonomy as practitioners because of what some would argue is over-standardization or over-routinization. Psychiatry has become increasingly bureaucratized since the 1980s as has the field of medicine at large. This yields a tense situation for doctors who must work within the system but also maintain their own sense of independence and decision-making skills. For instance, Gild and Winans (1995) explored physicians’ responses to reimbursement reductions and found that “a recurrent theme in the discussion of clinical practice changes was professional judgment,” or “…a physician's authority to make case-by-case clinical decisions” (based on charismatic authority). It, they say, “…emphasizes the primacy of physician autonomy” (p.487).

Though accountability for diagnosis and treatment was one of the goals of DSM (and an important one at that), the strict diagnostic categories often make practitioners trained in psychoanalysis and deep assessment of patients’ lives feel hemmed in. In particular, the relationship between DSM and managed care often means that psychiatrists are pushed into making diagnoses they may not see as entirely fitting of their patients. Thus, what Timmermans and Berg (2003) describe as a shift from autonomy to accountability in medicine helps to explain the multifaceted feelings about DSM (and symbolically of evidence-based medicine in psychiatry more broadly) that we shall see in the coming chapters. In shifting from the dynamic to the biological model,
the goal was to create accountable, evidence-based treatment. In the process practitioners have lost some of their ability to choose what kind of treatment they feel is appropriate for a patient, and to decide how a patient should be diagnosed.

This desire for autonomy shines though in descriptions about “expertise” and how psychiatrists and psychologists describe what it means to be a good practitioner. In fact, for psychiatrists, being good at what you do has a great deal to do with the ability not to rely on diagnostic categories. Luhrmann (2001) explains that psychiatry residents start out critical and wary of DSM categories, but they grow to admire the doctors who have so much experience that they no longer need to consult the criteria on a regular basis. Autonomy and expertise go hand in hand – in the beginning DSM is necessary for learning. Later, good clinical judgment is considered to be the defining characteristic of the seasoned practitioner, since she no longer needs to rely on DSM. However, the categories are somewhat internalized; just because the manual is no longer necessary does not mean the categories are any different. Autonomy is at least partly about perception. Further, DSM is often critiqued, though, as Luhrmann (2001) also points out, it is only once a doctor feels expert that she feels she can “challenge the categories” without challenging “the existence of organic disease” (p.51). No matter how seasoned the professional, there is a continued tension between needing the criteria for good medical practice and being able to move beyond it as an expert.

This ability to perceive one’s own professional expertise and to navigate the goals of professional practice rests on what Fujimura (1987) calls articulation work. “Articulation consists of all the work needed to bring the production tasks together and
achieve a given project's ends” (p.260). As we shall see, psychiatrists and psychologists develop set ways of achieving their goals – helping patients, and reducing symptoms through medical intervention or talk therapy. Fujimura proposes that articulation work is necessary in order for scientists to construct what she calls doable tasks. Though she describes the necessary alignment of various levels of work within the scientific field (experiment, laboratory, and social world) it is clear from my interviewees’ narratives that articulation work is necessary in order to construct doable tasks at the level of practice alone, even when it is a single practitioner navigating her own private practice. The psychiatrist in private practice need not negotiate with other members of a scientific discipline in order to get work done. However, for practitioners who are trained in multiple schools of thought, in multiple treatment modalities, the articulation work is crucial for creating consistency in practice. Otherwise, the task at hand - the treatment of the patient - would not be do-able at all. Fujimura reminds us that “[a]llignment is achieved through articulation” (p.283).

**General Goals**

This dissertation focuses on the boundaries (or lack thereof) between the psychoanalytic and biological treatment paradigms in the practice of a select group of mental health practitioners. Though this project is not representative of all mental health practitioners or even of all psychiatrists, psychologists or psychoanalysts, many of the themes raised in this project extend beyond my sample. Certainly the need to and the way in which these practitioners manage the possible tensions between these
paradigms highlights tensions in modern medicine, and the power of the medical model. In order to “see” these boundaries, I begin by describing the key issues in the field today. I then focus on the tensions that exist for certain members of my sample who are caught between the psychodynamic and biological models because of their particular kinds of training. Do psychiatrists trained only in the biological model differ extensively from those who are trained in psychoanalysis? How different are psychologist analysts from those with a medical degree? How much does the biological model figure in the practice of each of these groups and how central is talk therapy? Finally, given the potential tensions between these different treatment models, and even between practitioners in these different theoretical camps, how great is the experience of these tensions? In seeking the answers to these questions I provide a bottom-up insight into psychiatric practice.

Methodology

All interviews were gathered in semi-structured, approximately forty-five minute interviews between August 2007 and May 2011 with psychiatrists and psychologists who practice in and around New York City. All interviews were carried out in the private offices (in four cases the homes) of interviewees. The sample was gathered using a snowball methodology, originating from a contact at a New York City psychoanalytic institute. Of the participants, twenty-six were women and fourteen were men. Their ages ranged from thirty-seven to eighty, with an average of fifty-three. The interview
guide consists of twenty-six open-ended questions\(^9\) (discounting demographic questions), divided into three substantive areas: 1) professional background, including training and thoughts about psychiatric practice in general; 2) treatment practice and preferences, including thoughts about why patients enter treatment and what causes psychiatric conditions and 3) theoretical issues, including opinions on what suffering is and how it should be conceptualized.

This analysis is based on interviews with three groups of mental health practitioners: twenty interviews are with psychoanalytically trained psychiatrists who attended medical school and pursued residencies in psychiatry. Later they enrolled in psychoanalytic training programs, which required an additional five years of education in psychoanalytic theory and practice as well as undergoing psychoanalysis during that time. Because of their dual training in both the biological and psychodynamic models I dub these practitioners *biodynamic*. Because these doctors were trained in both models, one might hypothesize that they are caught between often opposing – at the very least, competing – schools of thought. Using these interviews I investigate to what extent they are able to rationalize the use of the two paradigms together in order to practice without experiencing conflict.

Another ten interviews are with psychoanalysts who were trained in psychology and have PhDs rather than MDs. I call these practitioners *psychodynamic* psychologists, since their training is almost entirely in the psychodynamic model. The psychologists are a crucial part of my sample, as they provide a comparison to the medically trained

\(^9\) See Appendix 1 for the interview guide.
practitioners. The psychologists in this project were all trained largely in the psychodynamic tradition in graduate school and then in psychoanalytic programs for an additional five years. Additionally, they do not prescribe medications as psychoanalysts prior to the 1980s did not. Because of this, they are the closest to traditional psychoanalysts that one can find today. Because they do not have medical training, they allow for a determination of the extent to which medical training (especially in the current biological era) affects practice. In sum, psychologists perform a great deal of the talk therapy that is practiced today and therefore are an important comparison group to the medically-trained psychiatrist. My final group is comprised of ten mainstream psychiatrists, who I call biological psychiatrists; they have not done any psychoanalytic training. For this analysis I have purposely excluded social workers (MSWs) from the sample, as their training is radically different from that of psychologists and psychiatrists who undergo approximately the same number of years of training prior to psychoanalytic treatment.

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10 See Table 1 for a brief description of training and practice differences.
11 See chapter two for a more detailed description of training.
Table 1. Training and Practice Characteristics

<table>
<thead>
<tr>
<th>Group</th>
<th>Degree</th>
<th>Training</th>
<th>Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Biological (N=10)</td>
<td>MD</td>
<td>4 years Medical School/ 1 year internship in psychiatry/3 years of residency in psychiatry</td>
<td>Psychopharmacology/some talk therapy</td>
</tr>
<tr>
<td>Psychodynamic (N=10)</td>
<td>PhD/Certificate in psychoanalysis</td>
<td>4 (or more) years of graduate School/1 year of internship in Psychology/5 years of psychoanalytic training</td>
<td>Psychodynamic talk therapy/psychoanalysis</td>
</tr>
<tr>
<td>Biodynamic (N=20)</td>
<td>MD/certificate in psychoanalysis</td>
<td>4 years Medical School/ 1 year internship in psychiatry/3 years of residency in psychiatry/5 years of psychoanalytic training</td>
<td>Psychopharmacology, psychodynamic talk therapy, psychoanalysis</td>
</tr>
</tbody>
</table>
All names are pseudonyms that were randomly assigned and derived from street names in Brooklyn, New York. Any potential identifying details have been removed in order to protect the anonymity of the subjects. Therefore I do not describe any of my interviewees in depth; even in chapter two where I provide a more detailed look at individual practitioners, I have been careful to remove any potentially identifying markers, opinions, training experiences, and affiliations. Given the very small community of psychoanalysts in New York City I will not provide any demographic descriptions, including gender. I use the generic “she” throughout this analysis, and only identify interviewees by the kind of practitioner they are (biodynamic, psychodynamic, or biological) and their age range and/or years in practice and only when relevant. Because gender is not of central importance in this analysis, the generic “she” does not detract from the analysis of my interviewees’ statements. I have chosen to describe my interviewees as female rather than of both genders mostly for the simple reason that the majority of my interviewees are female. This was not intentional, but occurred because I started with female contacts who referred me first to their friends (in order to get psychiatrists to agree to be interviewed and give up what could be paid time, personal contacts are crucial), and so on. Thus, while there are a fair number of men (fourteen) in the sample overall, there were certainly more women (twenty-six). Further, of the specialties in medicine, psychiatry is one of the most female-dominated. Medicine is still male-dominated - according to Census data from 2008 only 30.5% of physicians and surgeons in the United States are female; psychiatry, pediatrics and obstetrics/gynecology are where the greatest number of female physicians are found. In
2006 the American Medical Association reported that, of practicing psychiatrists, 27,319 were male and only 14,066 female.

Of psychiatry residents at institutions affiliated with the American Psychiatric Association in 2009-2010, 45% were male and 55% were female; these percentages have been relatively stable over the last three years (APA 2010). Though it is unclear why more women than men are residents in psychiatry despite the fact that there are more men overall in the field, there are two possibilities: One is that this feminization has happened very recently, since the statistics from the AMA are from 2006 and the APA report is from 2010. There are a few anecdotal reports that this is the case. The other possibility is that fewer women go on to practice after training, though this is less likely.

Of those residents in 2010, the most women in any specialty are in pediatric/child/adolescent psychiatry (seventy percent) (APA 2010). This is a particularly important explanatory factor for my sample; one of my initial contacts specialized in child treatment and therefore my snowball sample is skewed toward those who specialize in child and adolescent treatment (though these practitioners all treat adults as well). Another reason my sample is more female than male is because almost all the women in the first sample (the biodynamic group) referred me to other women. I presume that this is because they referred me to friends who they knew were likely to
agree to be interviewed; it is taxing for doctors to give up forty-five minutes, during which time they could see a paying client\textsuperscript{12}.

All interviews were digitally recorded, transcribed and coded first by hand, and then using ATLAS ti, a qualitative data analysis software package. While this dissertation is based on information from all forty interviews, only statements that are representative of the sample overall appear. As noted, this qualitative methodology is particularly critical for understanding what practice looks like, how practitioners think about their patients and psychiatric illness more broadly, and to what extent the extensive literature on the theory about differences between the psychoanalytic and medical paradigms actually represents the practice and opinions of practitioners. To date there is no other study of psychiatric practice involving this kind of interview data – to be sure, there is no other project that investigates the decision-making process within this range of issues from etiology to prescribing.

\textsuperscript{12} There are several possible explanations for the overrepresentation of women in psychiatry compared to medicine at large. One is that, in a field that is increasingly based on evidence (hard science), psychiatry has come to be seen more as women’s work. Though psychiatry today is largely dedicated to medication treatments, there is still a significant amount of talk therapy being practiced, the arbiters of which must be empathetic, good listeners. These are traditionally female characteristics. Another is lifestyle choices and family obligations that make psychiatric practice more reasonable for women than, say, surgery, which is more demanding of time and on a less predictable schedule. The most general explanation involves the increase in women in medicine at large. In 1930, after all, only four percent of physicians and surgeons were women (Adams 2010). There are myriad explanations for the feminization of women in medicine at large, ranging from the fact that more women entered the workforce over the course of the 20\textsuperscript{th} Century in most fields, thus more women were drawn to medicine overall, to the fact rises in immigration brought women who were more commonly in medicine elsewhere in the world to the US (Adams 2010).
Because I focus on doctors in private practice, most of what they discuss is limited to their ideas about a very particular kind of patient: mostly middle to upper middle-class, largely white, mostly New York City residents. These doctors mostly treat depression, anxiety, ADHD, and substance abuse problems. Therefore ideas about treatment are also influenced by the kinds of illnesses and the type of population they are likely to see. Some of these practitioners do see patients with psychotic conditions or severe borderline personality disorder, which is notoriously difficult to treat, but this is not the common story for the private practice doctor. There is, as a general rule, much greater disagreement about the etiology of neurotic conditions than is the case for psychotic disorders, which are widely accepted to be biological in nature; disorders such as schizophrenia and bipolar disorder, which have relatively stable prevalence rates globally and historically, are generally assumed to stem from neurobiology.

_A note on cohort effects_

It is important to note at the outset that for the biodynamic group the factor most responsible for causing heterogeneity in the sample (represented by the dual modal numbers of treated patients) is their training cohort. Of the biodynamic practitioners, seven are over the age of sixty and therefore trained before the shift to biological dominance. Unlike their contemporaries, these psychiatrists would not have been heavily schooled in biological treatments in their medical training, and would only have come into the biological model when they were already beyond the training years. Therefore, they are much less likely to see the biological model as the most appropriate
treatment even though they are psychiatrists. They are instead much more likely to favor the psychodynamic model. Though they still see themselves as medical doctors and do prescribe medications, they do so much more because it is what has become the status quo of the discipline and less because they feel that biological etiology outweighs psychological factors. They also do not support the notion that biological treatment is more effective than the psychodynamic approach. However, as we will see in chapter five, the biodynamic group face more potential professional tensions than the biological group because the majority of the latter group trained after the shift to biological dominance and therefore do not have any allegiances to the psychodynamic model.

**Chapter Outline**

In Chapter One I discuss the historical changes in psychiatry since the 1980s. Here, I describe essential elements of the psychoanalytic and biological approaches, thus providing insights into the character of classical and contemporary psychiatric practice. I briefly touch upon the state of psychology, which has moved much more toward evidence-based treatments and short-term therapies. This is also relevant for psychologists who refer patients for medicines, and for those who trained in psychoanalysis at institutes where there are MDs (as mine did) it is significant because their MD colleagues influence them. I begin with the guiding principles of Freudian psychoanalysis and move through the psychiatric paradigm shift in the 1980s, which radically altered the face of psychiatric treatment, relegating talk-therapy to secondary status and bringing to the fore new biological treatments; this is the story of the
medicalization of psychiatry, which sets the stage for the questions to which I offer answers throughout this analysis. What kinds of boundary distinctions are there between psychoanalytic and medical approaches? What differences are there between the three kinds of practitioners in the study? The disparateness of the biological and dynamic paradigms in terms of the way they conceptualize and treat mental illness influences the field of psychiatry and psychology today.

In chapter two I explore how these treatment paradigms operate in everyday practice and when doctors think about their patients. I explore the key issues in the field: the influence of medicalization on practice, how practitioners propagate the medical model, and what the boundaries are between meaning-making and medicalization. In this chapter I move more fully into the data to describe feelings about medication and what role it plays in practice, feelings about DSM, and what the key principles are that set psychoanalysis apart from other kinds of treatment. In investigating these issues I address to what extent the paradigms described in chapter one are relevant for practice today and to what extent allegiances to the biological or the psychodynamic model influence the key issues in the field.

In Chapter Three I provide portraits of interviewees from each of the three groups: biodynamic psychiatrists (psychiatrists trained in psychoanalysis), psychodynamic psychologists (psychologists trained in psychoanalysis), and biological psychiatrists (psychiatrists). I do so using to the greatest extent possible, their own words; I explore in-depth the narratives of practitioners in each of the three groups. I use these portraits to describe training, basic assumptions about patients, feelings
about medication, and other relevant issues in the field that highlight the discussion in chapter two. This chapter is meant to provide a more personal look at a few “typical" doctors, why they chose the profession, and how they treat their patients. For the biodynamic and psychodynamic group, why did they train in psychoanalysis and what benefit does it confer for treating patients? We can see in these narratives the different goals and underlying theoretical assumptions of these paradigms that lead to tensions for the practitioners who must navigate between the two models.

In chapter four, I focus on these tensions between the psychodynamic and biodynamic models and look more closely at the meaning-making/medicalization divide; I discuss the tensions practitioners describe between biological and psychodynamic theory and between the different kinds of practitioners trained in these two paradigms. In other words, in the tensions between these treatment models, we can see the classic divide between one model that is dedicated to meaning-making and another to the efficient alleviation of symptoms with medications. Here I use the biological group as a background comparison; I move away from their narratives since they have only trained in one of these two models and tensions are much less of an issue for them -- they need not think about talk therapy at all in their everyday practice. I find that tensions exist for the biodynamic when they interact with non-analysts, when they are prompted to think about their dual professional identity, and when describing differences between biological and psychodynamic theories of etiology and treatment. Clashes exist for the psychodynamic group as well in interacting with non-analysts, but also with the biodynamic psychiatrists. Most psychodynamic practitioners found themselves to be the
marked group in their psychoanalytic training institute – that is they lack something the rest of the people in psychoanalytic training have: a medical degree. Ultimately, the clashes in this chapter highlight the power of the biological model.

In chapter five, I describe routines the biodynamic group uses in practice to avoid facing tensions between the biological and psychodynamic model. I also show that the psychodynamic group employs a set of explanations in order to assuage the tensions between the two models, most notably those that exist between themselves and other practitioners surrounding the prescription of psychotropic medications. This is the story of consistent practice in the face of theoretical discrepancies. This is, again, irrelevant for the biological psychiatrists, who I use here mostly as a comparison group. One would assume that the biodynamic group would experience the greatest clash because of their dual training, but in fact they do not. The psychodynamic group are in fact the ones who experience the most tension because of pressures to refer patients for medication, to think diagnostically, and because psychiatrists make them feel lesser than. To be an analyst in a medical world without medical training leads to a need to actively manage relationships with psychiatrists who prescribe medicines for their patients and to rationalize their training with psychiatrists who assume they are super-psychiatrists because of their ability to practice both talk therapy and to prescribe medications.

I conclude by offering some future research directions, namely adding compositionally different samples to the project that will help expand its scope to offer a more holistic perspective on mental health practice. I also suggest some implications of the dominance of the medical model in psychiatry. Further, I ask what we can learn
from the impact of the medical model on practice and more generally about how to resolve tensions in professional practice – not just in medicine, but in any field where practitioners must operate in competing paradigms. In sum, this final chapter will provide some interpretations of the effect of the imbalance of meaning-making and medical practice and the way in which the boundaries between the two are erected, actively maintained, and have become blurry in practice.
CHAPTER ONE

The Psychiatric Paradigm Shift: From Meaning-making to Medicalization

*Psychoanalysts cherish the complex art we practice; most of us have made considerable sacrifices to become good at it. Currently, we face a world that seems eager to devalue our skills, our commitments, our values. A few years ago, in a visit to the Menninger Clinic¹, I felt like the friend of a family in which someone was dying of cancer: Everyone knows the prognosis is grave, but feels that talking about it will not help. The atmosphere of the institution was suffused with concern that the long-term, intensive, humane, compassion-driven kinds of treatment we have all struggled to learn how to provide are being replaced by hasty, superficial, impersonal, market-driven and ultimately corrupt practices that scarcely deserve the name psychotherapy. (McWilliams 2000:372)*

Over the course of the 20th century a paradigm shift has occurred in psychiatry. In this chapter, I detail the transition in the 1980s in which the *Freudian, psychoanalytic or psychodynamic* “talking cure” that dominated psychiatric theory and practice for most of 20th Century ceded to the *diagnostic* or *biological* model. The biological revolution radically altered psychiatric practice, and the contentious process of shifting from a discipline that valued deep exploration of the psyche to one that advocates short-term, evidence-based treatments continues to cause tensions for the psychiatrists and psychologists in my study. The skills to elicit discussion of childhood experiences, of trauma, and to uncover repressed memories and desires are no longer the central

¹ The Menninger Clinic in Kansas, named after Karl Menninger, one of the first prominent psychoanalytically-influenced psychiatrists in the United States, remains one of the few major centers for psychoanalytic training and treatment in the US.

² There were, of course, other psychological theories the influence of which waxed and waned over the course of the 1960s and 1970s, such as Gestalt psychology and self-psychology. In fact, most of these therapies developed in opposition to psychodynamic therapies, though the psychoanalytic school was always more dominant than any of these other schools (c.f. Horwitz 2002).
lessons of psychiatric training. Psychiatrists, today, are mostly trained to diagnose mental illness and prescribe medications to relieve patients’ symptoms.

Though a quarter of my interviewees are psychologists, not psychiatrists, this story is relevant to their experiences as well. Psychological training has, too, become much more heavily focused on short-term, evidence-based therapies, even though psychologists are not medically trained, nor are they permitted to prescribe medications. Psychology is a social science\(^3\), not a medical field; its origins are in European philosophy and behavioralism, and can be traced to such figures as Immanuel Kant and Ivan Pavlov. Even if psychological training has become much more about finding efficient treatments for psychic pain than about the meaning-making process and deep explorations of the mind that characterized both psychology (c.f. McWilliams 2000) and psychiatry (c.f. Hale 1995; Horwitz 2002; Shorter 1993; Shorter 1997) for the majority of the 20\(^{th}\) century, this social science is still influenced by Freudian (and post-Freudian) theories of the mind. Some psychological training programs are still grounded in ideas about the subconscious, repression, transference, and the importance of sexuality as a driving force in both early childhood and adult life, though it is not relevant to my study\(^4\). In psychiatry, a branch of medicine, the anchor to Freudian theories that were a major part of the training psychiatrists received in their residency

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\(^3\) Today some would argue that psychology is based heavily in biological thinking as well.

\(^4\) All of the psychologists in this study report that their graduate training was psychodynamically-oriented.

\(^5\) In psychology at large, behavioralism is the dominant psychological treatment and it is adamantly anti-Freudian in its theory and treatments.
and internship years is now largely peripheral or even non-existent in many training programs.

Though the discipline of psychology was highly influenced by psychodynamic theory\(^6\), the opportunity to practice psychoanalysis is a relatively new one for psychologists, as they could not officially train in psychoanalysis until 1991, when the “Psychoanalytic Lawsuit”\(^7\) against the American Psychoanalytic Association was officially settled in the favor of the psychologists and social workers who filed the suit. Until that settlement, few institutes would even allow psychologists to train in psychoanalysis, and those that did required psychologists to sign a waiver stating that they would not practice psychoanalysis even though they had been trained in psychoanalytic theory (Kalinkowitz and Aron 1998; Hoffman and Zalusky 2002). Many of the senior psychoanalysts believed that only medical doctors were trained thoroughly enough as mental health practitioners to practice psychoanalysis, even though Freud himself was an advocate of allowing non-medical practitioners to practice psychoanalysis. Though he was a medical doctor, Freud admittedly did not think highly of physicians; he was reported to have said of MDs that “they were merchants, trading in the mitigation of

\(^6\) Though the terms psychodynamic and psychoanalytic are used somewhat interchangeably, the one distinction is at the level of practice. While there is not a difference between the two in terms of the theory they represent, psychoanalytic practice describes classic, four-time-per-week treatment, whereas even a sporadic treatment can be psychodynamically-informed, which simply means it is influenced by psychodynamic principles.

\(^7\) This lawsuit was filed in 1985 by a group of psychologists who wanted to train in psychoanalytic institutes run by the American Psychoanalytic Association, which maintained that only medical doctors were qualified to practice psychoanalysis.
miseries they scarcely attempted to understand” (citation missing). Freud was an advocate of “lay analysis,” or the practice of psychoanalysis by those outside the mental health fields; he did not think that medical or other professional training was a prerequisite for the practice of psychoanalysis.

Freud in fact trained one of the most famous psychologist psychoanalysts, Theodor Reik. Though a direct descendant of Freudian psychoanalysis and one of Freud’s prized students, Reik (having fled to the US in 1938 from burgeoning Nazism in Europe) was never accepted by American psychoanalysts. From the beginning of the psychoanalytic heyday in the United States (in the 1950s), psychiatrists were unwilling to accept that non-MDs were capable of practicing psychoanalysis, which can be largely attributed to psychiatry’s ongoing battle to maintain dominance over the treatment of mental illness (c.f. Abbott 1988). Because of his inability to break into the field, Reik instructed non-MD audiences interested in Freudian theory. Those lectures were the foundation for The National Psychological Association for Psychoanalysis (NPAP), which is still one of the most prominent institutes in New York City and in the United States at large for non-physicians to train in psychoanalysis.

Today, given the relatively low enrollment in psychoanalytic training⁸, the psychoanalytic training institutes that were once exclusively for psychiatrists would likely be in even more peril than they are if not for the participation of non-MD analysts.

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⁸ It is difficult to accurately assess the number of practicing psychoanalysts in the United States. Consider the following comparison: While there are thousands of new psychiatry MDs and psychology PhDs awarded each year, only a handful (about 10) of those graduates will enter each of the few psychoanalytic training programs in the US each year.
For instance, of candidates (all people in the program who have not yet graduated) in psychoanalytic training at a prominent New York City institute, only seventeen were PhDs of approximately seventy candidates. At another, five out of twenty-seven are psychologists and the rest are medically trained. Further, of the 223 general faculty members at that institute, only twenty-eight are psychologists.

Most relevant, for the purpose of this analysis, is the extent to which psychoanalysis and meaning-making practices were favored in these mental health fields until the 1980s, and the radical about-face toward medical, particularly biological treatments. This shift is, of course, much more pronounced in psychiatry than psychology, but as we shall see in later chapters, it is also hugely influential for the psychologists in my sample, since they are all trained in psychoanalysis and therefore come into contact with psychiatrists and the medical model during that training. Further, the psychologists in my sample were all trained in graduate programs that they describe as having been predominantly psychodynamic (i.e. the behavioral model was of little influence in their training), so their theoretical training is most closely aligned with what psychiatrists would have experienced pre-1980 in psychoanalytically oriented medical programs. In sum, I focus much more heavily on the history of psychiatry, as three fourths of my sample is made up of medically trained psychiatrists, and three fourths of my sample is made up of psychoanalysts.
Though psychiatry has a long history in the United States, in this chapter I explore the period most relevant to my study: the latter half of the 20th Century. The psychoanalytic heyday is where I begin, since this period was so influential in the development of key theories still used in talk-therapy today, and especially since so much of my sample is psychoanalytically trained. I then describe the diffusion of the biological mode, which radically altered theories about the etiology of mental illness, the entire practice of psychiatry, and thus the experiences of both practitioner and patient alike. In sum, I detail the story of what Edward Shorter (1993) describes eloquently as a shift in focus from the mind into the body. I do so in order to provide a background for understanding the statements of my interviewees, which fill the pages in the chapters to come.

The Psychoanalytic Heyday: Exploration of the Psyche and the Meaning of Symptoms

The prominent medical historian Roy Porter (1997:516) describes Freudian psychoanalysis as a field that “...changed the self-image of the western mind.” With the introduction of Freudian principles, neither psychiatry nor notions of the psyche and the self would ever be the same. It is because of this far-reaching impact that I begin by providing a short description of the basic history and principles of psychoanalysis in American psychiatry. Though it was in 1900 that Freud published The Interpretation of

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10 In this analysis I describe American psychiatric and psychoanalytic practice. The history is somewhat different elsewhere, especially in Europe.
Dreams, and he made his only trip to the United States in 1909, where he delivered a keynote speech at Clark University, his work really began to influence psychiatry in the United States in the 1920s, and was much more widely read in the United States starting around 1940, one year after his death (see especially Hale 1995; Lunbeck 1994). In American psychiatry it was largely posthumously that Freud’s work revolutionized the way people conceptualized mental illness. It was in post World War II era America that increasing secularism and social conservatism (especially surrounding sexuality) led to an increased desire to understand the psyche and the connection between these social factors and illness. This cultural climate was fertile ground in which psychoanalysis was easily able to take root.

Psychoanalytic theory presented a new language for understanding psychiatric conditions because it was based on the notion that mental illness was not a drastically different state of being from normality (Lunbeck 1994:306). In fact, Freud considered dysfunction to emerge from the same childhood experiences as healthy psyches. He conceptualized most of his patients’ symptoms to be what he called neurosis, generally some type of manifestation of anxiety, the experience of which was the central concern of Freudian psychoanalysis (Brenner 1974). Neuroses were presumed to be the result of psychic conflict rather than biological malfunctioning, which had been the major theory

11 The most succinct definition of neurosis can be found in neurotic conflict, wherein instinctual drives are unable to be discharged. Tensions arise and “ego becomes progressively less able to cope with the mounting tensions and is ultimately overwhelmed. The involuntary discharges manifest themselves clinically as the symptoms of psychoneurosis...neurotic conflict is an unconscious conflict between an id impulse seeking discharge and an ego defense warding off the impulse’s direct discharge or access to consciousness” (Greenson 1995:17).
of the etiology of psychiatric symptoms through the early 1900s; psychoanalysis turned American psychiatry on its head by suggesting that psychiatric symptoms were rooted in psychological mechanisms and life experiences. It was this orientation toward the influence of the past on the present and the assumption that the mind is ever-changing, active, in motion – in short, dynamic – that challenged prior explanations focused on the body and the brain (much as biomedicine does today).

In short, for Freud, good mental health was dependent on successful navigation of childhood psychosexual stages. Problems, namely neurotic symptoms, emerged from stumbles or atypical movement through these stages. For instance, one could become “cathected” or stuck in a particular stage (i.e. the oral stage) and develop a neurotic tendency in that vein (i.e. biting one’s nails). But these deviations could happen to anyone; it was not a particular kind of person who struggled with mental illness. Further, everyone experiences neurosis, which was conceptualized as the natural result of struggling through childhood development. For instance, the notion of an Oedipus Complex for boys (and an Electra Complex for girls) is one of Freud’s most infamous and widely debated influences on theories of childhood psycho-sexual development. In this phase, between the ages of three and six, he argued children learn to identify with same-sex parents (Brenner 1974). The result of successful navigation of this subconscious process is that children develop the gender roles that will solidify as they grow into adulthood (Rosenfield and Smith 2009). While most people navigate this stage of life successfully, others are unable to for a variety of reasons, and this can explain neurotic symptoms that develop later in life (Peron 2002). In this way, Freudian
theory was both universalistic (everyone must go through these stages) and individual (it identifies how a given patient navigated these stages or got stuck along the way).

Thus, Freud opened the door for a more complete understanding of both problematic and “normal” behavior. Even normal people were neurotic; no one moved through life completely unscathed, and therefore everyone had the potential to be symptomatic. In this way, psychoanalysis shifted the attention of psychiatrists and laypeople alike to milder conditions and away from psychosis, which had been the focus of psychiatry through the early 20th Century (Porter 1997). Although illness categories in early psychoanalysis were vague and not meant for acute diagnosis, dynamic psychiatry was the first instance of an actual field of mental health that included professional and diagnostic tools. In sum, Freudian psychiatry made illness seem less exotic. Further, psychiatric symptoms were now a medical and philosophical issue rather than a moral one. Hence it became less necessary to isolate or stigmatize individuals who experienced said pathology, as had been the case in Asylum psychiatry12 that prevailed until Freud’s influence diffused into American Psychiatry. Dynamic psychiatry re-conceptualized mental illnesses as representations of psychological experiences and processes rather than as functions of innate biological states. Dynamic psychiatry was

12 The asylum era refers to the period prior to the psychoanalytic heyday in which the majority of those with mental illness (then, only characterized by the most severe symptoms) were isolated in prison-like facilities. The asylum was the solution for removing those with severe mental illness from society, much as prisons were for removing criminals. Treatment, though experimental and often cruel, was not the primary function of these asylums, which have oft been described as human warehouses. For a further discussion see especially Grob 1994; Hale, 1995; Porter 1997; Whitaker 2002.
meant to identify for its patients a biographical context in which various conditions emerged, with the idea that recognition of past (especially repressed) experiences could, over an extended period of time, free people from their neurotic tendencies, whether it was a phobia of cars or a tendency to experience intense sadness.

In practice, Freud’s work would not have extended as far beyond Europe without Harry Stack Sullivan, perhaps the most important figure in the American branch of psychoanalysis (Greenberg and Mitchell 1983). Freud’s contemporaries were divided over the issue of culture and to what extent psychoanalysts should take culture into consideration when treating patients. Sullivan advocated and advanced psychoanalytic techniques, but also fervently disagreed with the lack of context in Freud’s drive theory. He (along with other prominent psychodynamic theorists of the time: Erich Fromm, Karen Horney, Clara Thompson, and Freida Fromm-Reichmann) is responsible for the most prominent re-workings of drive theory, which he claimed was an inadequate explanation for neurotic behavior. Most importantly, Sullivan pointed to an “...underemphasis [of] the larger social and cultural context which must figure prominently in any theory attempting to account for the origins, development, and warpings of personality” (ibid 80). Sullivan’s work was heavily influenced by the pragmatist school, of which he was well informed in his years at the University of

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13 Though Freud was certainly much more interested in the psychological underpinnings of neurosis, he firmly believed that there were biological roots to thinking and behavior. That he advocated for drive theory is a prime example of this kind of thinking – people, for instance, are biological driven toward certain types of thinking and behavior. Sullivan was fervently against this biological basis of Freudian psychoanalysis. It was one of his deepest disagreements with Freud.
Chicago by both psychiatrists and social theorists such as George Herbert Mead, Charles H. Cooley and Robert Park. An investigation of macro-social influences on individual-level phenomena abounded in the work of these theorists, who suggested that social structures were key factors in determining people’s life chances. There was, therefore, a deeply social bent to Sullivan’s work, especially in his focus on how interaction and relationships affected psychological function and troubles.

Because Sullivan studied in the 1920s, he was privy to American asylums in their peak. He spent much of his career studying schizophrenia, since the severe symptoms of this disorder (namely hallucinations and delusions) were likely to lead to treatment in institutional settings. At the time, the most prominent theory on schizophrenia was that of Emil Kraepelin, who was responsible for much of the earliest classifications of mental illness. Kraepelin is both credited and criticized for his conceptualization and measurement of mental illness, which was based on specific illness categories with sets of symptoms (c.f. Horwitz 2002; Kirk and Kutchins 1992). In Kraepelin’s era, many lauded his model for neatly categorizing the symptoms of illnesses that were difficult to identify and treat. Sullivan, however, became quite critical of the Kraepelinian classification scheme later in his career, and even accused Kraepelin of mistaking symptoms of schizophrenia for behavior that stems from hospitalization; in other words, rather than identifying anything truly characteristic of a certain type of illness, Sullivan claimed the Kraepelinian system risked inaccurately capturing behavior borne of the institutional environment. Sullivan went as far as to claim that the Kraepelinian approach is more about the researcher’s attempt to objectify and characterize the
patient than to understand or make sense of his behavior. As we shall see, these are critiques of the contemporary, biological model in psychiatry, for which the Kraepelinian system laid the groundwork.

Instead, Sullivan spent his career arguing that schizophrenia is socially and culturally emergent, rather than the result of some biological trait\(^\text{14}\). Later Sullivan expanded his theories to include non-schizophrenic behaviors, and became one of the most prominent founding theorists and practitioners of American psychodynamic psychiatry. It is in great part due to Sullivan that dynamic psychiatry was infused with such a strong opposition to the biological approach, and that psychoanalysis is so concerned with interpersonal relationships that influence what was formerly characterized as a brain disease. In the dynamic era theoretical approaches to dealing with mental illness emerged, and people began to ponder the origins of and most affective approaches to treating mental illness. All the major players in the field of psychoanalysis were well trained in the philosophy of science and hoped to further their discipline through theories on the emergence of mental disorders. Though early analysts were all medical doctors, there was a heavy reliance on philosophical and generally theoretical knowledge more than medical or biological explanations for illness. Sullivan was a powerful figure in the push to avoid conceptualizations of psychiatric symptoms as representations of biological malfunctioning.

Psychoanalysts in the 1950s and 60s were medical doctors, but medical practice was quite different then than it is today. Medicine was oriented toward in-depth

\(^{14}\) Today, however, it is largely undisputed that the etiology of schizophrenia is biological.
relationships with patients. People often had one doctor who would treat them (and likely the rest of their family) from childhood (perhaps from birth) through their adulthood (perhaps until death), and medicine was a much more general practice than it is today; specialties within the larger field of medicine were not yet common, so general practitioners were responsible for much more patient care (c.f. Porter 1997). Therefore in the dynamic tradition, which emerged during this era when doctors had relationships with patients, symptoms were a starting point, but were located in the context of patients’ complex lives. Though psychiatry has always been concerned with some form of diagnosis, psychiatrists of the 1950s and 1960s, who were mostly trained in psychodynamic theory, rarely consulted DSM II even though it was written by their colleagues and heavily influenced by Freudian terminology and a psychodynamic perspective. According to Kirk and Kutchins (1992) “DSM was of little practical consequence to most mental health professionals...” The conditions identified in DSM II were simply split into neurotic or psychotic categories, which were the basis of classification and the measurement of severity in the Freudian system.

Psychoanalysts recorded symptoms, but they did not focus on objective classification since their goal was to understand the mind through individual cases, as in Freud’s “Ratman,” “Wolfman,” and “Little Hans” (Freud 1940). The level of patient analysis in Freudian practice is exemplified by longitudinal case studies that provide detailed information about individual lives and insight into each patient’s life story and

15 Neurotic conditions are less severe conditions such as anxiety, whereas psychotic conditions involve the most severe symptoms such as the delusions and hallucinations that characterize schizophrenia.
general character. Psychiatrists during the Freudian era knew their patients well and could establish connections between present thought and behavior and past experience. In short, for Freudians, ever-changing subconscious processes – present in all human beings at all times – are the basis of psychoanalytic treatment, which involved an in-depth knowledge of patients.

The conditions in DSM II are divided into “neurotic” and “psychotic” categories, mostly as a distinction of severity, but also clearly highlighting the underpinning in psychoanalytic theory, as these terms are unmistakably Freudian. For example, in DSM II, as a part of the umbrella category of neuroses, anxiety neuroses are categorized in the following manner:

This neurosis is characterized by anxious over-concern extending to panic and frequently associated with somatic symptoms. Unlike phobic neurosis [a second neurotic category]..., anxiety may occur under any circumstances and is not restricted to specific situations or objects. This disorder must be distinguished from normal apprehension or fear, which occurs in realistically dangerous situations. (APA 1968)

DSM II provides a vague, general outline of a condition, but does not provide a specific description of symptoms for identifying the disorder; the practitioner is responsible for making that decision based on an intimate knowledge of the totality of the person. Even though dynamic psychiatrists did record symptoms, they were not concerned with objective classification since their goal was to understand the mind of their patients, rather than to categorize presumably isomorphic symptom sets. In Zerubavel’s (1997) language, the dynamic tradition was clearly a very different cognitive lens than the biological. Light (1980:180) describes the initial interview with patients in the dynamic
tradition to involve a search for “clues’ to the patient’s dynamics.” Working with patients is about uncovering who they are and how they think, with a focus on how past conditions affect present experiences. While DSM II appears at first glance to be a system of classification in which patients are lumped together – as there are only a few discernable conditions, all of which are given vague descriptions – it is, in fact, the vagueness of the conditions that leads to a necessity for practitioners to be discerning, using a deep analysis of each person’s life. The context in which conditions are present and the interpersonal relationships of the patient are of equal relevance. However, its lack of validity and reliability left it open to criticism and increasing calls for a new classification system (Kirk and Kutchins 1992:28-32).

Dynamic psychiatry revolutionized the way people viewed mental illness and provided society with a language and a forum in which to talk about and question the concept of abnormality. The spread of dynamic psychiatry was in no small part due to the emergence of a “culture of psychotherapy” (Horwitz 2002). This culture, however, depended on individuals who were well-educated, had ample incomes, and often belonged to persecuted ethnic groups. In the mid 1900s, after the Great Depression subsided and the economy rebounded, artists, intellectuals and Jews were especially interested in the idea of psychological exploration. It was a time when political and social conservatism abounded especially pertaining to sexuality, and dynamic psychiatry was concerned with freeing oneself of repression. This appealed especially to American Jews in the mid-20th Century, as religious persecution was not uncommon, and to young intellectuals; artists, writers, and social theorists espoused a need to radically alter
Americans’ puritanical perspective on sexuality. In 1975, one study confirmed that it was in fact upper and upper-middle class, largely white, and mostly professional people who were engaged in psychoanalytic treatments. The likelihood of choosing analytically oriented therapy was also drastically increased if one was a “friend and supporter of psychotherapy”: “77 percent of physicians seeking psychiatric treatment, 62 percent of writers and artists, 60 percent of college professors and instructors, 59 percent of social workers, and 56 percent of lawyers ended up with psychoanalysts” (Hale 1995:340). In sum, Freudian psychiatry flourished in mid-1900s US culture because of a variety of cultural conditions.

However, as Americans moved into the later part of the century, and the prevailing political and social epistemologies shifted, dynamic psychiatry lost its foothold as the dominant means for dealing with psychological distress. Equally influential was the notion of “hard science,” “facts” and “proof,” which became increasingly important to all scientific disciplines. Psychoanalysis was ill equipped to defend against accusations that it was an “unscientific” means for dealing with illness (c.f. Hale 1995:300-301).

**Enter Diagnosis: The Diffusion of the Biological Model**

In the 1970s, psychiatry floundered in the face of deinstitutionalization\(^\text{16}\), increasing critiques of the psychodynamic approach, and the rising role of managed

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\(^{16}\) Deinstitutionalization describes the mass exodus of mostly severely ill individuals into community settings. The intention of this government and insurance-driven project was to shrink the size of the mental health care system, which was extremely costly and had
care, which sought the most efficient and cost-effective means of treatment. At the same time, psychoanalysis came to be seen as an unscientific, subjective means for dealing with illness. It was out of seeming necessity that psychiatry adopted a medical model. The shortcomings of the dynamic model left it open to criticism, namely its inability to effectively treat the severely mentally ill (individuals with psychotic symptoms). Especially with a population of formerly institutionalized people thrust into community settings, a medical paradigm that could quickly and effectively treat severe symptoms was desirable and necessary (c.f. Hale 1995).

In other words, the criticisms of psychoanalytic treatment were particularly poignant given the mass deinstitutionalization of the majority of America’s most ill psychiatric patients, who were now living in community settings and in need of efficient treatment for severe symptoms. Some psychoanalysts realized their methods were not amenable to the treatment of individuals with severe mental illnesses, though Freud did (controversially) treat a handful of patients with quite severe symptoms such as

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been extensively criticized during the anti-psychiatry movement (driven by Thomas Szasz in the US and Michel Foucault in France) and more general civil rights movements of the 1960s. However, upon their release from institutions, the community programs that were meant to take the place of institutional treatment never operated in the way that had been intended by policy-makers and there was little treatment and few resources available (c.f. Estroff 1981). Today, this is considered to be one of the worst policy failures in American History, largely because deinstitutionalization ironically made the mental health field larger and more costly (Light 1980:9).
“conversion hysteria\textsuperscript{17},” a disorder in which, among other symptoms, patients lost functioning of their arms.

American medicine was also rapidly becoming a scientifically minded community in which existential wonderings, questions of human nature, and individual-oriented treatments were increasingly unacceptable: a discipline was no longer scientific if it could not be held numerically or statistically accountable for its progress (Porter 1995; Starr 1982). Scientific inquiry, equated with objectivity, led to an increased call for proof of efficacy, and psychoanalysis was simply not a discipline set up to measure progress in quantifiable terms (c.f. Shorter 1993; Shorter 1998). Many classically trained psychoanalysts were adamantly opposed to measuring the effectiveness of their field and the progress of their patients using these quantifiable measures. It seemed counterintuitive to the way they conceptualized the psyche and psychiatric treatment, but also came to be seen as a marker of the rigidity of psychoanalysts and the dogmatism of psychoanalysis, critiques that are still levied today (McWilliams 2000:375).

\textsuperscript{17} Hysteria was a commonly diagnosed condition in the Freudian and pre-Freudian era. Arguments as to whether it was a biological or psychologically-born phenomenon abounded, with Freud believing staunchly in the latter. Hysteria was almost entirely diagnosed in women and was thought to be the result of trauma, sexual repression, and what were then considered to be female dispositions (c.f. Lunbeck 1994:209). Hysteria involved symptoms such as inabilities to move either entirely or certain parts of the body, screaming, sighing, and general misery. Today, mental health professionals argue about both the etiology and diagnosis of hysteria, though the symptoms of this disorder are relatively non-existent in contemporary American society. It was a culture-bound disorder (c.f. Hale 1995; Shorter 1997).
Consider an interchange between Peter Rudnytsky, author of many volumes on psychoanalysis, and Roy Schafer, prominent psychoanalyst, who Rudnytsky interviewed in 2000. Schafer, who is now in his 90s, is a classically-trained analyst. In their conversation, Rudnytsky mentions a famous psychoanalytic study of children, saying “empirical studies seem to me to play an indispensable role in sifting out which theories in psychoanalysis continue to be vital and which theories are outmoded.” Schafer responds with a resounding “no,” pushing Rudnytsky further to ask, “…whether psychoanalytic theory, either of a particular school or considered as a totality, is something that can be assessed within any framework outside that of psychoanalysis itself, or can it find its validation only from within its own way of thinking?” Schafer responds, “That’s what I believe…I object to its being called a science (Rudnytsky 2000:225-226).

As early as the 1960s, but especially in the 1970s and 1980s, statistical studies and double-blind placebo medicine trials gained prominence in evidence-based medical research (c.f. Abbott 1988; Horwitz 2002; Porter 1997; Starr 1982). The biological model came to be seen as the scientific brand of psychiatry (Shorter 1997:288). The medical professions evolved to meet new standards of scientific rigor and efficiency that involved an abandonment of all things questionable, uncertain, or messy in favor of treatments thought to be truly measurable, capable of tracking progress, neat, and, in short, routine. By the 1980s biochemistry and medicine developed a “symbiotic relationship” (Kohler 1982), thus aiding in the production of new medications, especially those aimed at treating depression. As a part of this medical world psychiatry shifted
lenses and focused on diagnostic measures, and thus modeled itself on the natural sciences and medicine of the body. In doing so, psychiatry directed its gaze toward cures rather than treatments, so much so that many worry that “doctors and ‘consumers’ are becoming locked within a fantasy that everyone has something wrong with them, everyone and everything can be cured” (Porter 1997:718).

By 1990, the face of psychiatry had changed dramatically; “...at top ten medical schools only three chairmen (sic) were psychoanalysts or members of psychoanalytic organizations...[The] orientation of clinical psychologists...also changed; where 41% saw themselves as ‘psychodynamic’ in 1961, by 1976 this had dropped to 19 percent...” (Hale 1995:302). At the annual conference of the American Psychiatric Association in 1982, Gerald Klerman, then the most powerful psychiatrist in the American government in his role as chief of the Federal mental health agency, addressed critics of DSM III: “The theme of this meeting is ‘science in the service of healing.’ In my opinion, DSM III embodies this theme to a greater extent than any other achievement in American psychiatry since the advent of the new drugs” (quoted in Kirk and Kutchins 1992:6). The biological model propelled forth by the new diagnostic system had indeed taken a place of prominence in psychiatry by the 1980s.

Because of its basis in a set of strict diagnostic criteria, biological psychiatry offered a strategy for measuring progress much more clearly than any kind of talk-therapy ever had. In fact, this was the goal of the biological model, whereas dynamic practitioners were largely unconcerned (until they were in direct competition with the biological model) in envisioning their discipline as one that is empirically based. As
Horwitz (2002:5-6) explains, “[f]or its advocates, the model of mental illness in diagnostic psychiatry is not just different from, but better than the earlier dynamic model because the scientific methods it employs are equated with objectivity, truth, and reason...Diagnostic psychiatry...transformed psychiatry from an ideological to a scientific discipline.” That the biological model became common practice in psychiatry is illustrative of the general historical development of the medical model and the centrality of “hard science” and empiricism in modern medicine (Hale 1995; Horwitz 2002; Shorter 1997).

By the 1990s the practice of psychiatry had been radically altered. It was characterized by shorter office visits, increased medication therapy, a reliance on discrete diagnostic categories, and an etiological focus on biology and neurochemistry (Horwitz 2002; Kleinman 1988; Klitzman 1995; Shorter 1997). These changes were fueled by advances in brain scanning technologies\(^\text{18}\) and in the pharmaceutical industry\(^\text{19}\). In particular, in the 1980s, pharmaceutical companies released and psychiatrists began to widely prescribe new anti-depressants. New anti-psychotic medications came to be seen as relatively safe and effective treatment for more severe illness, and this was thought to allow formerly institutionalized patients to live in community settings (Estroff 1981; Shorter 1997). Though the exact mechanism of the

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\(^{18}\) These are the CAT (Computed Axial Tomography), PET (Positron Emission Tomography) and MRI (Magnetic Resonance Imaging).

\(^{19}\) Selective Serotonin Reuptake Inhibitors (SSRI) replaced Tricyclic antidepressants, claiming fewer side effects and greater efficacy. While SSRIs are safer because it is harder to take an overdose of them and they therefore cannot be used in suicide attempts, there is still a range of unpleasant side effects associated with them (c.f. Karp 1996).
biological etiology of mental illness is described as unclear at best in contemporary psychiatric textbooks, the clear assumption is that biology, neurochemistry, and their heritability is responsible for the range of conditions from depression to schizophrenia (c.f. Hyman and Nestler 2005).

The emergence of managed care was perhaps one of the most influential factors that pressured both doctors and patients into short-term evidence-based treatments. These influences are perhaps most eloquently described by McWilliams (2000:373) in her description of the denigration of psychoanalysis and what she describes as the perilous state of psychodynamically informed talk-therapy:

In the United States, the voice of the individual practitioner is no match for corporate forces. Managed care organizations, whose focus on the bottom line demands promulgating the myth that long-term therapies are ineffective, brand psychoanalytic approaches as empirically unsupported and productive of an unhealthy dependency. Disturbing adaptations to market forces corrupt the very definition of psychotherapy, as HMOs insist that a couple of sessions with a provider willing to sit on their panels and comply with their profit-driven restrictions constitutes the standard of care...The public, although increasingly upset about managed care in general, is still largely ignorant about the magnitude of erosion in their psychotherapy coverage. Even when it is widely known that good mental health care is impossible under the terms of many insurance plans, the stigma associated with psychological disabilities discourages all but the bravest from imploring our union representatives or employers for better mental health benefits.

Barlow (1996:1050-1051) explains that it is not just managed care that influences practice. In fact, before managed care, per se, arrived on the scene, clinical practice guidelines - first from government agencies and then from the American Psychiatric Association - were highly influential in pushing practitioners to focus on efficiency and
Practitioners who did not follow these guidelines were not protected against malpractice suits. These guidelines, which encourage pharmacological treatment and generally downplay the effectiveness of talk-therapy, emerged first for depression and not long after for many other illnesses, such as eating disorders, substance abuse, and bipolar disorder. Powerful lobbying groups such as NAMI (National Alliance for Mental Illness) have also pushed for the legitimacy of the biological model.

Finally, some argue, ushering in the biological model was intended to protect the professional dominance of psychiatrists in the field of mental health, especially since the psychodynamic model opened the door for psychologists, social workers, and even laymen to engage in talking cure treatments (c.f. Kirk and Kutchins 1992:8). “By 1980, psychologists in private practice provided as much outpatient treatment as psychiatrists” as did social workers; One third of treatment was by psychiatrists, another third by psychologists and the last third by social workers (Hale 1995:340).

Taken together, these powerful influences led to a psychiatric community\(^\text{20}\) that widely accepted the dominance of the medical model and relied on treatment with psychototropic medications. In-depth talk therapy now occupies a peripheral status in psychiatric treatment. Emblematic of and also driving this radical change was the 1980 publication of the American Psychiatric Association’s new version of its Diagnostic and Statistical Manual (DSM III). The new manual - the taskforce for which was chaired by

\(^{20}\) In the mental health professions at large there is more fervent debate, usually involving psychologists, social workers and other non-medically trained practitioners, though they too are highly influenced by clinical practice guidelines and managed care practices.
Columbia University’s Robert Spitzer (retired Professor of Psychiatry at Columbia University, and Chief of the Biometrics Research Department at the New York State Psychiatric Institute) and his colleagues, all deeply biologically-minded psychiatrists - replaced DSM II, the edition that was grounded in Freudian theory\textsuperscript{21}. Again, because of its underpinnings in psychoanalytic theory, the conditions in DSM II were classified very broadly. They were presumed to stem from psychological problems (e.g. repression or response to trauma) and were treated, therefore, by uncovering the roots in the psyche (Shorter 1997:299)\textsuperscript{22}. DSM III drastically shifted the focus of psychiatry to pathologies (real illness entities that deviate from normal functioning) that stem from biological malfunctioning.

The release of DSM III is widely accepted as “...one of the most significant events in psychiatry in the last half of the 20\textsuperscript{th} Century” (Kirk and Kutchins 1992:6). Gerald Maxmen, author of the popular book *The New Psychiatrists*, unequivocally supports the notion that “...the ascendance of scientific psychiatry became official” because of DSM III. Maxmen claims, further, that

...on this day, the APA published a radically different system for psychiatric diagnosis...By adopting the scientifically based DSM-III as its official system of diagnosis, American psychiatrists broke with a fifty year tradition of using psychoanalytically based diagnoses. Perhaps more than any other single event,

\textsuperscript{21} For a more complete history of the development of DSM III, see especially Hale 1995; Shorter 1997.

\textsuperscript{22} The basic ideas for DSM III were based on diagnostic categories that came to be known as the Feighner criteria, and were developed by a group of psychiatrists often referred to as neo-Kraepelinians because of their reliance on a strict classificatory system for the symptoms of mental illness. For a more thorough discussion, see especially Horwitz, 2002; Klerman 1977; Shorter 1997:300-301.
the publication of DSM-III demonstrated that American Psychiatry has indeed undergone a revolution. (quoted in Kirk and Kutchins 1992:7)

DSM III (and its more recent counterparts, DSM IV, IV-tr, and in 2013, V) classifies illness entities that are identified based on particular symptoms and become the focus of treatment. In contrast to the emphasis in psychoanalysis on comprehending symptoms contextually in the life histories of the individual, mental illness is now viewed as biologically borne and chemically driven. As Horwitz (2002:57) succinctly explains, diagnostic psychiatry “regards diseases as natural entities that exist in the body and that generate the particular symptoms a person displays.” The biological paradigm is concerned with disorders of the brain that produce symptoms that are identified in systematic ways and treated with medication, which is often both the beginning and end of treatment (Cassel 2004). Biological psychiatry re-conceptualized as organic illness conditions what were, in the dynamic tradition, considered a basic part of the human psyche (Horwitz 2002:68). Mental pain and suffering became something diagnosable and something located in the physical brain, and was therefore treated with alterations in the chemical properties of the brain. This is what Gilman (1987) described as a “re-Kraepelinization of American Psychiatry” (312) and what Rogler (1997) describes as a “remedicalization” of psychiatry. These theorists and others suggest that the move to biological psychiatry is a step backward toward pre-Freudian theories of illness.

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23 Emil Kraepelin is widely identified as the founder of scientific psychiatry. He was the first to develop a classification scheme of mental disorders and he conceptualized mental illness as biological, genetic malfunction.
Characteristic of this move toward symptom sets and discrete categorizations is the difference in the conceptualization of anxiety in DSM II and DSM III. DSM III (and its more recent counterparts), conversely, characterizes illnesses as discrete categories - disease entities that can be identified based on particular symptoms and that represent various types of pathology or abnormality. The motivation for the new edition of DSM was not novel realizations about the illnesses described therein. In part, the new discrete categorizations represented the desire of newly empowered pharmaceutical companies to prescribe medications for specific illnesses. In part they were a useful system for insurance companies in their attempts to manage psychiatric care and cut the costs of treatment. But the most poignant motivation was related to the desire to remove Freudian language from the American psychiatric landscape. By the time DSM IV was published in 1994 the term “neurosis,” the key term in psychodynamic theory and the concept at the heart of psychoanalytic treatment, was removed from the manual (Shorter 1997). What were neurotic conditions in the era of DSM II are now considered to be separate disease entities, evidenced by the categorizations of the now various “Anxiety Disorders.”

DSM III classifies Panic Disorder, Social Phobia, Simple Phobia, Obsessive Compulsive Disorder, Post-Traumatic Stress Disorder, and Generalized Anxiety Disorder each separately by specific symptom sets. For instance:

**Panic Disorder:**

A. At some time during the disturbance, one or more panic attacks (discrete periods of intense fear or discomfort) have occurred that were (1) unexpected, i.e. did not occur immediately before or on exposure to a
situation that almost always caused anxiety, and (2) not triggered by situations in which the person was the focus of others’ attention

B. Either four attacks, as defined in criterion A., have occurred within a four-week period, or one or more attacks have been followed by a period of at least a month of persistent fear of having another attack.

C. At least four of the following symptoms developed during at least one of the attacks:

1. shortness of breath (dyspnea) or smothering sensations
2. dizziness, unsteady feelings, or faintness
3. palpitations or accelerated heart rate (tachycardia)
4. trembling or shaking
5. sweating
6. choking
7. nausea or abdominal distress
8. depersonalization or derealization
9. numbness or tingling sensations (paresthesias)
10. flushes (hot flashes) or chills
11. chest pain or discomfort
12. fear of dying
13. fear of going crazy or of doing something uncontrolled

**Note:** Attacks involving four or more symptoms are panic attacks; attacks involving fewer than four symptoms are limited symptom attacks...

D. During at least some of the attacks, at least four of the C symptoms developed suddenly and increased in intensity within ten minutes of the beginning of the first C symptom noticed in the attack.

E. It cannot be established that an organic factor initiated and maintained the disturbance, e.g., Amphetamine or Caffeine Intoxication, hyperthyroidism.

**Note:** Mitral valve prolapse may be an associated condition, but does not preclude a diagnosis of panic disorder. (APA 1987)

Here, the specificity of the DSM III illness categories is evident, as is the focus on specific symptoms, many of which are physical. In particular, the description of panic disorder, above, accomplishes three crucial tasks at the heart of the biological model. First, it
distinguishes panic disorder from other kinds of anxiety disorders (point A). Second, it defines the duration of symptoms necessary for a diagnosis (point B). And third, it identifies the specific symptoms, which assesses the severity of the condition (points C and D).

DSM III provides for psychiatry the same kind of threshold measurement used in other branches of medical practice, which all seek to identify not only disease itself but also “risk factors” for its potential future development. In this way psychiatry, mirroring what has happened in medicine at large, has aided in the expansion of what Jeremy Greene (2007:4) calls “the domain of chronic diseases.” Whereas only the most severe symptoms used to be considered illnesses, today diseases are “…loose categories that themselves have never been connected to symptoms, entities such as mild hypertension, elevated cholesterol, and mild diabetes” (Greene 2007:7). In psychiatry the parallel would be, for instance, “dysthymia,” a commonly diagnosed, low-level depression that lasts over many months, or bipolar-II, a sub-threshold category of bipolar disorder that is markedly less severe than full-blown manic and depressive episodes. Horwitz (2007) shows that many low-level symptoms that used to be seen as “natural results of the stress process” are considered to be pathological under the current diagnostic system in psychiatry. Further, Horwitz (2002) shows that studies of mental health tend to dichotomize experiences (one is either well or ill), as is the case in psychiatry today, rather than conceptualize them as experiences along a continuum (behaviors, thoughts, actions, and emotions are not necessarily healthy or disordered).
The dichotomous classification has led to an inflation of the number of people who are seen as disordered. Greene explains the movement toward sub-threshold diagnoses in medicine at large:

By the close of the 20th Century...the diagnosis of any of these conditions required only numerical measurement above a statistically defined threshold. A blood pressure higher than 130/80 mm Hg was now hypertension. A blood LDL...cholesterol level greater than 160 mg/dL was pathologically elevated...these numbers are now central to the practice of diagnosis, their precision and standardizability allowing for a definition of disease in which the physical perceptions of doctor and patient are irrelevant. (7-8)

If it is to maintain evidence-based practice, DSM is crucial for psychiatry because there are no lesions to uncover, no “pathognomonic sign” (disease-naming marker) (Greene 2007:8). Thus, the discernment of disease is much less clear for psychiatrists, and identifying symptomatology is that much more important. In fact, after chapters describing the neurobiological foundations of mental illness and treatment, Hyman and Nestler (2005:173) write in their widely used neuropsychiatry textbook that:

Vulnerability to many of the most severe psychiatric disorders appears to be heritable, and identification of the specific genes and proteins involved would similarly revolutionize the practice of psychiatry. However, despite great effort, at the time of this writing, it has not yet been possible to identify the specific genes responsible for mental disorders.

DSM III is a tool of the medical model and contemporary psychiatrists regard the manifestations of these mental processes (symptoms) as the basis of treatment. At the center of diagnostic thinking is what Conrad (1992:211) describes as medicalization, a trend so central to modern medicine (and the modern world for that matter) that it is the crux of the legitimacy of the medical professions. According to Conrad:
Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using medical intervention to treat it...Medicalization occurs when a medical frame or definition has been applied to understand or manage a problem...

Because Diagnostic psychiatry equates psychiatric symptoms with medical disorders, mental illnesses can be discussed in medical terms and treated with medications. Anthropologist T. M. Luhrmann’s (2001:36) unique ethnographic work with psychiatry residents describes the influence of training in the medical model:

By the time young psychiatrists have finished training they can recognize the disorders immediately, the way plane spotters can spot Boeing 747s, the way bird-watchers can spot great snowy owls, the way dog lovers know the difference between a Jack Russell terrier and a beagle.

This medicalized version of illness is a direct consequence of a psychiatric paradigm shift from regarding personhood as a central element in understanding psychiatric conditions (dynamic), to a relative inattention to explication of illness and a reliance on surface-level evaluation of symptomatology (biological).

This central role of diagnosis, combined with changing beliefs about etiology, moved psychiatry from a discipline centered on talk-therapy to one formally similar to the field of medicine at large. Luhrmann (2001:112) eloquently characterizes the vast differences between the two approaches when she describes the division of dynamically and biologically oriented psychiatrists in training programs. She says, “I rarely – I am inclined to say never – heard a psychodynamically oriented psychiatrist discuss diagnostic categories in a supervision.” Her statement about medical school classrooms is just as striking:
Some mornings, men would come in wearing white medical coats. They would talk about neurotransmitters and catecholamines and draw diagrams of biochemical interactions on the board...other mornings, men...would arrive in tweed jackets, wearing spectacles. They would sit, hands folded, and talk with us about loss, mourning and the nadir point in psychotherapy. (5)

The insinuation, here, is that *it would never be the same man giving both talks.* This poignantly summarizes the theoretical divide between biological and dynamic psychiatrists in hospitals in the 1980s. Consider also the following interaction between then psychiatry resident Robert Klitzman (in reference to one of his patients) and one of his supervisors. He describes the following as prototypical of his experience in a prominent psychiatric residency program:

**Klitzman:** “She says she’s depressed.”

**Supervisor:** “That’s not enough for a diagnosis.”

**Klitzman:** “She looks kind of depressed, too”

**Supervisor:** “Lots of people say they’re depressed, but if she doesn’t meet these criteria, we don’t have target symptoms to follow for marking her progress and if we don’t it’s not worth treating her...remember to always DSM-III-r your patients in the beginning.” (Klitzman 1995:76)

Klitzman trained during the 1980s, when psychiatry residents were at the heart of the clash between those who still advocated for psychodynamic principles and those who propelled the shift toward biological treatments. He describes receiving competing advice from a psychodynamically trained psychiatrist, who lectured him on listening more holistically to the same distressed patient (above), and urged him to learn about the world in which she finds herself (Klitzman 1995:70).
Though critical, Kleinman’s (1988:17) description of the psychiatrist trained in diagnostics is informative. He explains that the:

...tale of complaints becomes the text that is to be decoded by the practitioner cum diagnostician. Practitioners, however, are not trained to be self-reflective interpreters of distinctive systems of meaning. They are turned out of medical schools as naive realists...who are led to believe that symptoms are clues to disease, evidence of a ‘natural’ process, a physical entity to be discovered or uncovered.

Again, this is dramatically different than the philosophically and psychologically oriented psychodynamic training. Similarly, after immersing herself in a psychiatric training program, Luhrmann (2001:68) observes the central tension between psychiatric paradigms:

[In the biological model] [t]he person diagnosing learns to distill a diagnosis out of a patient’s narrative and to see that many different lives share a common label. In psychodynamics, the models are rarely taught and memorized abstractly. For the most part, the models remain specific, as something some patient did at some time that is kind of like what she did some months later.

In the diagnostic tradition psychiatrists are not concerned with the individual or case-specific elements of the patient’s experience. In fact, they are trained not to be. A psychodynamic practice, conversely, would concentrate on individual-level meaning, leaving practitioners with case-specific information, much of which is so intimately related to the individual patient that it cannot be generalized. Though this was seen as a strength in the eyes of the psychodynamic practitioner, this idiographic (unique, subjective, characteristic of the humanities) view was seen as a major downfall of the psychoanalytic model, one that the biological revolution was aimed at generalizing. For
the biological, diagnostic psychiatrist it is the nomothetic (generalizable, and considered scientific) view that is most useful for understanding and treating mental illness.

This increasing centrality of diagnosis and biological thinking in medical practice leads to what Kleinman (1988) describes as characteristic of modern medicine: the separation between “illness experience” and “disease.” While the former represents the patient’s experience of a condition, the latter represents the doctor’s perspective on symptomatology, regardless of the patient’s understanding. Because of the prominence of the medical model in psychiatry, practitioners focus on disease as defined by the Diagnostic and Statistical Manual of Mental Disorders and have oft been accused by patients and theorists alike of ignoring patients’ illness experience. Similarly, Cassell (2004) notes that medical practice is no longer interested in the stories behind illness or the complete picture of conditions. Therefore practitioners are not trained to question the meaning and derivations of conditions, but rather to treat symptoms in the here-and-now and to focus on the body rather than the mind of the patient. Essentially, the meaning-making process has taken a backseat to symptom alleviation. In the contemporary medical model, it is only in cases where a patient does not fully fit a diagnostic category or expresses confusing symptoms that a more detailed history of the etiology of symptoms might be uncovered, not as a way to understand the patient’s experience or the meaning of her symptoms, but as a way to more accurately diagnose a disease and make sense of her symptoms. Many critiques of the diagnostic model are aimed at this lack of humanity and contextualization that characterizes modern medicine. Karp (1996), for instance, describes the frustrating experience of medical
diagnosis for depression; he recognizes the need for medical intervention, though explains the pain of not feeling understood in that model.

The DSM model is central for logistical reasons as well; a diagnostic system provides clear ways for understanding symptoms, which makes it easier to enact a treatment plan. As they are socialized into the discourse and practice of their field, psychiatry residents are rarely taught that the diagnostic method is one possibility in a range of treatment forms, but rather that the medical model is the means for treating illness. In fact, the socialization of psychiatry residents into the DSM model is one of the primary ways the biological model maintains its place as the dominant treatment modality in the United States. The salience of the DSM model, however, leads to a quite narrow view of what illness and treatment are.

Learning how to diagnose is a skill which psychiatric residents must learn before all others...paradoxically, however, as residents become more seasoned practitioners, diagnosis no longer retains this preeminent role; one learns to formulate a plan of treatment more by feel and common sense. But this may be no paradox at all if ‘feel and common sense’ have by that time become imbued with the psychiatric mode of diagnosis. (Light 1980:160)

The diagnostic categories become so much a part of the psychiatric worldview that they are internalized by practitioners, who feel as though they are classifying natural, objectively observable phenomena. In fact, this is one reason psychiatrists note a pull towards diagnostic psychiatry: it offers a connection to scientific rigor in a discipline whose Freudian legacy is often ridiculed by other medical fields for its lack of rigor.

Summary
This history of the last two decades in psychiatry is one in which proponents of the biological model have triumphed; there has been a radical alteration in the face of American psychiatry in a relatively short period of time. Until the 1980s, psychodynamic theory was dominant in psychiatric training, and psychoanalytic practices flourished, especially in major cities across the United States. For a paradigm that cannot offer the identification of a physical lesion, as in the case of cancer or arterial disease, the biological model in psychiatry has been remarkably successful at shifting the dominant conceptualizations of mental illness – perhaps even more so than Freudians were in the 1920s and 1930s. In the most general sense, the shift from dynamic to biological psychiatry can be understood as a shift in what psychiatrists regard as figure and ground. The greatest transformation is from personhood (captured through intensive meaning-making practices) to symptom (categorized through diagnosis) as figure, and likewise, from symptom to personhood as ground. In dynamic psychiatry symptoms are a jumping-off point that lead a practitioner to locate condition expression in the context of patients’ lives, whereas in the biological era, symptoms are often the start and endpoint of treatment. Practitioners trained in these two treatment paradigms are the product of thought communities (Fleck 1935) that provide different schemas for understanding or sociomental lenses (Zerubavel 1997) for seeing patients and their troubles.

24 These terms are derived from the notion in Gestalt Psychiatry that there are certain things in the environment of which we are aware (figure) and those that fade into the background (ground). Our perception of certain things as figure and others as ground is based on culture and socialization; we are trained to see some things and to disattend others (Zerubavel 1997).
In the contemporary world, Freudian psychiatry and psychodynamic therapy do not exist as the ideal-typical images presented in much explication of mid-1900s psychiatric practice. Most contemporary psychiatrists have little to no training in anything other than the medical model, and even psychologists, who are usually trained in some in-depth talk therapy in their graduate career, are not commonly psychodynamically oriented – short-term treatments and biological thinking have taken over psychological training programs as well (McWilliams 2000). This is fuelled by myriad forces, but the result is that both psychology and psychiatry students today are trained in professions that are not amenable to practicing psychodynamically informed kinds of therapies. Nancy McWiliams explains:

My current students talk movingly about their fears that the world into which they will graduate will not allow them to practice psychotherapy in a way that makes any sense to them...However dispirited my psychology students are, the situation of medical students, residents, interns, and beginning psychiatrists is even more dire. Recent figures on the cost of medical training show that the average debt of graduating medical students is now more than $75,000. In many programs debt exceeds $100,000. Who can afford the modest financial rewards of the psychoanalytic practitioner under these circumstances... If one is a doctor, it seems there is no cachet in being a therapist. (373)

Even for students who might want training in in-depth psychotherapy, it is cost prohibitive. And for doctors, choosing psychiatry (especially talk-therapy, which is less financially fruitful than psychopharmacology both because of lower session fees and a smaller market of potential clients) as a specialty is not nearly as financially viable as other specialties. Moreover, after choosing psychiatry as a specialty, and paying for training in psychoanalysis, psychiatrists cannot charge as much per session for talk
therapy as they can for biological treatments because psychologists and social workers offer that service at a lower fee. In order to have any significant pool of patients, MDs must lower their otherwise much higher fees. It is also certainly less prestigious, today, to be a therapist if one is a medical doctor, since practitioners with PhD, MSW and PsyD degrees can also practice talk therapy. In fact, medication treatment is the greatest differentiating factor between psychiatrists and other mental health professionals, who are often better trained to practice in-depth talk therapies than MDs. Strauss et al (1981:368) describe “different professions or their representatives” as moving in on the “province of mental health, which has been defined so far as the province of psychiatry, a branch of medicine.” Further, Kirk and Kutchins (1992:8) explain that DSM III, which lays out the criteria upon which medical treatment in based, was created at least partly in order “to reverse diffusion of power to other professions in the mental health enterprise.” In sum, the use of DSM and maintaining exclusive rights to prescribe medication are often cited as ways in which psychiatry has fought to protect the guild. Of course, patients also increasingly seek medical care for psychiatric symptoms, given that psychotherapy has lost its allure in recent years and that it has become so common to take psychotropic medications.

The central themes of both the psychoanalytic and biological paradigms, and particularly the theoretical chasm the literature suggests ought to be found between them, is the guiding framework for the questions asked of practitioners in this study. How dominant is the biological paradigm in practice? How much tension is there really

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See Appendix A for the interview schedule.
between the dynamic and biological approaches? Why and under what conditions is this tension experienced? Is being a psychiatrist today conducive to being a talk-therapist or has the biological model eclipsed the talking cure? And, are these tensions relevant for psychologically trained psychoanalysts as well? Given this relatively recent yet drastic change in the approach to treating psychiatric problems, we should expect that psychiatrists would be much more oriented toward the biological model than the psychodynamic, that psychologists would be significantly less medically minded than their psychiatric counterparts, and that those practitioners trained in both the medical and psychodynamic models will have to contend with the tensions between these two paradigms. For answers to these questions and to see how these issues play out in practice, I turn now to the narratives of the psychiatrists and psychologists in my sample. In the following chapter, I highlight the issues of utmost importance for my interviewees and for psychiatrists and psychologists at large. Many of the key issues in practice today stem from those that have long been present in the field and that I have described in this chapter.
CHAPTER TWO

Key Issues in Practice

In this chapter I identify to what extent the biological and psychodynamic models operate in my interviewees’ practices. In practitioners’ narratives of the central issues in their field, some of the essential differences between the biodynamic, psychodynamic and biological groups are evident. As expected, the biological group is clearly the most medically oriented and the psychodynamic group the most likely to favor psychodynamic principles. To some extent this maintains the boundaries between the models and the doctors who operate within them. However, many of the central disparities between the psychodynamic and biological groups that existed in the field just a few decades ago are much less marked than they once were. This is largely because medications and standard diagnosis have become essential to mental health treatment.

I begin this chapter by exploring what my interviewees see as the overarching purpose of their discipline - the contribution psychiatry and psychology make to society. In these answers there is a wealth of information about treatment goals and how practitioners feel as members of a discipline that has undergone radical changes over the last several decades. I then explore three specific issues that help identify the role of meaning-making and medical treatments in practice: thoughts about etiology, the utility of medication (including how to discern which patients are candidates for medicines), and the role of DSM in their work. Finally, I present explanations from the biodynamic and psychodynamic groups as to what they feel sets psychodynamic therapy apart from
other kinds of treatment. My data clarify why these thirty doctors chose to train for an additional five years in this intensive brand of talk-therapy (even though this creates ideological and practical tensions for them, which we will see in chapters four and five), and highlight some key differences between medical and psychoanalytic training. In sum, I introduce the central issues that emerged in my interviewees’ narratives (which I also detail in chapter three), and explore some of the tensions between the paradigms (which I describe more fully in chapter four).

**Characteristics of Practice and Treatment Goals**

To fully appreciate the descriptions to follow it is crucial to know how much talk therapy and how much biologically based treatment these doctors practice\(^1\). My interviewees see, on average, seventy-three patients in their practice overall, though the range is from eight to 500. However, it is much more meaningful to break this down by subgroup. For biodynamic psychiatrists, the average is fifty-five with a range of eight to 300\(^2\) and dual modes of twenty and one hundred. The modal numbers, twenty and one hundred, are telling; because this group is trained in both psychoanalysis and biological treatment their practices can vary significantly depending on the way their patient population plays out in a given year (or month for that matter), and in particular on how many analytic patients a doctor sees, since each case takes up four office hours

\(^{1}\) See Appendix Two for a full table of this data.
\(^{2}\) Someone who sees eight patients likely has a heavy teaching load, or is practicing part-time. Someone who sees 300 patients is likely to do a lot of hospital work, and see hundreds of patients very infrequently. Both numbers are actually very unusual for the biodynamic group and therefore skew the average.
per week\textsuperscript{3}. Further, these two modal numbers for the biodynamic group are representative of a very significant cohort effect. Though the majority of the biodynamic psychiatrists in my sample trained around the time when the shift toward biological dominance in residency programs was crystallizing, and are therefore much more attached to the biological model than their more senior counterparts, there are seven doctors in the biodynamic group who are over the age of sixty and who, therefore, trained before the shift in 1980. They are much more likely to practice in a manner resembling the classic psychoanalytic model, though because they all prescribe medicines, the biological model is certainly a major factor in their work and their conceptualizations of patients’ troubles. It is only on a few factors that they differ markedly from the rest of the biodynamic group. The biodynamic group is much more heterogeneous than either the biological or psychodynamic groups; biological psychiatrists are largely trained in diagnosis and psychodynamic psychologists are almost entirely trained in the psychodynamic model. One exception to this is in the biological group, as we shall see, where some doctors are strictly psychopharmacologists and others practice some talk therapy.

For the psychodynamic psychologists, the dual median numbers of patients are fifteen and twenty. The range is from eight to thirty with a mode of twenty. Finally, for the biological psychiatrists, the median number of patients and the modal number are both one hundred. The range is twenty – 500. The modal numbers quite clearly and

\textsuperscript{3} In fact, within the groups, the modal number is much more telling than the average since there is at least one atypical doctor in each group, and given the small group size this can drastically alter the averages.
accurately show the differences between the groups; in particular, it is telling that the two modes for the biodynamic (i.e., twenty and one hundred) map precisely onto the psychodynamic psychologists and biological psychiatrists, respectively. This is representative of their dual training and the extent to which their practice can differ in terms of size and the kind of treatment they offer their patients. They can look either much more biological or much more dynamic, though their thinking and opinions are not drastically different even if their practice is.

It is also important to note a difference in the frequency with which practitioners see their patients. Analytic patients are seen four times per week. For the biodynamic and psychodynamic group, most other regular patients are seen either once or twice per week, though the biodynamic group may see a small number of patients for medication only. Usually these are patients in treatment with a fellow analyst who has either chosen not to do the prescribing for their own patients or who is a psychologist and therefore cannot prescribe medicines. Treatment also varies depending on patient’s insurance, financial status, and symptoms. Psychologists do not see patients for medication and therefore rarely have infrequent patients, though if they see child patients they may occasionally see a patient only a few times for educational testing, something only psychologists are qualified to perform. Otherwise all their patients tend to be regular, which helps explain why the average number of patients for the psychologists is low and the mode is only twenty. If, for instance, three patients are in analysis (twelve hours per week) and the rest are in two-time-per-week therapy (thirty-
four hours), and if teaching, supervising, and committee responsibilities take up another several hours per month, a psychologist’s practice is full even with only twenty patients.

For the biological psychiatrists it is much more variable. A great majority of their patients are medication-only patients (who may be seen for as little as twenty or thirty minutes and as infrequently as every few months). As I mentioned above, there is a divide between biological psychiatrists who spend the majority of their time prescribing medicines and those who practice talk-therapy regularly\(^4\). The definition of regular patients is variable for the biological group; they might see anywhere from a few patients (as with psychopharmacologists) to up to half their practice for some version of talk therapy. However, there are very few biological psychiatrists who see patients more than once a week, and they may only see patients they consider to be regular once or twice a month. They also do not generally practice psychodynamic talk therapy, which means the meaning of talk therapy is quite different from that of the analysts. Much of the time in therapy with these psychiatrists is spent checking up on how things are progressing with medicines. They might also briefly discuss general life issues, changes, or trends in patients’ lives. Even the biological psychiatrists who do not report seeing patients for medication understand talk therapy very differently than the biodynamic or psychodynamic practitioners.

Particularly telling is how many patients are taking medications, how many see psychiatrists for medications only, and whether psychoanalytic cases make up any

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\(^4\) This is the reason for two separate portraits from the biological group in chapter three.
significant number of the patient pools for the biodynamic and psychodynamic groups. Again, because my sample is varied, I report medians and modes instead of means; they are much more accurate descriptors. For the psychodynamic practitioners the median numbers of patients who take psychotropic drugs (though another doctor prescribes them) are six and seven with dual modes of six and nine. The median numbers of patients who do not take any medicines are nine and ten with a mode of six. Thus a significant number of psychodynamic psychologists’ patients take medicines.

However this study is indicative of a crucial need to understand practice on a much deeper level than via these kinds of statistics. For instance, the modal number of psychiatrists who see patients for medications only for the biodynamic group number is fifty whereas it is twenty-five for the biological group. On the surface, it would seem as though the biological group is in fact performing more talk therapy than the biodynamic group. However, an alternate and much more accurate explanation for the counterintuitive finding that biological psychiatrists see fewer patients for medications alone than do the psychoanalytically-trained biodynamic psychiatrists has to do with income and the financial viability of their practice. If a biodynamic psychiatrist sees half of the patients in her practice for talk therapy, she is pushed to see medication-only patients to make up for the financial loss of seeing patients in talk therapy, for which she will make far less money than she will for writing a prescription. A biological psychiatrist, on the other hand, who sees patients for medications only Even though the biological group sees far more patients for short, medication-based visits, they may not

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5 See Appendix Two for summary tables.
consider these visits medication only visits, whereas a biodynamic psychiatrist who is trained in in depth talk therapy will consider any patient who is not in regular in-depth talk therapy as a medication only patient. In other words, the very definition of therapy influences the ways interviewees respond to this question. Thus, the more telling numbers are as follows: For the biodynamic group, the median percentage of patients who take medications is fifty as is the median percentage of patients who do not take any medicines. For the biological group, the dual median percentages of patients who take medicines are ninety and ninety-five and the median percentage that does not take any medicines is ten. As the literature suggests, of my three groups, patients who see biological psychiatrists receive the most medications, which is a much more objective measure of their biological orientation than their reported therapeutic cases.

Finally, it is noteworthy that such a small percentage of patients are in psychoanalysis: for the biodynamic group, the median number is ten as is the mode is. For the psychodynamic group, the medians are zero and four and the mode is zero. While the range extends from zero to six for the psychodynamic group, it is telling that half the sample does not currently have any psychoanalytic patients. However, this is not entirely unexpected. For a range of reasons I will explore there are numerous cultural and structural barriers to having a practice based in psychoanalysis. It is notable that the biodynamic group sees on average more analytic patients than the psychodynamic group. Psychoanalysis is time consuming and requires practitioners to reduce their hourly fees, since it is rare that a patient can afford four-time-per-week treatment at a full fee. Thus, it is possible for MDs to see enough medicine-only patients
to make up for loss of wages due to the reduced fees that come with seeing patients multiple times per week. The psychodynamic group does not have this option and therefore may not be able to take on more analytic patients. Further, these numbers do not tell all since even the patients the psychodynamic group sees once or twice per week (who do not “count” as analytic patients) are in talk-therapy based on psychodynamic principles. Even if the frequency of the treatment is less than traditional analysis would dictate, the underlying principles of the treatment is the same.

In general, these numbers are indicative of the treatment goals of each of these types of practice. All three groups share the goal of symptom reduction, whether it is through medical means or via the use of talk-therapy; all of the practitioners in this study aim to make the lives of their patients more comfortable, and in severe cases, livable. For the biological group, symptom reduction is the main goal – treatment begins and ends there. Thus it makes sense that they prescribe the greatest amount of medication. For the psychodynamic group, symptom reduction is important, especially if a patient presents with a condition that is impeding or destroying his or her life. Though symptom reduction is an early goal, it is not the only and certainly not the ultimate one. Psychodynamic treatment is mostly focused on understanding and knowing oneself. Therefore, the fact that fewer patients treated by the psychodynamic group take medicines than the other groups is not surprising; that nearly half their patients take medicines is startling, since the psychodynamic perspective has generally regarded symptom reduction as a secondary result of new self-knowledge. For the biodynamic psychiatrists, the extent to which symptom reduction is the primary goal is dependent
on the patient’s symptoms. Thus it makes sense that they are in between the psychodynamic and biological group in terms of the percentage of patients taking medicines.

To return to an earlier point, it is important to note that the numbers do not tell the whole saga here. What the biological psychiatrists consider to be talk therapy (what they provide to the few patients who are not taking any medicines and some who are) is vastly different than the kind of talk therapy offered by the analysts. For the former, they may see their patients very infrequently and practice much more problem-focused therapies that are often based on a version of Cognitive Behavioral Therapy. Or they offer what they describe as “supportive” therapies that are mostly aimed at providing some basic counseling to patients. Psychoanalytically trained practitioners may see patients who take medicines and may not practice much traditional psychoanalysis (for a range of reasons I explore shortly), but they think dynamically nonetheless. Dr. Coffrey [psychodynamic] is one of the few practitioners in my sample to currently work in a clinic setting with patients who have psychotic symptoms, and to also be a specialist in CBT even though she is an analyst. This setting is not one in which traditional analysis or even in-depth talking treatments are possible, but rather where short-term behavioral treatments are much more realistic. She is therefore able to explain how psychodynamic principles can be crucial to a treatment even if the treatment itself is not psychodynamically oriented:

Everybody has a psychology. Everybody has psychological conflicts, and how they manifest themselves and what you do with them is different [for different kinds of patients]. I mean, this is a clinic for people with schizophrenia, basically.
These people come in, and they’ve got some of the same issues with their mother, their father, their feelings of this and that. But is that what you’re going to be treating them for? No, not generally...And it doesn’t mean you don’t use it as part of what you’re thinking about in how to approach them...they have an unconscious emotional conflict. Even if the person is coming in for CBT and just wants to get over the panic of elevators, or they want to get on dates or something like that, and you’re going to treat it with just that straightforward [approach], you can still have a psychodynamic understanding of it. In my CBT supervision with residents we will talk about all of that. Treatment wise, we don’t deal with it, but it will help explain a little bit to the resident what is going on. Then also, you have a better idea again that you’re doing the right kind of treatment. You haven’t forgotten something. If you understand, then say, “Yes, this is an issue here,” but it’s not the primary issue for this patient, or it’s not the cutting edge issue. And by doing that, then you can feel, “Okay, I really have considered the patient’s issues and not just put them into [a certain] treatment because that’s what I do.”

Psychoanalytic training is not just about engaging in psychoanalytic treatment, but about learning to see the complexities involved in people’s thinking and problems. It is for this reason that many psychoanalysts report doing the extra five years of training necessary to become an analyst. As Dr. Haman [psychodynamic] describes in response to my question as to why she became a psychoanalyst:

...I just had the sense from talking to people and from wherever, I don’t know exactly all of where, but mostly maybe my therapist [a psychoanalyst who she saw for many years starting in college] that it would just make me a better clinician, and even if I never did any analysis again on anybody, that it would have an influence on my work with everybody, which it absolutely has.

Thus the numbers are telling, but they do not necessarily inform us about the lens through which practitioners see their patients, or their schemas that dictate thinking about etiology and appropriate treatment. In the description Dr. Coffrey provides above, it is clear that she finds it useful to think dynamically even about patients to
whom she knows there is no chance of offering psychoanalytic treatment. This is what leads Dr. Kane (psychodynamic) to tell her psychology graduate students: “even if you don’t go on in psychology or analysis you can broaden or enrich your perspective” by learning the principles of dynamic treatment. A practitioner does not need to see a patient four times per week or be formally trained in psychoanalytic treatment in order to make use of psychodynamic principles. This, in fact, is often what both the biodynamic and psychodynamic practitioners point out – that they do not expect everyone to be trained in psychoanalysis (nor was this ever the case), but rather that psychiatry students should be exposed to basic dynamic principles and the tools for meaning-making practices instead of only being taught about diagnosis and medicines.

The perceived contributions of psychology, psychiatry and psychoanalysis

How these forty practitioners understand the contribution their profession makes to society at large informs the way they think about and see their allegiance to particular treatment modalities. These answers also underscore some of the differences in the treatment goals between the three groups – namely the use of the biological model for symptom alleviation, and psychodynamic therapy to explore the psyche and provide the patient with self-awareness.

For the psychodynamic psychologists, Dr. Brighton summarizes beautifully what she thinks the contribution of her field is to society. She says:

I think it’s a gift to offer anybody the chance to get a grip on their unconscious destructive behavior, to think about the meaning and purpose of their lives, to
dabble in freedom and choice. Those are just huge. Not to mention symptom relief; relief from day-to-day suffering. If you can be the person that helps with that, it’s very nice.

Dr. Brighton captures the essence of the psychodynamic group’s feelings regarding what both their profession at large and they, as individual practitioners, offer people: the possibility to understand themselves, first and foremost. This may come along with symptom relief, but the primary goal is to explore the psyche and to have more personal control.

Given their psychoanalytic training, the biodynamic psychiatrists are also attuned to the potential benefits for patients’ overall self-concept and behavior. However, they are more focused on the contributions to understanding illness and treating disorder than the psychodynamic group. Dr. Warren (biodynamic), for instance, shares her ideas on the contribution of psychiatry:

If you look at the schizophrenic population, I think the medications and the treatment have made a huge difference…When you look at the more serious illnesses, it’s pretty obvious. I think when you look at the more neurotic stuff, it’s a little controversial and a little bit less clear. When it comes to the more neurotic stuff, and the personality disordered stuff, I personally think it makes a difference. And I’ve certainly seen a lot of patients get much better and that’s tremendously rewarding, and I actually think I see them get much better than the schizophrenic patients ever can. But it seems less easy to quantify in a research sort of setting, but clinically it does seem to be the case.

Dr. Warren talks in terms of illnesses, which represents a major difference between herself and Dr. Brighton (above). Part of the reason for this is that Dr. Warren focuses on psychiatry, a medical field, while Dr. Brighton is specifically talking about psychodynamic treatment. Dr. Warren also points to an oft mentioned dichotomy in
treatment between the most ill patients (who, in general, these doctors do not treat) and the less severely ill (neurotic) patients (the majority of patients in private practices). When making this distinction, the implication is that the efficacy of treatment for more severely ill patients is easier to track; they make clearer progress because they are given medications and because their symptoms deviate so much more from the norm that any improvement is much more marked. The patients with low-level symptoms might actually be harder to treat because they tend to respond to medications less successfully and are more likely to be treated in talk therapy, which is a slower, more involved process. Even though, like nearly all the doctors in this study, she spends most of her time treating less severe patients -- and her clinical experience leads her to believe that talk therapy is a great help with this -- Dr. Warren’s first instinct, in terms of what contribution her profession has made to society, is clearly more about illness than understanding the psyche. This is consistent with the overarching goal of psychiatry today. Dr. Warren’s statement about the different kinds of patients and the appropriate treatments for their symptoms also has implications for the practitioners who treat these populations – treating schizophrenia and bipolar disorder is much more medical, whereas treating neurotic problems is much more about uncovering patients’ feelings and experiences. This sets up a hierarchy wherein the biological practitioners are the most medical (and therefore legitimate in the current psychiatric climate), the biodynamic are the next best thing since they too can prescribe medicines, and the psychodynamic are the least valid as treaters of mental illness.
Dr. Elliot provides a quintessential answer for the biodynamic group as to what the main contribution of her field is when she says:

The two things - one is Freud’s influence on the culture, the fact that there are unconscious processes, that what’s manifest is not always what’s there, that people have emotional lives that may surface that they may not even know about. But the other contribution has to do with mental illness in that things can go wrong in a person that can produce what we might call irrational behaviors or syndromes that are very difficult to live with. And that includes illnesses that we now classify as illness, and that seem to have a strong biological or genetic component, which includes bipolar illness and schizophrenia...There may be genetic, physical triggers to all of those things, but...the fact that those things exist...that these are human problems and that they need attention and that they should be seen with some dispassionate view like anything else - like diabetes or something like that.

Dr. Elliot alludes to the same two contributions to the field as Dr. Warren – understanding neurotic symptoms and treating severe mental illnesses. Her answer is much more characteristic of the biodynamic group because she specifically addresses the psychoanalytic contribution to society, rather than focusing solely on the role of mainstream psychiatric treatments. In fact, she quite clearly isolates biological psychiatry as treating mental illness, and the Freudian model as one meant to explore the psyche.

Many of the doctors in all three groups were perhaps most concerned with their field’s ability to reduce stigma for people suffering from the range of conditions they treat. This is most clear for the biological psychiatrists like Dr. Hart, who explains that the major contribution psychiatry has made to society is in educating people:

That there is a psychological life, that physical symptoms can absolutely be manifestations of underlying psychological difficulties. I think there’s a lot more
awareness in society about that. I think psychiatry is trying, and not so successfully, to take away the stigma in some of the major medical illnesses. I mean, these are illnesses, like schizophrenia, that people do not understand, and that people who suffer from these have a very difficult way of life. The families have a terrifically difficult time, and they’re not understood. They’re still not understood, so certainly, the field has a long way to go, but I think - and helping to legitimize these as real illnesses, you know, on par with epilepsy, whatever, these are for real and very disabling.

In doing so, Dr. Hart also confirms the general sentiment of the biological group that the main focus of psychiatry is “major medical illnesses.” Dr. Elm (biological) summarizes how important it is that psychiatry is a medical field:

I think that the recognition that there is a relationship between emotional experience and physical health is valuable, and psychiatry has really played a role in demonstrating that or at least acknowledging that. I think that having a medical facet of medicine, in which people feel like they’re really listened to and heard is a positive thing for the population and I think that having medications that allow people to function who wouldn't function otherwise is an enormously positive contribution that psychiatry has made.

Dr. Elm emphasizes that the major contribution of her field is in being a branch of medicine. It is also important that the biological and biodynamic group implicate themselves as the treaters of a medical condition, thus reinforcing their roles as medical doctors.

Those with psychoanalytic training, especially the psychodynamic group, who are not medically trained, more readily point to the service their field offers patients for understanding themselves in a deeper way and uncovering the reasons why they may be symptomatic in the present. Those with medical training (both the biodynamic and the biological group) are more apt to refer to the benefits of treating severe mental
illness and of coming to see mental illness as something equivalent to, and as important and debilitating as, physical illness. The testament of doctors is in line with trends in the literature, which show that those with medical degrees treat more of what is considered to be illness or disorder, and those with PhDs treat more of what is considered to be problems in living and more existential explorations of the psyche. This may also help to explain why those with medical degrees (the biodynamic and biological group) are highly focused on the contribution their field has made to alleviating the suffering associated with disease, and to using the disease model to reduce the stigma associated with what they consider to be medical conditions, just as diabetes or heart disease are.

Overall, the perception that the biological model is the most important contribution of psychiatry is prevalent among those with medical training; even the biodynamic group (despite their training in psychoanalysis) speaks about the biological contributions more readily than the psychoanalytic. For the psychodynamic group, though they make mention of symptom relief, their notions about what they offer their patients is very different than the biological and biodynamic groups – for them it is first and foremost self awareness that the work they do with patients can provide. However, the fact that the psychodynamic group mentions symptoms relief at all (and they all do) is indicative of just how important the notion of evidence-based treatments, based specifically around the reduction of focused symptoms, has become. The blurry boundaries between the two paradigms are visible in notions of etiology.
The Causes of Illness: The Trifecta of “Biological Programming,” Experience and Interaction

In this section I convey practitioners’ ideas regarding the forces that drive the development of symptoms that lead patients into their offices. Conceptualizations of etiology are informative per se in identifying how doctors think about the derivations of illness, but also in understanding why a practitioner might choose a given treatment for a specific set of symptoms. Etiology and treatment are intricately connected.

Most of the doctors in all three groups were taught that illness is “bio-psycho-social.” As such, when they respond to questions about the etiology of mental illness, most refer to these three causal factors. However, as Dr. Lewis (biodynamic) decries, “what every training program will tell you...if you were to learn psychiatry, that’s [the bio-psycho-social] what people think that they are going to get. Ya know, it’s really not.” It is clear in the statements below that the conceptualization of the ‘social’ does not generally go beyond immediate environment (often described as immediate family). Further, the environment figures much less than the “bio” and “psycho,” and the degree to which practitioners consider the latter varies. The psychodynamic group are the most likely to consider the psychological influences as primary etiological factors, and the biological group are the most likely to consider genetic traits, though heritability is certainly a common consideration across all three kinds of practitioners.

Dr. Butler (psychodynamic) explains the widely accepted model of the interplay between biology and environment:

...[symptoms] can be genetically-based in part, and they can also be experientially-based, and they arrive and there’s a kind of diathesis model where
you may inherit genetic vulnerabilities, but it may take adverse environmental conditions to bring it out. And I do think family dynamics can be - heaven knows we’re all exposed to them in one way or another - but I think people essentially get programmed with a whole lot of default assumptions and expectations and behaviors growing up that in a sense you could see therapy as a way of reprogramming almost.

In explaining etiology, Dr. Butler is drawn to a particular explanation of treatment. Given that people are “programmed,” her job is, then, to “reprogram.” Since Dr. Butler explains that genetic vulnerabilities are triggered by environmental conditions, there is also an implicit assumption that those biological triggers can be reprogrammed or perhaps deprogrammed.

Dr. Dean (biodynamic) explains a similar notion:

Well, it’s always a combination of factors. Someone has a psychiatric illness, OK, it’s for a number of reasons: Firstly, because they had some kind of inborn genetic vulnerability or biological, they were born with a vulnerability and upon that vulnerability was played some stress perhaps in interaction with the parent. A parent who might have gotten away fine with a child who wasn’t vulnerable, but this interaction brings about some kind of a deficit of some sort so it’s not nature versus nurture, it’s nature and nurture interacting together always...Someone may have a trauma, that’s more unusual - but if someone’s been in a war for example. Everyone has their breaking point, ya know.

In Dr. Dean’s words, we can see the centrality of medical thinking in her description of an “inborn genetic vulnerability,” but also the clear assumption that that biology is in constant interplay with “nurture,” in this case represented by parenting and war. On etiology, the biodynamic and psychodynamic ideas are remarkably similar and therefore indicative of similar treatment (though for the psychodynamic group this involves a
referral to another practitioner, whereas the other two groups are able to prescribe medicines).

For the biological psychiatrists the focus of treatment tends to be more on physical health, largely because of notions of biological etiology. Dr. Brooks says:

Well, I think there’s some biological loading, probably genetic in large part. And the environmental - I think social interactions and issues contribute. There are other biological things out there. I mean toxins and this and that and you know someone has a tumor in their brain or something so there are those things as well, so it depends on the disorder. You know, schizophrenia is probably the result of many different biological things and the brain’s too complicated, we don’t understand it yet. Looking for a genetic cause, the age of the father, whatever you know it could be all those. I mean it’s hard to say. I don’t think we have it yet.

Though Dr. Brooks describes her approach as bio-psycho-social, it is clear that the “bio” is most salient in her thinking about etiology. She also expresses optimism about the future of the biological model, which is a common sentiment, especially for the medically trained doctors. Again, there is not a radical difference in the thinking between these three groups, since all are taught the same model of etiological factors. In fact, even the psychodynamic practitioners, who are presumably the least medically oriented, are quick to point out the influence of biology.

One would not expect psychodynamic psychologists to think biologically. However, the psychologists in my group spent five years training in psychoanalysis with psychiatrists who were trained in biological psychiatry. This socialization into medical thinking and pressure to fit in with medical doctors was highly influential in their likelihood to think of biological causes, something they were not taught to do in their
own graduate training, and something they did not expect to encounter in psychoanalytic training. As Zerubavel (1997) reminds us, “...the cognitive stances we adopt as members of particular social environments...constrain our mental ‘vision’ by exerting upon us tremendous pressure to conform to them...” (p.32). For the psychodynamic group, then, the exposure to biological thinking in psychoanalytic training can be jarring, and is a new lens for understanding etiology and treatment. Once they have this lens, it becomes an important part of their conceptualization of their patients, and exerts pressure on the psychodynamic group to (for instance) send their patients for medication referrals (see chapter four). On the other hand, given their primary professional socialization in medicine, attributing symptoms to biological causes makes sense for the biological and biodynamic group. It is striking, however, that Shorter’s (1993) description of psychiatry as shifting its focus from the mind to the body is also at least partially characteristic of the psychologists in my sample. Psychoanalytic training is, of course, largely dynamic, so it is remarkable that the psychodynamic practitioners actually come to be so constrained by the medical model. I turn to this somewhat ironic process in chapters four and five.

**DSM as the “Cookbook”**

In describing the strengths of DSM, the notion of standardization is particularly relevant for the field of mental health in order for it to operate within the medical model even though there is a lack of ability to point to real markers of disease. Psychiatry is not like cardiology, for instance, where one can see problems in the heart or blockages of the
arteries and make treatment decisions based on these visible markers of illness. In psychiatry the markers are for the most part imagined. They may be depicted in imagined models of brain segments and neurochemical/neurotransmitter diagrams, but cannot be measured in doctors’ offices. Therefore, for psychiatrists, standardization becomes even more critical for diagnosis, for treatment, for validating the medical legitimacy of those treatments and their role in the medical community. Several of the biological and one of the biodynamic psychiatrists described the benefits of brain scanning (fMRI or otherwise) for identifying illness, though largely as a potential future development in the field. Especially in private practice, this technology is not currently practical. The most biologically oriented of all my interviewees, Dr. Evans (whose narrative appears in the following chapter), works in a building that has at least one fMRI machine, though she did not mention these kinds of scanning technologies as a routine part of her practice. In lieu of techniques like imaging that actually show brain functioning, DSM is the diagnostic standard mental health practitioners have. In this section I describe the role of DSM, the ambiguous feelings surrounding its use, and the method of classification that comes from the simultaneous need for standardization and the desire for autonomy in practice.

*Diagnosis as a Precursor to Prescribing Medicines*

Though it is used by all mental health practitioners for making diagnoses and coding insurance forms, DSM is much more central to the practice of a psychiatrist than a psychologist. It is a publication of the American Psychiatric Association and it is used
for diagnoses that play a role in the determination of which medications will be prescribed. For instance, if someone is diagnosed with major depression, they are likely to be offered one of the SSRI\textsuperscript{6} medications such as Prozac, but if someone has a bipolar illness, a doctor would be careful to stay away from SSRIs as they are known to trigger mania, one of the main mood states associated with bipolar symptoms. Instead, a bipolar diagnosis would be much more likely to yield a prescription for a mood stabilizing drug. The diagnosis is needed in order to choose the proper medicine. This is precisely why standards are so important in the field of mental health. However, DSM also helps organize thinking that is not necessarily tied to prescribing practices. In that sense, psychologists are just as likely to consult it as MDs. In fact, for the doctors I interviewed, whether they were trained medically or as psychologists, there is very little difference in how they think about the utility of DSM. There may be more reason to use the manual if medication is to be prescribed, but the actual categories are influential for all the practitioners in each of these three groups.

\textit{A Good Practitioner is Discerning; The “Dangers of Diagnosis” and the Benefits of Organizing “Complex Emotions and Behaviors”}

Practitioners in all three groups present the dangers of over-diagnosis as something their training and expertise must combat; they describe the need for DSM to be used only as a guide by a discerning doctor. Overall, psychodynamic psychologists and many of the biodynamic psychiatrists agree with Dr. Adams’s (psychodynamic) statement that

\textsuperscript{6}Selective Serotonin Reuptake Inhibitors (SSRIs) are the most commonly prescribed class of drugs for treating depression. The first in the class was Prozac, which was released in the 1980s.
“DSM is really messed up because it’s so behavioral and the categories...bleed into each other.” She continues:

For example, you see a person where there’s a strong family history of mood disorder, let’s say, and they have children. Let’s say there’s been suicide on one or both sides of the family. There’s been maybe some manic episodes and depressive episodes. And they have a child, and the child has ADHD. Very common situation. Is that ADHD? Is that some kind of general physiological or biochemical disequilibrium that’s expressing itself this way, in this generation, or at this age, but it’ll change later? I find that whatever that is that’s being transmitted biologically can take different forms and at different ages...So, I think it’s a waste of time to worry too much about what is the diagnosis, but rather to be sort of open to seeing how it evolves and what’s needed at a particular time...even in medicine [at large], I think good doctors are open to the possibility that what their patient has is something that doesn’t neatly fit into any category.

Here, prestige is tied to being a “good doctor” who does not take anything at face value, who does not make snap judgments, and who thinks flexibly both in the moment and about the future. Dr. Dean (biodynamic) also describes the dangers of diagnosis:

Someone who has one symptom may fit into a different diagnostic category. Just because you chose one ultimately doesn’t mean he doesn’t fit into the other one too... I think that in some ways it prevents our students from getting to know the patient sometimes because they’re so busy trying to accumulate symptoms so that they can figure out what the diagnosis is sometimes at the expense of finding out more about the patient. DSM ultimately, I think, is more of a research tool, which is valuable, than it is a great clinical tool.

Dr. Dean, perhaps most importantly here, points out that DSM can be dangerous for students because they learn to classify people’s symptoms, rather than really attend to the humanity of the patient. Recall Kleinman’s (1988) critique of the lack of attention to “illness experience” in modern medicine, and Luhrmann’s (2001:36) description of
residents who are taught to identify their patients the way one might distinguish between breeds of dogs.

However, it is precisely for this reason that many other interviewees report that DSM is so useful; though it makes young psychiatrists rigid in their thinking about symptoms and illness categories, it assists them in getting a handle on a patient’s problems. A resident’s knowledge base is generally not yet broad enough to diagnose based only on the feeling they get for a patient in an assessment. Dr. Brooks (biological), for instance, says, “as a trainee, you’re sort of barraged by stuff, and complex emotions and behaviors.” Though very few of my interviewees see severely ill people (since this is rare in private practice settings), all of these doctors start out working in hospital settings, where they do treat this population. It can be an overwhelming experience to quickly identify what kind of illness patients have and what kind of help would be most useful for people with severe symptoms such as hallucinations and delusions. DSM is useful precisely in this kind of environment. In fact, it was developed with this goal in mind – to increase the validity and reliability of diagnosis (Horwitz 2002; Kirk and Kutchins 1992).

This need to organize thinking especially for residents is not just a phenomenon in psychiatry, but in any profession in which one must find a way to understand a new situation or process new information. As Zerubavel (1997) explains, “[i]n order to make sense of novel situations, we...often try to mentally force them into...pre-existing schemas” (p.24). Speaking to this issue, Dr. Warren (biodynamic) says: “...you can’t really do studies without something like a DSM. You just can’t because if some guy out
in Kansas is calling something one thing and we don’t even have the criteria to validate that it’s the same thing, that’s ridiculous.” Further, for the young (oft described as naïve) psychiatry resident, patients’ troubling symptoms are easier to understand and tolerate emotionally if they can be seen through a particular diagnostic lens and labeled as something familiar; a patient who describes being followed by threatening people, hearing voices and seems volatile is much more recognizable once he is labeled as schizophrenic.

Dr. Elliot (biodynamic) explains both sides of the argument when she describes DSM as a framework that allows psychiatric residents to learn how to understand their patients, but she also confirms the notion that a surface-level understanding of patients can be damaging for treatment. She says:

My own, emotional response - I feel that it’s a good sort of frame for beginners, but it really limits people’s understanding to follow DSM totally. I sort of feel that it’s important to know about what’s in there, but it often does not serve when you’re really trying to understand the individual person... I’m thinking about this in terms of young psychiatrists. It may limit the clinician’s understanding of the person in depth and the empathy with what the person experienced. And sometimes the young clinicians are so worried about how to put the person in the category that they can’t listen to what the person is saying about their life. Yeah I know they have a thing for extreme stress, but when you hear the story of someone who’s living in poverty, whose apartment burned down, who has drug addicts outside the door and all of that, stressful environment, sometimes it’s more important to hear the individual’s story, their life, ya know.

Dr. Warren (biodynamic) describes the same benefits of organizing one’s thinking early on in a treatment, but she also references the dangers of circumventing a deeper assessment of patients. Many interviewees describe the use of DSM by residents as
perilous if it precludes a more holistic investigation of a patient’s experiences. Dr. Warren explains:

You know, it’s interesting. DSM does play a role in my practice...especially when I’m taking a step back on an initial consultation, or if a patient comes in with a new description of symptoms I haven’t heard about before... When I’m sitting with someone and they’re talking about their week and something that happened, their conversation with their mother, I’m not thinking about DSM or whatever. And I think it’s interesting because I use DSM of course, but it’s funny I think to some degree I think the more clinical practice you have - and maybe, if I was a psychopharm person, I would do this differently - but like I’m not sitting there ticking off 5 out of 9’s\(^7\) all the time.

Again, “more clinical practice” is what makes DSM less central, and also provides a means for distinguishing oneself from the “psychopharm person.” Dr. Warren explains that she only really needs DSM if something novel arises – if a patient presents with a symptom she hasn’t seen before. In the same breath, however, she shifts:

...the funny part is like half the time I’m not thinking this is DSM, I’m just thinking oh, let’s get the symptoms of this and find out where we are on this, but it is DSM... So I do think it’s important, but...it’s so depressing to me how many people just use checklists these days...There’s a danger to that especially with teenagers I find because they break up with a boyfriend or girlfriend and one day they’re like the most depressed-looking kid in the universe and then if you saw them 48 hours later, and they’re with their friends, they’re fine...if you just use the DSM without good clinical judgment it can really be a joke.

Even if a doctor does not use standard checklists to fit patients into diagnostic categories, she is still influenced by diagnostic thinking. It is “good clinical judgment” that protects practitioners from making mistakes and, as some called it, “pigeon-holing” their patients. As Dr. Warren explains, when she is thinking about diagnoses, she may

\(^7\) A reference to checklists that use DSM symptoms to gauge depression.
not be directly referring to DSM, but those DSM categories that she learned in medical school and used in her residency all the time are there in her mind. They have become a major, if not the predominant, way of making sense of patients’ symptoms.

Dr. Mill (biodynamic) summarizes most of the general sentiments about DSM when she says the role DSM plays in her practice “waxes and wanes”:

Recently, I had to take a recertification exam for my board certification in psychiatry, so recently I had to study for a test on DSM... it’s irritating, it can be a real pain in the ass, but I remember the pleasure or the enjoyment of the fact that somebody, somewhere put all this work into kind of sorting this stuff out and it’s meaningful. It’s actually useful. It’s not the answer. It’s not the end-all. But it’s another one of the tools we have and it always reminds me, “hey, this is a good tool.” So, does it always play a role? Absolutely. Is it always the number one role? It’s always in the top. I think there may be a psychology/psychiatry difference there because...I imagine they may not use DSM or at least in the way that I might as a tool to steer things to help organize a lot of information. A meaningful way to start with, to begin with and then you rule things out, but I do believe it’s helpful as a guide...I mean it doesn’t contain everything. It doesn’t capture everything about a person...I think of it as something sort of plastic, meaning that I can use it the way I want to so I know the criteria. Say major depressive episode equals five of nine symptoms for more than two weeks, but I don’t particularly get too fussy about whether they’ve got four or five or whether it’s fourteen days or ten days.

Dr. Mill distinguishes herself from psychologists in saying that she has more information to organize, and therefore also justifies her use of DSM, which she feels conflicted about using in a structured way.

*Autonomy as Prestige*

Aside from using DSM in discerning ways, which establishes good clinical judgment, the prestige of not having to use DSM is a theme that became clear in the earliest
interviews. Dr. Gold (biodynamic), who has been in practice for over fifty years, seemed to regard my question about diagnosis as something beneath him. He somewhat proudly told me:

I could do a clinical evaluation without having to ask them any questions. Appearance, attitude, behavior, speech, affect, sensory perception. You can evaluate all those things without having to ask very much in the way of specific questions. You can do a whole mental status exam just by sitting down and listening to them.

Dr. Gold previously told me in a joking tone that psychopharmacology does not interest him. He says:

Let’s face it - writing prescriptions for pills for people that you see for fifteen minutes. I mean, it’s a great way of making money, but it isn’t very interesting. If you’re interested in making money that’s what you do and there are a lot of people doing that but it’s not very challenging.

Prestige here is constructed partly by pointing out the surface-level practices of other practitioners who are much more wedded to the diagnostic, biological model. The feeling of prestige helps psychoanalytically trained psychiatrists especially to distinguish themselves from other practitioners, who they feel are not as thorough as they are – who they consider less thoughtful, less insightful, less attuned to patients’ needs. Of all the practitioners I interviewed, Dr. Adams (psychodynamic) reported the least likelihood to use DSM. Though she says, “I have a resistance to thinking diagnostically,” she also says, “I find it useful once in a while.” Even though she does not think it is helpful to think about patients in categorical ways, even she consults the manual occasionally. Unlike a psychiatrist, she does not need to consult it for medicines and she says her diagnoses are mostly used for coding insurance forms rather than prescribing
medications. Outside of writing codes for reimbursement, Dr. Kent (psychodynamic) says she uses DSM “...only if I encounter something that seems very confusing and strange to me like that I've never seen. I might go and look to see if it’s listed and it’s called something.” Though they generally report that it is peripheral, DSM does influence psychologists’ thinking.

For all of these doctors, DSM assists in what Gerrity et al. (1992) refer to as the “the denial of uncertainty,” the main function of which is that it “allows physicians to make potentially threatening situations more understandable and controllable, thus enabling action to take place” (p.1029). By making patients more understandable, less exotic, by fitting them into a category, it is easier to treat them and easier to make sense of what the work ahead will be. It is hard to have a treatment plan without a diagnosis, and an essential part of evidence-based practice is laying out a course of action and goals. In order to alleviate a symptom, after all, a doctor must know what the entity she is treating is. Conversely, if it is a more existential mood state or desire to understand oneself that is the focus of treatment, then diagnosis is less relevant. DSM, then, is largely an organizing framework. Dr. Brighton (psychodynamic) says the manual does not really play much of a role in her practice, but she explains its utility:

Sometimes you might be a little confused about a picture of someone because they’re mixed and they have a lot of different things going on, and it might be a little helpful to go to the manual...I have a patient who has OCD, ADD and

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8 This notion that evidence-based practice is necessary for alleviating symptoms is not necessarily accurate, as evidenced by new studies that show the efficacy even of short-term psychodynamically informed talking treatments. However, in order to call something evidence-based, the model for treatment must involve the identification of an entity to track.
depression and she’s borderline character disorder⁹, so because she’s such a complex picture it’s sometimes helpful to just read all of what’s laid out so you have a clearer reason for why it’s so hard.

DSM helps her organize her thinking so she can get a clearer picture of what is happening with her patient, who has at least a dual diagnosis. In Cassel’s (2004) words, diagnosis makes patients more like textbook cases; for the practitioner this serves the purpose of organizing their thinking. Dr. Brighton immediately added the following, a major criticism of DSM:

It lacks any kind of description of etiology. How is a patient becoming OCD? OK, so you can say if a patient looks like this, this, and this she’s got OCD, but it tells you nothing about how to really treat that because it’s talking about it only in terms of treating it with medication. So, there’s nothing to help you treat those symptoms using an understanding, an etiology...

For psychodynamic practitioners, who are concerned, always, with the psychological etiology of the conditions they see, DSM provides them with very little other than a basic way to organize thinking. This is helpful early on in a treatment, even though the

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⁹ Obsessive Compulsive Disorder is “…an anxiety disorder and is characterized by recurrent, unwanted thoughts (obsessions) and/or repetitive behaviors (compulsions). Repetitive behaviors such as hand-washing, counting, checking, or cleaning are often performed with the hope of preventing obsessive thoughts or making them go away. Performing these so-called "rituals," however, provides only temporary relief, and not performing them markedly increases anxiety” (NIMH 2009). The symptoms of Attention Deficit Disorder “…include difficulty staying focused and paying attention, difficulty controlling behavior, and hyperactivity (over-activity)” (ibid). Depression manifests in many different forms, the most common symptoms are sadness, hopelessness, irritability, problems in sleep and eating. Character disorder is the older term for personality disorders, which refer to problematic and enduring patterns of relating to others, often with the result of isolation and difficulty functioning in professional and personal situations.
psychodynamic group is quick to point to its limitations in characterizing patients beyond an initial assessment.

However the very vagueness allows the practitioner the discretion to use what several doctors referred to as “good clinical judgment,” which Luhrmann (2001) describes as a common marker for residents in becoming a respectable doctor. Being discerning and not making DSM central is a matter of identity as a sophisticated practitioner. The fear, of course, is that some may not be as discerning. My exchange with Dr. Butler (psychodynamic) characterizes quite comprehensively the majority of the responses of both the psychodynamic and biodynamic practitioners. In describing the role of DSM in her practice, she says:

Well, other than what you put on the insurance form, which you know again, that’s a whole lot in itself, dealing with insurance companies. But you know I think DSM is a rough and ready tool. In the beginning, it can be useful just to assess what you’re dealing with and the degree of severity, and is this person a danger to themselves? But beyond that, as you get more into the work, I don’t really think about it very much.

Again, the utility of DSM is much greater when seeing a new patient, so that key issues are addressed. But Dr. Butler also confirms that DSM diagnosis provides an important threshold for measuring severity. DSM is also a clear representation of the presence of managed care and its influence on practice. When asked more pointedly if she finds DSM categories useful, Dr. Butler points to one of the most common responses for all three groups about the downside of DSM:

Well, up to a point. They’re kind of static. I mean, they’re not developmental, they’re a kind of labeling, a kind of box into which you fit somebody and I think
some of the categories don’t really, aren’t particularly illuminating or useful in terms of treatment... you can’t really pigeon-hole people that neatly.

In response to my question about why some people regard DSM as the “bible” of psychiatry, she says: “I mean it’s a kind of lingua franca, it’s just a convenience really. And the psychiatrists I know who are analysts I think don’t regard it as that in that biblical fashion. I think they’re more sophisticated than that. I mean, maybe psychiatrists who are more biological than that might see it that way.” Indeed, some biological psychiatrists do use DSM in daily practice and think much more categorically than the biodynamic and psychodynamic group, though most of those I interviewed do not see themselves as being that highly influenced by DSM. For psychoanalytically trained doctors, the rigidity of DSM is seen as key factor in leading psychiatrists to use it in a discerning way, and in preventing them from following DSM as doctrine. In this way, the psychodynamic and the biodynamic doctors regard themselves as more expert than the biological group – particularly the biodynamic because of their medical training. For the psychodynamic group discerning use of DSM provides a sense of prestige, which combats the cultural legitimacy of the medical degree they do not have.

*Between Group Differences in the Use of DSM*

For the biological psychiatrists the opinions about DSM are relatively similar to the biodynamic group, though the manual is definitely more central for them since their practices are much more likely to be based in psychopharmacology, which requires very accurate diagnosis of symptoms. The biological group is split between those who think
about DSM much more like a biodynamic psychiatrist and describe a need to be discerning, and those who think purely like a biological psychiatrist and do not see a problem with strict diagnosis. For example, Dr. Morris (biological) says:

I consult DSM if I’m having problems with a diagnosis. Like I’ll review certain subtle things and see if the patient fits here, fits there. So I use it like a resource...For other times, it’s just like a checklist for the insurance company like to make sure that I’ve got the right coding and stuff like that...I wouldn’t say it’s a big presence in the office except to get something to write down for the insurance. It’s not like a major part of my reading. It’s the cookbook. Like it gives you the recipe for each diagnosis...I think it’s really important to standardize diagnoses and to think through criteria. I think it’s a great effort. I don’t think it’s always a perfect effort, but I think it’s a great effort.

For the most strictly biological, such as Dr. Evans, whose practice largely involves treating children, DSM is the central diagnostic tool. When I asked her what role DSM plays in her practice, she replied:

I go through questionnaires based on DSM. You know there’s a rating scale or a diagnostic questionnaire that I go through...which is based off the DSM. Because it’s structured off the DSM I’m gonna have to say it plays a big role. DSM, it’s still the basis in terms of diagnostic symptoms - part of diagnostic evaluation.

The consensus for all three groups is that DSM is an important, though problematic tool for organizing thinking, with the exception of the most biological practitioners who perceive that there are many more positives than negatives (if any). Though my interviewees agree that it is too often used without discretion, they do not find that it plays a central role in their own practices because they use the manual in a judicious manner, referring to it when appropriate while being careful not to be overly categorical in their thinking about people, who they almost all remind me, do not fit neatly into diagnostic categories. At the same time all of these practitioners must use
DSM for insurance purposes, in a court room if they are called for any forensic work, for schools and parents if they work with children or adolescents, and because it is what they are trained to do as a first step in practice. DSM does play a significant role in their practices, but as Whooley (2010) reminds us, “...the use of the DSM is varied, representing a complex negotiation between individual psychiatrists’ views of mental illness, various constraints placed on their autonomy by outside actors and the local exigencies of the clinical interaction” (p.466). It is this complex relationship psychiatrists (and psychologists to a lesser extent) have with DSM that leads to the necessity of what Whooley calls “workarounds,” or ways in which psychiatrists undermine the DSM in practice. Whooley reminds us that the power of DSM is wrapped up in the extent to which it is used in practice.

On the other hand, Whooley finds that doctors are able to negotiate their use of DSM. I find that it is so ingrained in their thinking about patients, that Whooley’s workarounds may be more about psychiatrists’ sense of themselves and their autonomy than it actually is about the centrality of DSM in their practice. Even if they are working around it, they are still working in relationship to it. Diagnosis is particularly important because it has implications for treatment. Though diagnosis and treatment choice are inherently different, Berg (1992) describes the way in which they are conflated:

A solvable problem inherently contains a disposal [a course of action]: they are two sides of the same coin. Physicians do not first search for a diagnosis and then, subsequently, decide upon a therapy. This phased, two-step motion does not characterize medical problem solving. On the contrary, from the outset, the transformation process is unidirectionally geared towards the construction of a disposal. 'Diagnosis' and 'therapy' are terms which can be applied to this process
in retrospect, but in an 'in situ' study of medical practice the usage of these terms creates an artefactual distinction. (P.169)

This is less the case for the psychodynamic group than for the psychiatrists, but it is still certainly a factor in leading psychologists to refer patients for medicines, the motivation for which I now turn to.

**The role of medication in treatment**

When I asked psychiatrists when they would prescribe medications -- and psychologists when they would refer patients for medication consults -- there was an overwhelming consensus that psychotropic medicines are to be used when symptoms are interfering with daily functioning; prescriptions are to be given when the severity of symptoms has become such that a patient’s normal life (judged as such by the patient, the doctor, or some combination of the two) is in jeopardy, and when those symptoms have persisted for enough time that it is clear some intervention is necessary.

**People Deserve Symptom Relief: Assessing Severity**

Dr. Hart (biological) describes the overarching explanation for using medicine because it “can help provide quick relief for some patients.” She continues:

I think it’s a very helpful tool in treatment. I think, in the context of a whole treatment, it can provide a lot of relief to people. I think these are biologically-driven conditions in many cases, so I think - the medicines are not perfect by any means- but I think they can correct some imbalances, abnormalities, they can settle down the nervous system at times, and they can offer a tremendous amount.
When asked more specifically what are the key elements of a diagnosis that would indicate a need for medication, Dr. Hart explains that what she is looking for is evidence of “how acute” a problem is; if a problem is severe enough over enough time, medication is the best option. More specifically, for instance, Dr. Brighton (psychodynamic) informed me that her decision-making about referring patients for medication “has to do with functioning.” She explains of her patients that: “If their functioning’s falling down badly, they’re at risk for losing their job, not sleeping, gaining a tremendous amount of weight,” that would be the time when a medical doctor would be called upon for a referral. Again, the notion of acute severity is a key factor in decisions to use medicine. As described in chapter one, these notions of severity and duration come directly from DSM and provide the “gold standard” for medicating patients.

Dr. Kent (psychological) describes her threshold for treating people without referring them for medication. She says, “if they’re very depressed and they don’t seem to be functioning, then I would definitely refer them for medication or sometimes if they’re having very bad obsessional anxiety or sleep problems.” For psychodynamic psychologists as well, a certain acuteness of symptomatology is what would lead to the referral of a patient to a psychiatrist for medication. Dr. Adams (psychodynamic) explains this same phenomenon when she says:

I think some people suffer unnecessarily. I think a certain amount of suffering...is part of life and should not be thought of as something to get rid of. But then there’s, for example, if somebody is up all night, if somebody is really not sleeping, you know, they shouldn’t have to deal with that. Or, if somebody is
plagued with suicidal thoughts all the time. Or, somebody might really commit suicide... Or somebody is just agitated all the time.

Though there is normal suffering (described by other interviewees as anything from sadness because of the loss of a parent or spouse to a serious illness like cancer), Dr. Adams explains that there is also a point at which suffering is too much to bear for a patient and has reached a severity beyond what is tolerable for both the patient and the practitioner. This, in fact, is what interviewees describe as the driving force for patients to enter into treatment in the first place. For instance, Dr. Kent (psychodynamic) explains: “they just feel terrible and don’t know what else to do. In one of a variety of ways - they’re depressed or something bad has happened to them.” That pain may be intolerable enough to require medication, and the severity may also be what signified a need for treatment in the first place.

Sometimes, as Dr. Reeve (biological) explains, patients come in simply “because they’re not happy or something is not going well in their life or they’re too anxious about things and they come to recognize that.” Dr. Elliot (biodynamic) explains that the purpose of medication is:

...to relieve symptoms that are troublesome enough to interfere with the person coping with their life. Let’s say obsessive thoughts or depression or anxiety. So it can help relieve symptoms. It can reduce symptoms so that the person can then cope better and even work on their underlying problems better...Let’s say a person is anxious. You tamp down their anxiety, you have to give them a sleeping pill to get them un-anxious or maybe that won’t even do it, but there is a level in which something is so unbearable that’s all the person can focus on.
The consensus is that interference with what is normal or routine functioning, and/or the level of suffering reported by the patient are the main indicators for the use of medicines.

*Biological Etiology Begets Biological Treatment*

Another way of determining whether a patient needs medicines is to assess the extent to which he or she has “a biologically-based condition.” This is likewise the assessment insurance companies use to determine whether to reimburse for treatment.

Dr. Butler (psychodynamic) explains this:

In a sense, everything is biological. We’re biological organisms, but for some people even if they come in depressed, the very fact of being in treatment will lift them out of it. But for someone who has a really sort of unshakable, gloomy, deep-seeded depression that doesn’t really respond to psychological, therapeutic interventions, then I would definitely think about it [medication]. And you know it’s often the case with eating disorders that an antidepressant can really help a patient sort of get to a place where they can better deal with the problem. And anyone who’s bipolar or has a history of bipolar I would certainly refer... if you can resolve some of that really serious symptomatology, then it makes the patient much more able to cope, to function, to engage in the therapy in fact. I see it as putting them on a somewhat more normal plateau as it were, where they’re not so constantly overwhelmed by fighting depression or anxiety that they can’t really do much else.

While the psychodynamic psychologists express slightly more reservation regarding the centrality of medication in psychiatry, descriptions about which patients need medication, for whom it is most useful, and how it is useful to patients, it is isomorphic across these three groups of practitioners.
Advocating Appropriately-used Medications

Medicine is a topic of contention for psychodynamic practitioners who are trained in meaning-making but who exist in a medical world; this may be the case either because they are MDs who have been through psychoanalytic training or because they are psychodynamic psychologists who refer their patients for medications. Dr. Brighton, though critical of medicine’s overuse, is careful to clarify that it “...can play a very, very beneficial role.” “Presuming the patient has a good response to medication,” she says, “depression lifts, thinking is clearer, the patient can actually tolerate more looking into themselves.” However, she also conveys that there is a danger to the centrality of medications in treatment. The biodynamic group considered this to be much less problematic and the biological group was not at all concerned. Dr. Kent (psychodynamic) told me: “I think it’s tragic for many people who are sort of bogged up on medication. I mean, it’s bad. It’s bad for practice because many people expect to be cured in a quick way. It certainly seems to be bad for training in psychotherapy.” She is careful, however, to add that she is “not at all against medication.” In fact, she says, “I’m a big proponent of appropriately used medication.” She also says she is “conflicted” about how much of a problem it is that psychiatry is so medicine-focused because “it’s psychiatry’s job to do that.” This sentiment is substantiated by several of the biological psychiatrists who explain that most of their patients come to them specifically because they can prescribe medications, and because they, as psychiatrists, are the only mental health practitioners who can do this. Patient demand leads people who want medicines to those who can prescribe them. Of course, psychologists refer patients when they
determine it to be necessary, but patients who come into treatment knowing they want medicines are likely to go to someone who can prescribe them.

*Medicines as a Part of a Treatment Versus Medicines as the Treatment*

The most essential difference between the biological group and those with psychoanalytic training is that it did not even make sense to the former when I asked them what role medicine plays in treatment. For the biodynamic and psychodynamic practitioners, this question elicited a long response, but when I asked this of the biological psychiatrists they often looked confused and responded with something along the lines of: “it *is* treatment.” I continued to ask the question, though I realized after the first few interviews that it was really an almost absurd question to ask someone whose practice almost entirely revolves around prescribing medications. Having begun the interview process with the biodynamic group, I had become accustomed to hearing tales of the use of medication for productive talk therapy, and had not yet had to confront my own assumption that treatment is more than medicine – in fact, for many psychiatrists, it is not. This is at least in part because...“biomedical psychiatry is about doing something, about acting and intervening, the way doctors are supposed to do...the biomedical approach becomes a way to cling to one’s doctorly identity” (Luhrmann 2001:99). In fact, many of the psychiatrists in my study, both biological and biodynamic, became irritated with me if I insinuated in any way that psychiatry and medicine at large are in any way different – and even when I did not they often perceived that I was inferring this.
Ultimately, all my interviewees agreed that there is a qualitative and quantitative difference between symptoms that are minor troubles and those that are severe enough to required medication. They both feel different to clinicians and can be diagnosed as such. They all allude to the twin pillars of DSM diagnosis: severity and duration. Most also reference some version of the appropriateness of a symptom or the context in which it occurs, though this is not always the case for the biological group.

For those who spend most of their time on diagnosis, the symptoms are sometimes enough (regardless of why they emerge) in order to mitigate the prescription of a medication. However, most patients who wind up in a biological psychiatrist’s office are there precisely because they or another mental health practitioner believes their symptoms warrant medical intervention. This is not necessarily the case with the biodynamic group, even though they have a license to prescribe medication.

Psychoanalysts of all kinds are generally referred patients from other analysts, especially from more senior clinicians who are rarely sending them patients for prescribing purposes. Therefore, medicine will almost always be only one part of a treatment for analysts.

**Changes Since Training**

One of the clearest ways to assess practitioners’ feelings about and attitudes toward the centrality of the medical model and the shift away from the psychodynamic model is in their descriptions of how their field has changed since they trained. After all, only the youngest doctors trained in the post-1980 era when the biological paradigm had already
taken over residency programs. So almost all the practitioners in this sample were witness to the biological takeover.

*The Biological Revolution and Managed Care*

Dr. Hart (biological), who was in medical school in the 1980s and experienced the height of the shift to biological dominance, describes the drastic changes to the field between then and now:

> When I was in my second year of residency, what was an amazing experience is we had patients who were in the hospital for very extended periods of time, and you could see the patient and do every single day psychotherapy with the patient. By the time my residency ended, a couple years later, the whole reimbursement situation changed, and the talk was shorter length of stay. Then, you’re really dealing with a very acute population and the issue is to stabilize and get people into the outpatient realm.

Around the same time as the biological revolution took shape managed care also took over the field of medicine, to the extent that patients and doctors alike now had to have approval for treatments, which were always judged based on absolute necessity and cost-effectiveness. When I asked her what the main positives and negatives associated with that change are, Dr. Hart immediately thought of issues surrounding deinstitutionalization:

> I think there is something positive about trying to mobilize people to get them up and on their feet, and out and back into the world. I think that is therapeutic. But I think, unfortunately...especially when it comes to hospitalizations, people are in for probably too brief of a time for some of the conditions. The other huge problem with that is there isn’t really sufficient outpatient intensive care available. I find it very difficult sometimes to get people into a program that’s not once a week coming to an office. People may need something in between that and being in a hospital...
Patients may need something more than a once-per-week forty-five minute session, but that is not the nature of psychiatric practice today, at least in part because insurance will not pay for it. Not only has the length of inpatient stays dwindled since the 1970s, and has it become much more difficult to find hospitals willing to treat patients over more than a few days, but psychoanalytic treatments, which would require long duration of care, are relatively unavailable in those settings. In hospitals, which are designed to treat acute problems, there is no room for psychodynamic treatment.

New Medicines and Powerful Drug Companies

Current mental health reimbursement varies, as it depends largely on whether one has insurance through an employer or a privately obtained plan. Some PPO’s, provided by employers, for instance, will reimburse for a set rate for psychotherapy with an annual cap. This means a patient could see a psychotherapist once a week for the year at best. At worst many HMOs will only reimburse for short medication visits (fifteen-minute medicine checks). Parity laws in the last decade, namely a recent law passed by the Obama administration, have forced insurance companies to provide more coverage for mental illness (those deemed by doctors and insurance companies to be biologically-based). It is now illegal for plans offered by employers to provide any less coverage for a mental illness than they would for any other medical condition (Pear 2010). In general it is very difficult to get full coverage for mental illness treatments, and when there is coverage specifications are usually that it be biological treatment, and almost always that it is provided by an in-network physician, which limits the choices of doctors patients have.

According to Mental Health America (2011), “Of the 5.4 million people who sought mental health treatment in 1990, less than 7% required hospitalization. More than half of those who needed inpatient-care had schizophrenia, one of the most severe forms of mental illness.” Very few people today are hospitalized, and it is generally only the most severely mentally ill. Hospitals are allowed to hold people for no more than seventy-two hours, provide them with medication, and then, unless they are deemed a danger to themselves or others, they are released. Very little treatment takes place in hospitals today, and it is almost all biologically-based.
Pharmaceutical companies and the profiteering based on the production of new (particularly antidepressant) medications is another of the most commonly mentioned culprits in the drive toward the biological takeover of psychiatry. Dr. Carroll (biodynamic), who trained in the 1950s, describes the changes to the nature of treatment because of new anti-depressant medications:

[When I trained,] there was no psychopharmacology...just some heavy tranquilizers and they were experimenting with antidepressants. Originally, I did psychotherapy with people who would go into these depressions, and of course, when they’re in major depression, their thoughts are repetitive and we just used to sweat it out. Finally, the depression would lift spontaneously, and we had the illusion that we helped them work out of the depression, when it really is a biological illness, in most cases.

Indeed, most of the psychiatrists (both biological and biodynamic) point to the fact that the newest antidepressants are hugely improved and are able to help people out of depressions with far fewer side effects than ever before. For instance, Dr. Ferris (biodynamic) says:

Prozac and all of those antidepressants have really revolutionized treatment and made treatment much more available to so many more people. So I think from psychotic disorders to major affective disorders to you know chronic low level depression and so on there’s been huge change in treatment and that has made a lot of people more able to live their lives, better able to live their lives with much higher quality of life.

However, she and other practitioners recognize that the medicines are not perfect. My interviewees often express an excitement at the possibility that medicines will become even more effective and less likely to cause side effects. For instance, Dr. Sterling (biodynamic) says:
I think that one of the appealing things to me about being a psychiatrist at this point is because so little is understood about etiology and therefore there’s a huge amount of discoveries still yet to be made and a feeling of excitement around trying to understand it...I think whatever understanding we have of etiology is so incredibly far away from the actual complexity of who we are that it almost feels like silly to try and speculate. I mean take the SSRIs for example - that they are Selective Serotonin Reuptake Inhibitors. I feel like that’s about one of maybe 1000 things that they do. Maybe that’s the most incidental. I have no idea. Luckily we did find something that seems to work somewhat, somewhat, you know not incredibly well. But I think a lot of medications in medicine are like that; we have some idea of how they work. I mean some more than others.

That doctors feel less trepidation (even though there is a relative lack of knowledge about how they work) about prescribing the new medicines, and that patients are less concerned about taking them, means that many of the cultural and perceptual barriers to medicinal treatment have disappeared.

Dr. Carroll continued from her above statement, pointing to a theme I will return to in later chapters -- that it became difficult to be a psychiatrist who is also a psychoanalyst in the 1980s, because the expectation was that you should be able to perform both psychopharmacology and psychoanalytic treatments well.

So when the new medications came, and then one medication after another, I felt that I couldn’t spend all my time reading all these medication publications so I found a good psychopharmacologist and I referred my patients who needed some pharmacological help to the psychopharmacologist while I continued to work with them [in talk therapy].

For Dr. Carroll, that she stuck with the psychodynamic model meant she had to accept that she would refer patients often for medication, especially when it was not a straightforward case, because it is simply impossible to be as good at both kinds of
treatment. As we shall see later, the referral process can be contentious, especially for the psychodynamic practitioners, who worry their treatments will be disturbed by an outside influence. In the biodynamic group referral is much more common for older psychoanalysts who trained before the biological heyday. For younger biodynamic practitioners this is much less of a problem because they received a great deal of psychopharmacological training in medical school, and feel much more prepared to engage in that part of psychiatric practice.

The Marginal Status of Psychoanalytic Treatment

Speaking of changes since she trained, Dr. Remsen (biodynamic), who was a resident in the early 1960s nicely summarizes the main themes:

I would say the devaluation of in-depth therapies, the overvaluation to some degree of medication, and the disparagement of in-depth therapy, which I guess is one reason why it’s undervalued. There’s some residency programs which don’t even teach it, so how are you supposed to deal with patients? Patients all have dynamics; they all have histories. And it’s difficult to pinpoint things like that. My experience also is that there is less of an interest in the general population in in-depth, long-term exploration of psychic issues.

Dr. Remsen corroborates the frustrating and troubling experience of watching in-depth therapies become somewhat peripheral to the field of psychiatry as medical treatments took over, and even forced dynamic treatments aside. She refers to forces both within psychiatry and from without, particularly patient demand. Perhaps most telling was her

12 Though I do not have room to explore it here, another structural factor that influences the difficulty in being both a “good” doctor and psychoanalyst is the division of labor and specialization in medicine today, which I discuss briefly in Chapter One.
response when I asked whether this change affects the types of treatments that people seek. She is unequivocal in her response that it does:

I think a lot of psychiatrists and psychoanalysts have found that there’s some patients who can benefit from twice a week psychotherapy perhaps as much as they can from four or five time a week psychoanalysis. That is kind of a critical thing to say [of psychoanalysis], but I do think that it’s true. The other thing is finances and insurance coverage. I think one reason that a lot of people in Europe, for example, are in psychoanalysis - in Germany, I think, and some of the other countries in Europe have much higher percentages of people in psychoanalysis - is because it’s covered by insurance...Whereas here, I think you have a cap and if it’s psychoanalysis, you get nothing, and people are not willing [and she later recognizes that most patients may not be able] to pay the price, and psychiatrists have to earn livings, especially young people starting out with a lot of medical school debt, families - they want to live a little bit.

Some biodynamic and psychodynamic practitioners did acknowledge that four-time per week treatment is not practical today, and alluded to the fact that many psychoanalysts consider their two and three-time per week treatments to be psychoanalytic, even though they do not meet the classic definition of psychoanalytic treatment. There is a clear sentiment among those psychiatrists who trained either before or during the shift to the biological paradigm that a major paradigm shift has indeed affected the type of practice that the average psychiatrist has. In particular, there is a sense that patients do not opt for analysis anymore. Some of my interviewees recognize that most people cannot afford psychoanalytic or even just psychodynamically-oriented treatments, but many of them failed to mention this structural barrier to seeking the treatment they offer. There is a consensus among the biodynamic practitioners (and the psychodynamic) that these changes are unfortunate consequences of forces larger than psychiatry – namely that insurance companies have limited the kinds of treatments
available to their patients, which is intimately connected to patients’ inability to afford long-term psychotherapies. It is also not socially acceptable, in the way that it was in the Freudian heyday, to spend that much time in treatment these days.

Cultural factors (mostly the general devaluation of the psychoanalytic model) are highly influential. Many report that patients, given the biological option, feel dynamic treatment is unnecessary, ineffective, or they do not even know it is an option. Consider this interchange I had with Dr. Mill (Biodynamic) when I asked what usually leads people into treatment:

Dr. Mill: Even in New York, it’s been my experience that very few people come in requesting psychoanalysis. I have had that experience a few times, but they’re such special situations...People connected with the training institute might be interested in analysis or friends and partners of candidates studying analysis may want an analysis. They want it for themselves or their partner wants them to [he chuckles]. So I’ve had people come in and say I want analysis but it’s very rare.

DS: What is it about analysis, do you think, that attracts them?

Dr. Mill: It’s interesting because they don’t necessarily - you know, they have an idea of what analysis is, or even sort of a fantasy that may or may not actually resemble what analysis is. I would say not, usually...but, they do have a sense and a desire to understand themselves in a deeper way and they do have an idea that analysis, more than the other treatments available, is supposed to provide something, somehow, in some way, of exploring themselves or knowing themselves in a deeper way...I think I would say it’s a little more self-knowledge than symptom relief. Although sometimes their symptom is the pain and or the suffering they have from the sense they have that they don’t know themselves or they can’t understand why they’re in this situation they’re in, more than depression or anxiety or drug use...

DS: And, so on the other hand [for psychiatric treatment], it would be the symptoms?
Dr. Mill: Most people come in because they’re unhappy and that’s kind of different. The people who come in specifically for analysis, although that’s a tiny number, don’t necessarily say “well I’m just really unhappy.” They’re often really confused. They really don’t understand themselves.

Here, Dr. Mill validates the notion that it is friends and sympathizers of the psychodynamic approach that still use this kind of treatment, though it is a much smaller pool today than it was even 20 years ago (Hale 1995:340).

Some practitioners also allude to the impression that psychoanalysis and psychoanalysts are ineffective and even overly rigid in their approach. McWilliams (2000) describes some of the assumptions that lead practitioners to avoid psychoanalytic training, all of which my interviewees confirm: analysts are cold, narcissistic and arrogant, among other qualities. The treatment itself has also been caricatured in films such as Woody Allen’s (1977) *Annie Hall*, in which one of his most famous characters, the notoriously neurotic Alvy Singer, jokes that he has been in analysis for ten years. Similarly, Simon and Garfunkel’s (1966) *The Dangling Conversation* questions, “can analysis can be worthwhile?” When I asked the psychodynamic and biodynamic doctors if they see any downside or problems associated with the psychoanalytic approach, they all reported either that it is too time consuming, both for patients and for them, or that the psychoanalytic community is too elitist and unwilling to budge (though they agree this is less true than it used to be). Occasionally analysts themselves question whether analysis has uncertain results or even whether it can be counterproductive. It is for the same reasons that many psychoanalysts believe their patients avoid psychoanalytic treatments.
Dr. Mill also points to an important difference in the way biological treatment and psychoanalysis are conceptualized and used in practice today. Though psychoanalytic therapies were once used to treat more acute symptoms and still are occasionally today, for the most part, when patients have acute symptoms and seek psychiatric treatment, they seek the biological approach; they seek medicine. When they experience more existential problems in how they relate to other people, or feel confused or struggle to understand themselves, they may be more likely to seek a psychoanalytic treatment. Though unlike the period prior to the 1980s, many patients do not know what psychodynamic treatment is.

*Changes in Patient Demand*

Another commonly described change is that patients seek particular types of medical treatment. Dr. Gold (biodynamic), who trained in the 1950s height of psychodynamic influence, points clearly to the fact that patients are also responsible for the waning use of psychoanalytic treatments, and alludes to cultural notions that more immediate alleviation of symptoms is preferable over treatment that might require months or even years in order to see some progress. She says:

Well, the big changes are cultural shifts. People are less willing to come 4 or 5 times a week and apply themselves diligently to understanding themselves. People seem to want quick fixes. I think the drug companies have added to people’s wish fulfillment that a magic pill will solve all their problems.

Most of my interviewees note that there are many cultural factors that influence patient demand for psychoanalysis, psychodynamically informed treatment, and even
infrequent talk-therapy. Financial concerns are cited most often – psychoanalysts are attuned to this since (though it was at a reduced fee) they were required to pay for their own analysis. In general, practitioners have a sense that it is taxing for patients to pay even for infrequent treatment and that managed care has made it difficult for patients to pay for multiple sessions per week (or even per month). While most interviewees agree that patients are less willing to come in for talk therapy, and that this has something to do with a “quick-fix” mentality, they do also recognize that “will” is much more complicated than it may appear. For instance, aside from, but certainly related to, financial constraints are issues of time; Americans work more and there are more dual earner families than ever before, which means that treatments that are efficient and claim to be based in extensive evidence (and therefore seem more likely to succeed) would be favored over those that seem uncertain and are time-intensive.

Though the majority of my interviewees deny that patient demand has had an influence on the likelihood that they will prescribe medications, they do recognize that patients come into their offices with an idea about what kind of treatment they would prefer. It is clear that a preference for the biological model is not only the case among psychiatrists, but that laypeople as well are influenced by the power of the biomedical model, and already predisposed to ideas about treatment before they ever see a doctor. Practitioners in all three groups recognize that advertising, particularly television ads, as well as information patients get from the internet and from friends and family members, has an influence on their likelihood to seek treatment – particularly medical treatment. Once they arrive in psychiatrists’ offices, my interviewees claim that patients
often want to control their treatment (e.g. what kinds of medicines they want to take). Practitioners claim, however, that they are not swayed by these cultural influences; their job, they say, is to make the best treatment choices for their patients based only on the person in front of them, with only their symptoms in mind. It is for this reason that many of the biodynamic practitioners were quick to inform me that they refuse to meet with pharmaceutical representatives, since they worry it might sway them to prescribe certain medicines. They point out that this is what sets them apart from mainstream psychiatrists. Dr. Halsey, for instance, tells me:

I’m a consultant for a publication and they need people who are not paid by the drug companies and it’s very hard to find psychiatrists or child psychiatrists if you look into all the departments, the big heads and say you can’t be getting any money from the drug companies...so, I mean, that’s the moment - where do you turn to find people who are not influenced by the enterprise?

It is interesting that practitioners in my sample do not feel they are influenced by patients’ requests for particular medications, since most studies that assess the influence of patient demand on the likelihood to receive a prescription show that simply asking for medicines is highly predictive of increased odds of receiving them. For instance, in their sample of primary care prescribing of psychotropic medications, Sleath et al (1997) found that twenty percent of patients who received a new prescription had initiated the prescription (eighty percent, then, were physician initiated), and a startling forty-seven percent of patients who had previously been prescribed a psychotropic medicine had initiated their prescription. Given that this study is of primary care settings, it makes sense that there would be less discretion on the part of the physicians, since they are not highly trained in psychotropic medicines and likely listen to patients
more often than psychiatrists, whose entire training in medicines is in psychotropic drugs. It is also possible that practitioners in my sample feel they are more discerning about patients’ requests for particular medicines than they actually are.

Between-group Differences in Perspective on Changes in the Field

It is important to note that for the biological group this major shift toward medicinal treatment is considered almost entirely a positive one. For instance, Dr. Evans (biological), whose portrait we see in chapter three, says of his training during the paradigm shift: “When I trained was when the medical part of it was starting, and it’s continued since then, so I kinda got in at the right time.” Because his practice is almost entirely medical (as was his training) getting into the field as the biological model crystallized was good timing for him. For many of the more senior practitioners, alternatively, especially the biodynamic and psychodynamic ones, it is precisely this medicalization of psychiatry that was experienced as a contentious and drastic change, and in some cases even a problematic one. Most interviewees agree that the biological model has done a lot of good and the medicine has changed people’s lives, allowing in many cases for much more functional and less painful existences. However, (barring most of the biological group) most interviewees worry about the extent to which the biological model figures in both theory and practice.

The more senior psychoanalysts trained during an era when it was considered prestigious to be an analyst, and analysis fit with their psychiatric training, given the heavy slant toward psychodynamic thinking in residency and internship training at the
time. However the majority of the analysts in my sample, who are currently in the prime of their practice, trained as biological treatment was becoming more prevalent, and felt it was important to train in psychoanalysis precisely because of the aforementioned changes to the field of psychiatry and medicine more broadly. Therefore, implicit in their descriptions of why psychoanalytic treatments are unique are insights into what they feel the biological model lacks. For the psychodynamic group, who did not train in medical programs, their ideas in the following section provide insight into why they feel deep exploration of the psyche is so important.

**The Unique Attributes of Psychodynamic Treatment**

Even though they may not practice a great deal of traditional, four-time per week psychoanalysis (if any at all), all thirty analysts in my sample feel that their thinking is influenced by their psychoanalytic training, and they all find it useful and present in their day-to-day work. Because these doctors chose to train for five years in psychoanalytic theory and treatment, it is crucial to understand what they feel they can offer to their patients that they would not otherwise be able to – and that presumably the biological group cannot. In answering my question about whether or not it is important to understand how patients perceive the meaning of their symptoms, Dr. Gold (biodynamic) describes her interaction with an adolescent who came in for treatment. At the same time she provides insight into what makes psychodynamic treatments unique and, specifically, what sets them apart from those that rely on a medical or diagnostic model:
[She] called herself “an emetophobic.” She has a fear of vomiting and she went on the internet. People who have a fear of vomiting are getting themselves a diagnosis. She has an anxiety disorder and it’s manifest in this way. Now what that emetophobia, what that anxiety is about will come over time. I’ve been seeing her for about two months and we’ve figured out one main reason, but most symptoms are multi-determined...one of the multiple determinants for this kid is aggression. It’s a way of expressing angry feelings. So her fear of vomiting near certain people in certain circumstances and not in others - that’s one that I assume as the treatment goes on we’ll find out other meanings for it too.

Dr. Gold’s reference to a process in which multiple meanings of a symptom will be uncovered is, in brief, what sets the psychodynamic approach apart from other, especially biological, treatments. The biological model would likely diagnose the intense fear this girl has as some variety of anxiety or panic, which is generally treated with medications. For Dr. Gold, however, the symptom is a clue to an underlying psychic conflict that must be worked out via talking about what the purpose of the symptom is and what the meanings of it are.

Frequency and Intensity of Treatment

For Dr. Brighton (psychodynamic) there is something about the regularity and general character of the treatment that sets it apart from all other kinds of talk therapy. When I asked her what guiding principles of the psychoanalytic approach make it unique, she told me:

...It’s the number of times you’re seen per week. Frequency, frequency of treatment. The quiet of the analyst, the quiet of the analyst. The respect for the patient’s conscious unfolding. What am I missing? It’s really transference.

13 “Transference describes the tendency for a person to base some of her perceptions and expectations in present day relationships on his or her earlier attachments, especially to parents, siblings, and significant others. Because of transference we do not
counter-transference\textsuperscript{14}, the frequency of treatment and the belief that what is curative is the interpretations that are made within the transference.

The intensity of the treatment is certainly something that sets psychoanalysis apart from other kinds of treatment. Even twice a week, psychodynamically informed therapy (the most common frequency for the biodynamic and psychodynamic group) is a drastically different approach to the infrequent visits that come along with standard biological treatments. The content of those visits is, of course, also different. Therefore, though it is clear from the numbers that traditional psychoanalysis is very rare for my interviewees (even more so today in general), the psychodynamic principles are what my interviewees describe as the really important part of the training, even if they do not practice psychoanalysis per se.

There is another meaning of intensity, aside from the temporal investment in the treatment. A common theme in the responses about what sets psychoanalytic treatments apart from others is that the patient must be able to tolerate the process of looking into herself and being open to seeing what is causing both her own suffering and even the suffering of those around her. For instance, Dr. Gold told me, “you can’t make an omelet without breaking eggs.” In reference to people who do not come in because of their own suffering, but rather because those around them are suffering -- from their

\textsuperscript{14} Countertransference, a reversal of transference, refers to the feelings the therapist has when with the patient. It was thought by Freud to be an impediment to treatment, though today, when used properly in a treatment, countertransference is generally thought to be a useful avenue for the therapist as clues to her own as well as the patient’s personality and style of relating to others.
narcissism, or anger, or manic symptoms -- he says: “They’re not suffering. Other people are suffering. And you may help them see something that causes them suffering, so that’s pain that comes out during the work of psychotherapy.” In other words, one’s hard, psychological shell may need to be “cracked” in order to reach the final goal – a cohesive, functional psyche. The process itself may be painful. Thus, the notion that any pain must be treated early on is not a key element to the psychoanalytic approach, as it is in the biological model.

The Practitioner as Key to the Treatment

Because the job of the analyst is, in Dr. Gold’s terms, to help the patient “make an omelet,” her abilities and even her personality are crucial if the treatment is to succeed. Dr. Taylor (biodynamic) describes the content of treatment as largely dependent on the analyst herself. She explains that the function of the analyst is one of the most important characteristics of psychoanalytically informed treatments:

...The major principle of psychoanalysis is this principle of unconscious mental functioning, right. That the assumption that you have as an analyst...is that your patient in front of you has expectations, wishes that guide their perceptions and their behavior that they may not be aware of. And sometimes in a helpful way, but often in a problematic way, and that is what your role as a psychoanalyst is - to help bring those to the fore, so that the patient can have a little more control.

Further, Dr. Gold (biodynamic) describes what she sees as her role as an analytically oriented therapist. She says, “My job is to try to help you understand yourself...,” and she explains that she tries to understand the language of her patients and their world in order to uncover the cause of their troubles.
Dr. Brown (biodynamic) also explains that she has a significant role in the treatment. Her explanation as to what makes psychoanalytic treatment unique is as follows:

One thing is our own sense of responsibility for our own psychopathology, you know, counter-transference issues. In psychoanalysis, in the 1930s, there was a sense of analysts being the arbiters of truth. I think there’s more of a two-person psychological model now where people look at themselves in terms of their own contributions to the treatment. I think one is the focus on counter-transference. I also think there’s a tenaciousness about not giving up and hanging in there with a patient for lengthy periods of time if necessary.

Dr. Brown describes herself and her fellow analysts as tenacious, where biological psychiatrists might describe unnecessarily long treatments. Certainly, the role of the therapist as a guide for the patient in learning about and understanding herself makes it different from a practice in which the therapist identifies symptoms and prescribes medications as the main treatment.

In sum, psychoanalysts describe the intensity of the treatment, in terms of the frequency and the intimate involvement with patients (and their role in facilitating that), as what sets psychoanalytic treatment apart from other approaches. They feel their training and even their personality play a significant role in the treatment. Even though traditional psychoanalytic practice is rare if nearly non-existent, psychoanalysts in my sample are deeply influenced by their training in psychodynamic theory and identify qualitative differences between dominant contemporary psychiatric practice and psychoanalytically informed treatments. Even if a biodynamic psychiatrist does not currently have any analytic patients, her treatment is still heavily influenced by dynamic thinking, which means her practice will never be the same as a biological psychiatrist.
Discussion: An Analysis of Key Issues in the Field

I have painted a picture of many of the central issues in my interviewees’ practices, all of which point to the centrality of the biomedical model and the secondary status of talk-therapy. The biological take-over of psychiatry described by Hale (1995), Horwitz (2002), Shorter (1993,1998) and others is in fact a highly influential force in my interviewees’ thinking and practice, even though analysts, particularly the psychodynamic group, employ key elements of the psychoanalytic approach in their practices.

Regarding the contribution their fields have made to society, all three groups agree that allowing people a forum in which to talk more openly about their problems is a great gift to society, as is the potential to decrease the stigma surrounding mental health problems. However, the biological group is much more concerned with the medical aspects of treatment – the notion that mental illness is something on par with physical illness, and that there is a link between bodily illness and psychiatric problems. The biodynamic group describes the contribution of the field similarly, though they are more likely to mention Freud’s influence and exploration of the psyche. The psychodynamic group is the most likely to describe their field as one that offers their patients an ability to understand themselves. They are also much less likely to discuss illness or health per se. Given their training, these differences are to be expected. Remember, psychiatrists are trained first and foremost as medical doctors, whereas psychologists are trained as social (and behavioral) scientists. The majority of
biodynamic psychiatrists (save the most senior) trained in biological psychiatry first and in psychoanalysis after.

The central role of medication clearly shows the importance of the medical model and biological thinking for both the medically and non-medically trained practitioners. It is especially striking for the psychodynamic group, who are clearly less oriented toward the medical model than either the biodynamic or biological practitioners, but for whom the medical model does seem to have a fairly prominent role in their thinking, especially since they do not have medical practices. Not surprisingly, for the biodynamic group, medical intervention is slightly more prominent than it is for the psychodynamic psychologists. However, the similarity of the psychodynamic practitioners’ descriptions of the role of medication in treatment to their medical counterparts is quite striking.

When asked about medicines, the focus of the discussion is largely on the elimination of troubling and often painful symptoms; psychotropic drugs allow for the alleviation of mental suffering and for patients to return to normal functioning as quickly as possible. But medications are a multifaceted issue – even though most of the doctors with whom I spoke find there to be more benefit than cost with the use of medicines, the notion that drugs are too often used as a quick-fix is certainly prevalent. This is not as much the case for the biological group, but is certainly true of the biodynamic and psychodynamic practitioners, and is especially so for the latter. Most of my interviewees (save a few of the biological psychiatrists) at least made mention of the fact that medication should always be paired with talk-therapy, at least in the early
stages of treatment, and likely for the duration. It is quite striking how little the use of medicines is debated. When severity and duration meet criteria for a diagnosis of a condition that is typically treated with medicine (and few are not), there is very little opposition in any of the three groups to patients being on medications. Though it means referring patients to a psychiatrist, even the psychodynamic group (who we should expect to be the least medically oriented) advocates the use of medication for what they see as sufficient suffering or impairment. For them it is much less about a belief in biological etiology and much more about seeking any means necessary to help their patients (even if it causes them problems, as I describe in chapter four).

Though medical thinking is highly influential, the biodynamic and psychodynamic group are clear to point out that there is something the psychodynamic model captures that cannot be captured by any other kind of treatment. Medical psychiatry certainly cannot allow for insight into the mind or for uncovering how thoughts, feelings, and experiences figure in the development of any psychiatric condition – or in the narrative of any human being. This is not the goal of the biological model. Most of my psychodynamic and biodynamic interviewees agree this is not problematic as long as the dynamic model is not eclipsed. Professional contestations do emerge, however, as we shall see in Chapter Four, and biodynamic and psychodynamic practitioners express regret and even sadness that the dominance of the biological model, at least in training programs today, makes it much less likely that the psychiatrists will be trained in the psychodynamic model.
What emerges in discussions about medicine and diagnosis is the story of a field still struggling to be anchored in evidence-based medical practice, but one that is also still firmly tied to dynamically informed practice. For instance, Dr. Haman (psychodynamic) summarizes the issue:

There is this tension and this problem in psychoanalysis about being able to demonstrate it as an effective treatment in some scientific way. There’s a lot of debate within the field, I realize, about is this a science. Or is this something like a science? Is it an art, and if it’s an art, then how do you justify it as a treatment? And like all of that stuff I think is problematic. It loses some of its legitimacy in a way, not among those of us who are converts, but out in the press you definitely get that sense in the world that if there was more of a way to demonstrate its effectiveness in some scientific way, that it would help the field.

Though psychiatry is a medical field, it also offers a talking-cure that no other medical field does. There is a push to focus solely on biological factors, but psychiatrists deal with both mind and brain, and some recognize that it is not easy to separate the two. Dr. Gold (biodynamic), for instance, says, “I think Freud was aware that there was a biological substrate; the mind and the brain are two aspects of the same organ.” This mires psychiatry and the entire field of mental health in a constant debate, but also in a struggle to be medical. For psychologists who are analysts this is not as intense, but is certainly a part of their world, since patients arrive in their offices wanting to be sent for medication referrals, and because many of their analyst colleagues are medically trained.

Psychiatrists constantly reaffirm their medical doctorness in practice. Especially in terms of DSM, practitioners’ feelings are mixed and, in many ways, indicative of the tensions that exist between a diagnostic, more medically based model and a more
traditional psychiatric practice that is based on the instinct of the clinician and an orientation away from universal categories. When it comes to the role of DSM in practice, psychologists and psychiatrists are quite torn about where it fits in. In fact, many of my interviewees report using DSM because they feel stuck between a rock and a hard place; on one hand, lack of DSM use leads to lack of reliability in diagnosis, precisely what is criticized about the psychodynamic model. At the other extreme are over-diagnosis and what many of my interviewees describe as a sort of obsessive fitting people into categories.

Certainly, they agree, DSM is a useful research tool. It is an ever-present symbol of evidence-based medicine in psychiatry – it allows for the identification of traceable symptoms that can be monitored for intensity and duration, and hopefully alleviated as quickly as possible. Of course, the utility of DSM is also masked by its necessity for coding insurance forms, thereby allowing patients to file for reimbursement. Most of my interviewees feel that this is a tremendous problem in the field because it forces them to fit patients into categories which human beings are not likely to fall neatly.

DSM does, however, provide a service for clinicians in practice. As Timmermans and Berg (2003) suggest, there are two sides to the debate over evidence-based practices:

Because evidence-based medicine integrates clinical acumen with current best evidence, it makes the competent clinician even more competent and less likely to become blinded by experience or theorizing...Critics, on the other hand, charge that evidence-based health care turns clinical practice into bland and unsavory “cookbook” medicine. (P.19)
This is precisely the tension that my interviews note. DSM helps new doctors recognize illness, know how to treat it, and how to track symptoms over time. It allows for a language with which doctors can communicate and understand one another, and it makes it less likely that clinicians will make a mistake in diagnosing. But it also takes something away from practice; it removes some of the art of the field that was central during the dynamic era, when psychiatrists were expected to think deeply about their patients and come up with detailed explanations about the etiology of their symptomatology. For most of my interviewees the “cookbook” is both good and bad, and is described as both a cost and benefit of the medical model in psychiatry. It is less of a problem for psychiatrists who spend most of their time prescribing medicines, and more complicated for those who feel compelled to use it while still searching for the meaning behind symptoms.

A clear trend in the narratives of both psychiatrists and psychologists is the tension between proscribed diagnostic categories, the implied treatments they represent, and their own autonomy in practice. While they tend to write off DSM as somewhat peripheral to their practice (minus a few of the biological practitioners), they are also clear that DSM is helpful to them -- in communicating with other doctors using the same language, in making sense of journal articles where certain disorders are mentioned, in figuring patients out early on in treatment, in seeing complicated cases more clearly, and certainly for residents, as they start out and do not have enough of their own clinical experience to make judgments about patients’ symptoms. Timmermans and Berg (2003) suggest that: “Evidence-based medicine advocates
wanted to intervene at the moment of a health care provider’s special expertise: medical decision making, whereas it used to be that...to decide the proper course of action for a given solution was the unique prerogative of the individual professional” (p.13). As opposed to ignoring the DSM model entirely, claiming that DSM has a peripheral role in practice or that it is just a guidebook allows a clinician to maintain autonomy and decision-making, but ascribe to the notion that the evidence-based medical findings are important. The categories are generally described as useful, even if the manual itself is only consulted for insurance purposes, or if there is something confusing about a patient’s symptoms. The main goal of DSM, after all, was to provide an organizing framework for consistent practice and to increase reliability. Further, using DSM with discretion allows the practitioner to combat some of the feeling that there is no good choice – there is something to lose both with over and under-standardization.

Given the dominance of the medical model yet the continued practice of psychodynamically informed treatments by both the biodynamic and psychodynamic groups, I turn in Chapter Four to tensions that arise between the models. This is mostly a problem when encountering psychiatrists trained purely in the medical model – doctors who are much like my biological group, and particularly like Dr. Evans, whose portrait appears in the following chapter alongside portraits of other practitioners who employ many of the key issues described in this chapter.
CHAPTER THREE

Practitioner Portraits

In this chapter I offer an in-depth look at four practitioners from my sample: one biodynamic psychiatrist, one psychodynamic psychologist, and two biological psychiatrists. I do so to provide a holistic view of these practitioners as they discuss the central issues this project explores. I provide a more detailed portrait of these practitioners and how they think about the broad issues addressed in this dissertation, as well as the training process and experience for each of these three types of mental health practitioners. The portraits are not meant to offer a personal description or anything beyond the professional identity of these doctors; as mentioned earlier, this would be far too likely to make the practitioners identifiable given the nature of this sample. Instead, these portraits describe the kind of doctor one would likely encounter in each of these groups. Therefore, I provide minimal descriptions of physical traits and personality.

I have chosen these particular doctors because they describe some key traits of other practitioners with the same training. However, these individuals are not a perfect representation of all doctors in their given group, nor should they be taken as ideal types. Each doctor, for instance, relates unique elements of her story about how she wound up in the field, and personal reasons for being drawn to the mental health profession. However, the kinds of stories these doctors tell – of parents who are mental health practitioners, of influential childhood figures, of a propensity for thinking about the mind, or of a decision about what kind of practice they wanted to have – are, in fact,
characteristic of others in their groups. The portraits provide insight into the way a
doctor in each of these groups might be inclined to respond to the variety of questions
addressed in the interview. The exception to this is that the descriptions of training, at
least in basic structure, are exactly the same for all practitioners in each group. In other
words, the career trajectories and more general way of thinking of each of these types
of mental health practitioners is typical for each of these groups.

For the biological group alone I offer narratives of two separate psychiatrists. I
do so because there was a radical divide in this group between psychiatrists whose
practices are almost entirely biologically oriented and those who have at least a handful
of patients in talk therapy. For the biological group, talk therapy has a very different
meaning than it does for psychoanalysts; visits that include talk therapy may be as short
as thirty minutes and adhere largely to patients’ experiences with medications, with a
minimal discussion of events in their lives since their last session, which could have been
several months ago. For the psychoanalyst this is almost never the case, even for the
biodynamic group.

Because I began this project with the biodynamic group and used their contacts
to recruit my biological sample, the first half of the biological group (friends and
colleagues of the biodynamic psychiatrists) were more oriented toward psychodynamic
thinking than later interviewees in the biological group; some of the biological group
trained during the 1980s, so even though they are not psychoanalysts, they still received
significantly more psychodynamic training in medical school as the training programs
had not yet entirely switched over to the biological model. The first biodynamic
psychiatrist to follow, Dr. Sutter, is attuned to some dynamic principles because of her psychiatric training at a hospital oriented at least in small part toward that paradigm. Dr. Evans, the second biodynamic psychiatrist, whose words appear at the very end of this chapter, is a self-described psychopharmacologist, which means her practice is almost entirely oriented toward prescribing medications. Generally, psychopharmacologists do not have more than a handful of talk therapy patients, if any. In sum, because the biological psychiatrists in my sample varied in the extent to which they use talk therapy (though it is limited for all of them), it is important to represent both kinds of doctors here and to describe how these differences influence their thinking about the range of issues presented in this dissertation.

In this section I aim to represent the words of these four doctors, and to provide insight into their thinking to the greatest extent possible. Many of the themes presented in Chapter Two will be evidenced in the narratives of the doctors in this chapter. In particular, I explore more fully here the similarities in thinking about etiology, the role of medication in treatment and the use of DSM in practice. Though there are minor differences between the groups in terms of ideas about the course of treatment, on the central issues in the field there are far more similarities. The greatest differences are between the strictly biological (like Dr. Evans), whose practice consists almost exclusively of psychopharmacology, and the psychodynamic (like Dr. Kane), whose practice is based entirely on talk therapy.

Dr. Evans, MD: Biological Psychiatrist
Dr. Evans’s practice is in a pristine office building in Manhattan. The building is marked with symbols of biological practice – medical imaging machines appear behind glass walls, and a secretary responsible for the scheduling of the many doctors in the complex greeted me as I walked through the front entrance. Dr. Evans was one of only three doctors I interviewed who had secretaries, which is not especially common for psychiatrists and psychologists in private practice. I was originally scheduled to interview Dr. Evans back in 2008, but her secretary called me on several occasions to postpone and finally could not find another time for her to see me. I decided to move on with other scheduled interviews and come back to her at the end of the interviewing process, which is how I finally wound up in her office in May of 2011. Even so, she could only offer me forty minutes, which turned into less than thirty because she was running behind schedule when I arrived and had another patient already waiting for her while we talked. In fact, thirty minutes was more than enough time for this interview, as Dr. Evans’s practice did not lend itself to many of the questions I asked of the other doctors in the study. The short length of this portrait is representative of this difference.

Dr. Evans attended universities from the undergraduate level through medical school on the East Coast and considers herself a psychopharmacologist; her business card is inscribed with this title, which signifies a purely biological practice – one that revolves largely around the prescribing of psychotropic medications and a very low likelihood of practicing any significant amount of talk therapy. Of her approximately 500 patients, Dr. Evans only sees five for talk therapy. Though she describes these patients
as her “regular patients,” they come, on average, a few times a month. The majority of her patients are children and adolescents.

Though Dr. Evans’s practice is biologically oriented, and she enjoys this kind of practice, she describes what drew her to psychiatry as a decision not to be involved in a medical field that was purely about the mechanics of the body. Further, she did not want to be in a specialty that would not allow her to have a long-lasting relationship with her patients. When I asked her why she decided to become a psychiatrist, she told me:

It’s been so long. So I was starting out to be a pediatrician and then, in medical school, I actually spent two summers doing surgery because I thought I was gonna be a surgeon. I didn’t quite like the fact that in surgery you don’t get the chance to really speak to the patient. And then I think probably for me, when I was doing my clinical rotations in my third year, and pediatric was like my first one. My second one was psychiatry and I kinda like – I thought those were the two greatest things I had done, and I just sorta merged the two and then just kinda continued with it...I got sorta turned on by it.

For Dr. Evans there was a real decision to make because she enjoyed her experiences practicing medicine of the body, but a desire to know more about the patient and have a more meaningful interchange with patients drew her to psychiatry. And so she followed her four years of medical school, which is characterized by studies of bodily functioning, with four years of a psychiatry residency in a hospital setting.

The first year of residency is an internship, the first half of which is hands-on medical training. In fact, it is the only hands-on medical experience involved in becoming a psychiatrist. The second half of this year is the beginning of work in an inpatient setting, which involves treating psychiatric patients in a hospital setting using
medications and talk therapy (though talk therapy is not always part of the training today). Psychiatry residency is weighted much more heavily toward medication treatments, as there is a team of people responsible for each patient in a hospital setting; psychologists and social workers are much more likely to be the providers of talk therapy. Part of the way in which psychiatrists like Dr. Nelson, whose narrative appears at the end of this chapter, become so adept at diagnosing and prescribing is because that is generally their main (if not only) role in hospital settings.

The last three years of her training, known as psychiatric residency proper, involved a combination of treatment in inpatient hospital settings and outpatient settings, where patients come to the hospital for a session and then return to their regular lives. In addition, she was required to do rounds in the hospital, and attend case-conferences where individual cases are presented to an audience of residents as a training exercise. In the last two years, Dr. Nelson underwent one-on-one supervision of her cases, intensive class work in diagnostics, the brain and medications, and a small amount of coursework in talk therapy.

Dr. Evans was in medical school in the 1980s, when the field of psychiatry drastically changed. Of that shift, she describes the positives and negatives in the following way:

Definitely more positives because we have better understanding of the brain, the nervous system, mechanism of action, of medications and I think the real biology behind something that’s still stigmatized in a lot of areas, so I see actually much more positives. I’m not sure what I would say are the negatives.
Dr. Evans did not point to anything negative about the medical model or biological treatment at any point during the interview. For her, the availability of new medicines and the centrality of the biological model in psychiatry have only led to advancements.

When I asked her what role DSM plays in her practice, Dr. Evans indicated that it is fairly central, though when I asked her specifically about any problems she sees with DSM, she did point out that:

The problem is if you stay too structured you may not kind of open up things more to see – I guess in some ways you don’t want to over diagnose...And I think you don’t want to kinda box yourself in. Like the power of suggestion. I think it’s good to use as a blueprint or a structure but not everybody’s gonna fit it. Especially with kids because I think the DSM was really mostly made for adults. They really don’t fit into their boxes. They’re still in kinda a state of development...

However, she describes DSM as “very comprehensive:”

It’s very structured so I think in that sense it’s very beneficial because you go through – it’s very comprehensive. I think you go through current symptoms, but you also ask just kinda lifetime things. And I think if you fall back on a structured thing that’s based on DSM, you’re not going to omit anything. Is really kind of all inclusive.

Upon meeting new patients, Dr. Evans does what she describes as a thorough diagnostic interview. Describing her process in terms of her child patients, since they make up the majority of her practice, Dr. Evans explains the important factors needed to diagnose:

I need historical perspective. I need teacher reports, any testing. I usually ask if they’ve had psych testing. I talk to the teachers. I talk to other people in the lives of the child. I really sit down with the parents and get kind of an elaborate chronological order of symptoms as kind of a gold standard. And then a very thorough history, including a family history.
Dr. Evans uses checklists geared toward childhood diagnosis of psychiatric symptoms that are based on DSM categories, so even when she doesn’t use DSM categories directly, they are still highly influential in his diagnosis.

When I asked her what the etiology of psychiatric conditions is, she replied simply, “Genetics. Genetics. Genetics.” After a few moments pause she adds, “and environment,” but makes sure to clarify that “the genetics will predispose to a particular response” even when there is a clear environmental stimulus.

Perhaps most indicative of the kind of practice Dr. Evans has was her response when I asked what the role of medication is in treatment. Her reply was one of confusion – she looked at me as if pleading for an explanation as she said, “What do you mean ‘the role’?” I began to explain, but only got two words out when she interrupted me to add, “I think it is treatment. Especially for something like ADHD or depression or anxiety.” In other words, for the disorders for which there is a clear diagnosis and for which medicines are considered effective and relatively benign, medication is the treatment. She was careful to add that many of her patients are in talk therapy with another therapist, but for her the medication is clearly the treatment. Also quite indicative of how Dr. Evans thinks about her field are her thoughts about the contribution psychiatry makes to society. She told me: “I think our field has grown tremendously in neuroscience and biology. I think it’s really destigmatizing mental illness. I think it’s really getting us far greater understanding of etiology and hopefully the early identification and treatment.” For her, the goal of psychiatry is to continue to
advance biological treatments and, she hopes, for the technology to identify underlying biological markers of illness.

**Dr. Sutter, MD: Biological Psychiatrist**

Dr. Sutter’s office is in an affluent suburb of NYC, where beautiful tall trees line the streets and the air is heavy with the smell of freshly cut grass. On an afternoon in April of 2011 she greeted me in her waiting room, as she was still in mid conversation with someone via a Bluetooth headset; I could not tell if she was talking to me or the person on the other line. She was apologetic about the delay, yet we would be interrupted several times during our conversation by her blackberry, even though this was clearly not a work day for her; she was dressed informally, and referred to having come from dropping her kids off somewhere nearby. Though she was kind and helpful, she had clearly fit me into a solidly booked day (of non-professional activity), and there was, therefore, a sense of urgency about finishing in the allotted time. This, however, did not present a problem as we completed the interview, even with some pauses for unanticipated conversation, within forty minutes. This was not uncommon with the biological group.

Dr. Sutter was born in 1957 and grew up in the New York City area. She attended an Ivy League school and began medical school in 1981, finishing in 1985. She therefore moved into her internship and residency during the beginning of the biological heyday, and did so at a prominent hospital in New York City. At the time of her interview Dr. Sutter had about seventy-five patients in her practice, about fifteen of whom she sees
on a regular basis, which for her is generally once a week. The remaining sixty of her patients are either in very infrequent behavioral therapy or they come for medication management alone. In her own words:

I have a lot of people where I start them with combined [talk therapy and medication]. I have very few people who I just do therapy with. I think most people don’t go to a psychiatrist anymore if they don’t need meds. I have a lot of people I’ll start with in combined therapy and meds seeing once a week or some of those that I’ll see twice a week and then go to once a week. So the therapy needs will wane and I’ll see them just for meds then. I’d say that’s a lot of my med patients, although I do take some patients just for meds.

Even the patients Dr. Sutter starts out seeing for therapy ultimately become very infrequent therapy patients, or do not come for therapy at all after a certain point.

When I asked her if she has any patients who are not on medications, she replied:

Yeah, I have started this little niche of couples and family treatment. Right now I’m seeing two regular hours of that. I’m not medicating any of those people. I have one patient who I’m not medicating, I guess, and I’m seeing her for therapy. But I will medicate her. I’m just trying to figure out what she needs. She needs something.

Aside from an anomaly of two families, who come to counseling for specific relationship problems rather than for psychiatric symptoms, Dr. Sutter’s practice is clearly dominated by medical treatments.

We began our conversation by discussing why Dr. Sutter decided to become a psychiatrist, which she describes having considered even before medical school:

I went to medical school thinking that I might be a psychiatrist, either that or family practice. My father was a psychiatrist and my mother was an internist so I sort of had, like I knew about both. I was pretty sure I wanted to do psychiatry. I had done some crisis intervention stuff; I worked at shelter for battered women
and I’d done lots of stuff like that before. But it was really during the third year that I decided definitely I was more interested in the psychiatry part.

Given that she did not definitively choose psychiatry as her specialty until her third year of medical school, I asked her if there was something about the field that set it apart from other branches of medicine, or what it was that really drew her to psychiatry rather than another medical specialty. She told me:

I think a combination of interest in having long-term relationships with patients in a pretty intimate kind of way that you don’t really get in the rest of medicine...And just feeling like I could really make a difference in people’s lives.

Our conversation then turned to the major changes she’s seen in psychiatry since she trained in the 1980s, to which she had a mixed reply. She described the downside of the push toward biological thinking, but quickly followed up with the great benefits of medicinal treatments:

...I mean, the huge thing that happened is that medicine changed since I trained. Managed care hit when I was a resident... [Before, insurance] paid like ninety percent of therapy for residents like once or twice a week for the whole year. It was endless, endless coverage. There’s not that kind of coverage anymore for residents or anyone. Insurance coverage changed and it just drove huge changes. I’d say fifty to seventy-five percent of my prescriptions that I write for patients, I have to call the insurance company to get a pre-authorization. It’s a total waste of time because they always approve it, or they usually approve it. I don’t know why. It’s just a waste of time. I used to be able to write a prescription and that didn’t used to happen, so there’s all this managing...What is good is that first of all, almost all of the medications that we use now weren’t around when I was training. They’re all new and they’re all better. There’s much more choice and effective medications, which is probably why you can do really effective psychopharmacology now in the way that you were just beginning to then...things have so many less side effects and there’s so much more array of choices of what you could use.
Given the centrality of medication prescriptions in Dr. Sutter’s practice, her feelings about what indications might lead her to prescribe are crucial. When I asked her what would indicate that someone should be on medication, she explained: “You know, I think certainly if they have mental illness that responds to medications. So, sometimes it’s one hundred percent clear that someone needs medication because they have a clear-cut depression...” She also explains that she divides her patients into three categories when they come into her office, the first two of which are the patients for whom medications will be recommended:

I think of the people who, they just need medication. There’s no question. And I’ll say to them, “I think it would really be a huge mistake for you not to try a medication.” Those are the people where they have serious depression or serious anxiety or serious attention deficit disorder or some bipolar disorder or psychosis - things that medications work really well for. It’s just stupid not to take them. So, it’s like having high blood pressure. You wouldn’t go into a doctor’s office and say, “I’m gonna talk to you about your high blood pressure and try and help mellow you out.” You’d say, “Look, you have blood pressure that could really kill you and it’s making your life - it’s gonna cause all sorts of bad things, so you need medicine.” Those people I say, “I really think it would be a huge mistake if you don’t take medicine.” Then there’s the group of people where I say it’s sort of optional, where I think it would help, but they could decide and they have to weigh the pros and cons and the side effects. It’s not that medicines are side effect free. And I’ll discuss the side effects with them and then I’ll say to them, “You know, you can try and you’ll decide if you think it’s helping or not”...Those are the people who have sort of mild depression or mild anxiety where cognitive behavioral therapy or some sort of therapy can make a big difference in terms of learning various relaxation techniques...someone who has panic attacks, someone who has phobia of planes, for instance, you can give them medicine. But also, my officemate...does amazing cognitive behavioral therapy with anxiety disorders. I say to them [patients], “There’s a treatment. It works really well. It’s not drugs. You will get cured and you could do that.”
There is clearly a group of people for whom Dr. Sutter feels she must recommend medications, but she confirmed that the difference between that group and the patients for whom she would not push medications as much is the severity of the symptoms. For instance, the patient who is phobic of flying has an acute symptom with a clear stimulus. He or she could take a medicine as needed or could try to work it out in a problem-focused therapy. Whereas the patient who has many panic attacks over the course of a day with no clear-cut stimulus would be a much more likely candidate for Dr. Sutter to recommend medication. Dr. Sutter also describes a third group of people who do not need or who cannot take medication:

I just think they don’t need medicine. Or they can’t be on the medicines. I have one guy who had a heart attack and he really needs medicine for ADHD but he can’t be on it. Or I have another guy who had a congenital heart problem and again, he really needed ADHD medicine...You teach them the technique, I mean, there are lots of things that people who have ADHD can do to help themselves organize themselves that they do anyway when they’re on medicine.

Though they are different groups, for Dr. Sutter, patients who do not need medications and those who cannot take them are lumped into one category. Her role is the same for someone who cannot take a drug as it is for someone for whom she would not recommend one. This third group is the least relevant to her practice; this is because, as Dr. Sutter explains, patients who do not need medicines are less likely to end up in a psychiatrist’s office these days (as opposed to psychologists or social workers), because it is more costly to see someone with a medical degree. She seems to lament for a brief moment that today, if a patient does not need medicine, they do not necessarily need a psychiatrist.
The prevalence of medical treatment in her practice maps onto Dr. Sutter’s thinking about the etiology of mental illness, which she says has “two components:”

I think that if you look at study after study it’s usually borne out… it’s the biology and the environment and it’s the interplay of the two of those. And the biological component is huge, but then the environment is also huge. And when I say biology I’m speaking very broadly; not just genetics, but environmental - all the crap that our bodies have been exposed to and trauma and you know pregnancy and whatever...

For her, even the environmental is portrayed as being a part of the biological. The biological is “all the crap that our bodies have been exposed to,” and even trauma. If this is the case, then treating even what is influenced by the environment with medications should theoretically treat symptoms. In this sense, Dr. Sutter explains that biology underlies all experiences, and it is therefore logical that medicines can help even conditions that do not stem from genetic causes.

When I asked her what role DSM plays in her practice, Dr. Sutter responded, as most doctors did, by saying, “very little” and laughing in a way that insinuated that she thinks little of the manual’s utility. However, she continued:

It plays a few different roles. One is that you have to put a diagnosis down for insurance, and I try and have that diagnosis be accurate… partly because it becomes record. I don’t wanna commit fraud. I don’t wanna label people with things they don’t have because that’s a bad thing… So with someone who’s depressed, I would wanna be thinking, “Is this just a standard depression or is this someone who has some sort of bipolar disorder going on,” because that would definitely mean I would think differently in terms of the medication treatment. But I’m very careful about labeling. For people who wanna know their diagnoses, I’m always saying, “It’s like seeing your brown hair. It doesn’t say that much about it.” I’m not a labeling person… I don’t think my practice is un-DSM related. I think about it and I have one on my desk and I pull it out regularly to look at and put numbers down and stuff, but it’s just a little too simplistic.
The importance of careful diagnosis, for Dr. Sutter, is largely to avoid unnecessary labeling, which makes sense given that Dr. Sutter believes that the contribution psychiatry has made to society is largely to do with destigmatizing mental illness. She says she has:

...seen mental illness go from being really stigmatized and really hidden and too many people not getting help for what their problems are to it being much more acceptable to get help and to the help that we have being much more effective...both medication and therapy, we have just so many more, way more effective treatments than they had twenty-five years ago.

When I asked her to think about any issues she finds with DSM use, she responded, “just that it’s sort of cookbookie and doesn’t tell you that much about a person.” But when I asked her what the greatest strengths of DSM are, she responded with the same phrase, “that it’s cookbookie,” and that because of DSM:

...everyone knows what major depression means and that when you read a study and it says, “The people in the study were diagnosed with major depression recurrent, you know who they are.” When it says, “They didn’t have substance abuse or they didn’t have borderline personality,” you just know who those people are and then you could sort of think of your own patients.

So DSM makes it possible for practitioners to communicate with one another, to understand the studies they read, and to make associations between those studies and what is going on with their own patients. It provides them with a shared language with which to discuss illnesses and patients. Even though this allows practitioners to do their job, it is also limiting – in fact, the strengths and weaknesses are one and the same.

When asked about the role of medication in treatment, an issue that is intimately linked to DSM thinking, Dr. Sutter told me: “I think it’s a really important
modality of treatment that could really make a huge difference. Sometimes it completely gets rid of symptoms really quickly or not quickly enough, but it really can change people’s lives.” Unlike her biodynamic counterparts, Dr. Sutter did not connect medication to talk therapy. The only relationship she described between the use of medication and talk therapy is the use of sessions for discussing experiences with medications. For instance, she says:

I don’t know if you call that therapy but there’s being a doctor, sort of discussing the medication and talking about the pros and cons of it and why you take it and why it’s important to take as prescribed. Or if you’re not gonna take it as prescribed, call me and tell me about it. You don’t like it, don’t wanna take it again, let’s figure out what you’re gonna do. I spend a lot of time talking about that stuff with meds. But then, most of the people coming to see me have big, for instance, lived a year where you’ve gotten breast cancer and had your husband maybe leave and your mother die, the medicine’s not gonna fix all that. So there was a lot of talk that needed to be done…Most of the people that walk in my office have some of them huge life issues going on.

She is clear that medicine won’t fix everything, but she is also clear that a major part of talk therapy, for her, involves discussing the drugs she has prescribed.

Dr. Kane, PhD: Psychodynamic Psychologist

I interviewed Dr. Kane, a soft-spoken psychologist, in November 2008. She speaks in dulcet tones and sometimes gets lost in her own thoughts, trailing off in the middle of sentences and starting new ideas before finishing others. She is often concerned with making sure to offer the “right” answer, and fears she will rethink something after the interview and thus not be helpful to my project. Dr. Kane was born in the 1960s and
grew up in Connecticut. She attended prestigious East Coast schools from college through graduate school and was a psychology intern in New York City in the 1980s.

Her psychological training involved four years of classroom experience, characterized by seminar attendance, and extensive reading in philosophy and psychological theory; in short, Dr. Kane had a typical experience in a social science graduate program. Her training was predominantly psychodynamically oriented (as opposed to behavioral training, which was becoming increasingly popular in the 80s). During this time, Dr. Kane was also involved in various clinical placements, which means she was at practice working with patients in a clinical setting for most of her graduate career. This was followed by one full year of internship. In order to qualify to be psychoanalytic candidate, psychologists must also do one year of clinical work beyond internship, so unlike Dr. Nelson, her medical counterpart, Dr. Kane could not go straight from graduate school into analytic training.

At the age of thirty-five she started the five-year training in psychoanalysis (the same post-doctoral training described above for Dr. Nelson), schooling she describes as progressing naturally from her deep interests in Freudian theory, in investigations of the mind, and in developing meaningful relationships with patients. At the time of her interview, Dr. Kane was seeing approximately twenty patients, three of whom were in analysis and three of whom were on some kind of psychotropic medication. With only twenty patients, Dr. Kane’s practice is quite intimate. She sees even her non-analytic patients multiple times per week, generally for several years. When I asked her why she became a therapist and when she made the decision to go to graduate school in
psychology, Dr. Kane explained that she knew long before college that she would be a psychologist:

I have an interest in what motivates people, in people’s inner lives. I find it intellectually very stimulating and challenging to make connections between past and present for people. On a more surface level, I enjoy talking to people one-on-one and a type of intimacy that comes out of the relationship is very satisfying in a certain way...I decided very early on. I was about twelve. I took a book off my parents’ bookshelf entitled “I’m OK You’re OK”... it is funny ‘cause it’s a book very much of the 60s or 70s and at twelve you become more open to things and just ‘oh my goodness, what an interesting way to think about people’ and to kind of diagram what’s going on. I remember it in the most vague terms...but it just caught my attention and it seemed like “oh, well this is an area that I could be thinking about.”

Just a minute later, Dr. Kane described an interaction with a patient who came across the same text as an adult, and it was clear that they had bonded over the shared experience. I could see that Dr. Kane had genuinely warm feelings about this interchange, and that this is what she loves about her work.

The decision to become an analyst felt like a continuous endeavor from graduate school for Dr. Kane, since the same interests that led her to psychology in the first place also led her to psychoanalysis. She describes her choice to enroll in a psychoanalytic program as something that happened “pretty early on.” She explains further:

I can’t pinpoint the age but probably even before college, even before I really knew what it was about because when I went on to read more in psychology as a teenager and started to read a little Freud - even though I didn’t really understand it - the concepts captured my attention and I was very intrigued by ideas of complexity, of human functioning, and so it was very satisfying to me to read about, to think about, to consider about my parents and people around me and what was going on. It was a passion from early on.
In comparison to Dr. Nelson, Dr. Kane did not describe the pragmatic details that influenced her decision to train in psychology or psychoanalysis. For her, it was affection for psychoanalytic ideas and practices, a deep way of exploring functioning, and a fascination with the psyche. She did not feel that learning how to be a good talk therapist was a task, but rather that it really fit with who she was already, both personally and professionally. This zeal for analytic thinking is clear in how she describes what sets psychoanalysis apart from other treatments. She describes it as “an interest in...depth of functioning, and also the interest in creating a long-term relationship or conversation as a mode of treatment.”

Dr. Kane teaches courses that pertain to the use of psychoanalytic principles in understanding social and cultural phenomena; her interest in psychoanalysis is much more than as a treatment paradigm - it really is a worldview. When I asked her what she sees as the contribution psychology and psychoanalysis make to society, she indicated that her thinking is very much about the contributions psychoanalytic theory, rather than practice, makes to society. She says:

It adds a way of understanding and thinking about societal phenomenon...for instance, selections from a book I assigned to my psychoanalysis class is on terrorism and violence and selections are written by psychologists and some MD psychoanalysts, but in terms of how to understand, for instance, the upbringing of someone who would become a terrorist or the mindset of someone who’d become a terrorist or the experience of being dehumanized and then dehumanizing others. I mean that’s just a specific example of how I think psychology connects to an understanding of social phenomenon and current events.
Quite differently than Dr. Nelson, Dr. Kane makes no mention of reducing symptoms or mental illness per se. For Dr. Kane, the contribution of her field is much more about thinking about the mind.

When I asked her what it is like to be part of the psychoanalytic and psychological communities she, quite similarly to Dr. Nelson, who described shedding some of her psychiatric identity after doing the psychoanalytic training, told me:

I identify much more with the psychoanalytic community. I feel that I have much more in common in that world than I do with the general psychological community. Early in my career I would go to American Psychological Association conventions... I identified in that world. But as I became more immersed in the psychoanalytic world, those are the conferences that I go to - or lectures - so I don’t really participate in the mainstream world of psychology. Let me add one piece to that, which is that I teach...psychology students, most of whom have no interest in psychoanalysis at all. Even if you don’t go on in psychology or analysis you can broaden or enrich your perspective [with psychoanalytic principles]... So, anyway, my sort of emotional and professional affiliations are in the psychoanalytic world, though I have a foot in the psychological community.

She explains that it is sometimes difficult to train psychologists whose thinking is, today, not likely to be analytically oriented; though Dr. Kane feels strongly that psychoanalytic principles are useful for any trainee, the pushback or “kick-back” she describes when she teaches psychodynamic ideals marks her difference from the mainstream psychological community. She explained further that her students view psychoanalytic theory as unnecessary for their practices, and are actually antagonistic to Freudian ideas about the central role of sexuality in psychological development and adult thinking.

Not only does she feel differently than the majority of the psychologists she trains, but when asked if Dr. Kane sees herself differently than the psychoanalysts who
are MD’s, she replied that she thinks she is more likely to think like a biodynamic psychiatrist than like a psychologist, as she explains here:

I actually don’t think there’s a huge difference in thinking. I think that there are, around the periphery, like an MD psychoanalyst might jump in more towards medical or diagnostic, DSM diagnostic explanations for things...Psychologist analysts may be a little less prone to pigeon-hole, more open to the broader phenomenon of the patient ‘cause our training is not so diagnostically and bodily- you know, bodily in a literal way. So I think that’s around the periphery, but I think for the most part I’m more likely to think like an MD psychoanalyst than the average psychologist who’s not an analyst.

However, when asked directly if she sees tensions existing between psychologist and psychiatrist analysts, she replied emphatically:

Yes. Yes. For example, I was at a symposium this weekend...and one of the presenters whose presentation was wonderful, he gave some really great case material, he’s somebody who I’ve heard before and respect a great deal. He’s an MD psychoanalyst and totally gratuitously in the context of his presentation, he said that MD psychoanalysts are more likely to focus on the body. But he didn’t mean literally the body like symptoms or diagnoses, just on patients’ experiences of their bodies. And I happened to be sitting, by coincidence, in a row where there were several psychologists and we sort of turned and looked at each other like what the hell is he talking about...It was not accurate and I had no idea why he put that in there. It just didn’t even make any sense...I do think that MD psychoanalysts think of themselves at the top of the hierarchy.

Even though Dr. Kane believes that her thinking is aligned with MD analysts, she clearly feels as though there is some way in which they relegate the psychodynamic psychologists to secondary status, and sees their medical training as the factor that allows them to do so.

Though DSM was designed by and for psychiatrists, Dr. Kane does have to think about DSM categories and use them for insurance purposes. When I asked her what the
role of DSM is in practice, she chuckled and responded, “Very little.” However, in the next breath she said:

I feel *obligated* when first meeting someone to consider DSM because I want to think about whether I *ought* to be referring them for medication, for instance, or whether there’s character pathology that I should be taking into account, or thinking about as I approach my work with this person. But beyond the first couple sessions or unless I hear new material as we go that then puts me back to criteria for [something like] depression, I consider it very little ever once I’m midst a treatment. [Italics added]

Given that Dr. Kane is a psychologist and cannot prescribe medications like her MD counterparts, she describes the obligation as an “ought” feeling that she should refer patients for medications when symptoms are quite severe, when the intensity and/or duration of a patient’s symptoms are beyond a tolerable range. When I asked her whom she tends to refer her patients to for medications, she informed me that she would “prefer to refer to fellow analysts,” citing with a smile that they “can have a conversation that makes sense and takes into account the dynamics of the patient.”

Because of that, a biodynamic psychiatrist is also less likely to get in the way of the treatment plan or alter the narrative that Dr. Kane and her patient have previously established about the treatment overall, and about the meaning and cause of the patient’s symptoms.

Because she refers her patients for medicine, the role of medication in her treatment is certainly a consideration, as Dr. Kane explains:

I think one role that it sometimes can play is to sort of free up someone from symptoms that couldn’t then interfere with their life and that they’re freed up actually to focus on other more neurotic issues. I’m not a big medication person, as I’m sure most psychologist analysts are not ‘cause I think that sometimes
there’s a lot of fantasy around medication, a lot of ideas about “well now I’m better” and appreciating sort of the short-term, cut and dry, yes/no aspects of it, as opposed to the actual hard work of an on-going therapy.

Though Dr. Kane cannot prescribe drugs and only a handful of her patients take them, she makes it clear that, for patients with severe symptoms, she will certainly refer them to an MD. Dr. Kane is very careful to pay attention to the meaning of medications for her patients, and will discuss, in-depth, how the patient feels about being on medicines.

When asked specifically if she considers the prominent role of medication to be problematic for the psychiatric profession, Dr. Kane shrugged sort of exasperatedly several times during her response, which was as follows:

"I think it’s very problematic and I think it’s driven by reasons other than actually what’s helpful for patients, such as insurance company reimbursement...This isn’t something I’ve thought about a lot, it’s not something I think about a lot, but The American Psychiatric Association, since that’s their thing, medication is their thing, you know. It may be a way of protecting the guild essentially, and insuring a livelihood for their members...I think it’s a problem for psychiatry in that psychiatrists coming up are not being trained to do very much psychotherapy, and certainly not very much psychodynamic psychotherapy, so I think they’re becoming, as I see it, almost robotic in a certain way.

This over-reliance on medications is not the same in her profession, but since she teaches analysts in training Dr. Kane has become familiar with the kind of training psychiatrists have, and clearly feels there is an inadequacy for psychiatrists when they enter that training, and may even struggle (as Dr. Nelson describes in the last narrative in this chapter) to become good talk therapists.

Summarizing her thinking quite nicely, Dr. Kane’s succinct reply to my question about the etiology of the conditions she treats underscores that she is always thinking
about both inherited vulnerabilities as well as the influence of current and past environmental factors, but that the latter is most present for her. Her reply was simply, “well, nature and nurture, biology and environment. Environment including early history, chance...I think more about the environmental, more about the nurture.”

**Dr. Nelson, MD: Biodynamic Psychiatrist**

I interviewed Dr. Nelson early on in the project in June 2007; she was my fifth interview. Because she has an academic interest in the training of psychoanalysts, she was able to vocalize some of the key issues in this project with ease. Dr. Nelson was done answering my questions about ten minutes before we were scheduled to end, which was rare for the psychoanalytically trained practitioners, who tended instead to go over our allotted time. Since I informed doctors that the interviews would take approximately forty-five to fifty minutes and this one was complete in significantly less time, Dr. Nelson seemed curious why we had not needed the entire allotted time. We concluded that she needed less time to mull over these theoretical questions, especially regarding etiology and the role of medication in practice; she had answers readily available because she teaches this subject to residents and new analysts. This, however, also increased my need to draw her out, as her assumption seemed to be, often incorrectly, that her answers were self-explanatory or that I had the same knowledge base as her students.

Dr. Nelson was born in 1959 and was raised in and around New York City. She attended a series of elite schools in the Northeast, and started four years of medical
school in 1979. Dr. Nelson describes what she calls “the development of her interest in psychiatry” as something that emerged during medical school:

When I went to medical school, I thought I was going to do some kind of community health, public health. I was somewhat of an activist before I went to medical school and I worked doing organizing, and just eventually decided that I wanted more technical skills to offer people. And so medical school just seemed like the most humanistic approach to getting technical skills. I was doing environmental work and instead of continuing...I shifted towards health care, but then in medical school it really just took me by surprise how much I liked psychiatry, and rather than train as a physician, as an internist or a surgeon or a dermatologist, and then yet still figure out a way how to apply it and integrate it with my politics, I just sort of went the other direction and decided that I was most interested intellectually in psychiatry and why not just do it?...I just really like being with patients and thinking about, observing how their minds worked and relating to them in therapy. And emotionally I just thought the whole mind, body thing was fascinating, so I just sort of went with my gut on what was intellectually interesting to me.

She began training when there was still a significant presence of talk therapy training in residency programs, though even then, one year before the release of DSM III, the focus was shifting toward diagnosis and prescribing practices, and had certainly crystallized as such by the time she graduated.

Dr. Nelson practiced for approximately six years and then entered five years of psychoanalytic training in 1989, which she completed in 1994. While in psychoanalytic training, Dr. Nelson was herself required to be analyzed by a training analyst (who has experience in the field and has been through a rigorous certification process), which is a mandatory part of the program. This means that she was seen by her training analyst four times a week. Dr. Nelson also had to take on three analytic cases (four sessions per week) over the course of the five years. Each of these cases must be supervised by a
different training analyst, which amounts to forty-five minutes per case per week.

Finally, all five years of training include coursework. At the same time trainees perform their regular duties – for instance, seeing their regular patients and teaching psychiatry residents. Given such an undertaking, I asked Dr. Nelson why she decided to train in psychoanalysis. She explained that:

...in psychiatry residency, we had lots of different teachers and the teachers who I found most engaging intellectually, and who I also developed the most rapport with were the analysts...I was gravitating towards them as mentors. And then I really liked working one on one with patients and eventually...I was trying to integrate having a family, and being somewhat available and balance work and family life. I was toying with how to do it all, how to at least find whatever it is that I had to work at intellectually interesting that I started feeling like private practice was probably most likely going to be the emphasis. And I was interested in psychoanalysis and developing my therapy skills and working further with those mentors from the analytic institute, and so it came together really as a decision as a way to integrate work and family.

The training in medical school to prepare a psychiatrist to practice in-depth talk therapy is minimal at best, which left a void if Dr. Nelson wanted that to be the focus of her practice. She would not be ready after psychiatric training alone, she felt, to have the kind of private practice that was meaningful to her unless she trained as an analyst.

At the time of her interview, Dr. Nelson was seeing approximately fifty patients. Though she is a psychoanalyst, she sees about twenty patients infrequently for medication only. She has five patients who are in analysis, which means she sees them four times a week, for forty-five minutes each session. Therefore, a considerable number of her patient hours – in fact, about twenty hours per week (an “hour” is forty five minutes) - are spent doing psychoanalysis. Fifteen of Dr. Nelson’s patients are not
on any medications, which means about one third of her practice is non-medical. This is in part because of the high number of hours she spends with those five analytic patients, who are less likely to be on medication than other patients because they come to treatment, in general, to explore deep issues of their personality and life experiences, rather than for immediate symptom relief.

Dr. Nelson explains that the most important contribution psychiatry has made to society is that it provides a particular kind of health care that “takes care of people’s emotional well-being and treats their mental illnesses.” She describes psychiatry as an essential component of the medical system. Pausing for pointed laughter as she hits terms such as “evidence-based” and jokes about her colleagues taking the psychotropic medicines they prescribe, Dr. Nelson summarized her thoughts about the dominant treatment modality in psychiatry today:

In mainstream American psychiatry I would say it’s medical model, DSM-based, where people make diagnoses and then offer treatments based on the diagnoses, some of which are evidence-based. But I think the dominant thrust right now is in medications for psychiatrists - I mean for psychiatrists to prescribe, and take if they wish. And I think talking therapies have been less popular, but there are a group of them that are evidence-based that still remain cornerstone in mainstream psychiatry [she later explains that this is largely CBT¹]...

She indicates an awareness of being part of a small, local group of therapists, and that psychiatrists in other parts of the country would likely be less oriented toward talk

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¹ Cognitive Behavioral Therapy is a short-term 12-week program of therapy that focuses on changing thoughts and behaviors. Therapists and patients work with standard protocol including worksheets and homework assignments. It is generally used for anxiety, though versions of it have been used for other conditions as well.
therapy and much more toward biological treatments. She also noted that this is in part because of the availability of patients in New York who can afford to pay for treatment that is not reimbursed by insurance companies, whereas in other parts of the country patients are more limited by what treatment their insurance company will pay for. They are also, by virtue of location, less likely to know non-biological treatments are available. These macro-level factors are key structuring agents of psychiatric practice and practitioners are very aware of them.

Because she considers herself part of a minority that practices psychoanalysis, Dr. Nelson is keenly aware of what sets psychoanalysis apart from the medical treatments psychiatrists so commonly offer.

In terms of psychoanalysis in my practice, I see it as the way to offer the deepest treatment experience. And it fits a niche in terms of treating people who are suffering from sort of coping problems and character problems. The group of people who would take advantage of it are often people who would take advantage of other modalities, so they may also use medications and other kinds of therapies before entering psychoanalysis, but the psychoanalysis offers the most intensive, rigorous approach to personality and character problems and higher-level neurotic problems for those who have the motivation to do it.

In her description of psychoanalytic treatment, Dr. Nelson takes a pragmatic approach. She explains who benefits from it: people with neurotic problems (rather than more severe conditions like major depressive disorder or psychotic disorders like schizophrenia), as well as those who are motivated to understand themselves and are not just looking for symptom reduction. She also makes sure to mention that even in-depth talk therapy is usefully combined with medical treatment, a theme that proves to be central for the biodynamic group.
When it comes to her professional identity, Dr. Nelson finds her role as a biodynamic psychiatrist complicated. Here, she describes the difficulties of maintaining full membership in the two different professional communities that make her biodynamic: the psychoanalytic and the mainstream psychiatric. As someone who was drawn to medical training, becoming a psychoanalyst did not come naturally. For Dr. Nelson, even though she was interested in it and felt motivated to train in psychoanalysis. However, about a decade after her analytic training, she now feels much more aligned with other analysts than she does with mainstream, biological psychiatrists. She describes the experience of being both a psychoanalyst and a psychiatrist:

I really see myself more and more sub-specializing in psychoanalysis and psychoanalytic therapies, so that’s probably what I’m best at. And I’ve had to tolerate that I’m not best at general psychiatry, but that I’m a good enough pharmacologist for what most people need. And then I use consultations when I get out of my range and so that’s really been the transition: the sort of accepting that I may be expert at one thing, but not at something else...For me, really learning how to get good at psychoanalysis has taken a huge amount of work and it would be hard for me to also put the work into keeping up with the cutting edge of pharmacology at the same time.

Dr. Nelson takes the question of how it feels to be both analyst and MD quite literally when she describes her lack of ability to physically participate in both communities. Her description was of an almost painstaking decision to give up being a really good psychopharmacologist in order to be a better psychoanalyst. However, she describes no difficulty in practicing both for the majority of patients and sending the more complicated medicine patients to other MDs. Though she has had to make some
concessions in her own identity as a psychiatrist, the problems she has faced have mostly been in trying to stay equally informed about the latest news in both treatment paradigms. She is someone who is very family-oriented and has designed her practice precisely around being able to have time for her personal life.

In psychiatry at large today, two of the most central issues are the role of medication in practice and the use of diagnostic categories – two issues that really go hand-in-hand\(^2\). When I asked Dr. Nelson about the role she sees for medication in psychiatric treatment, she told me: “I see it as the shortest route to alleviate pain - not necessarily suffering, but you know if someone fits into a DSM diagnosis that medicine treats, I basically feel like it’s my obligation as a physician to offer it up.” Her distinction between pain and suffering stems from an earlier question in which I asked her to think about any qualitative differences between the two terms. Her differentiation was in describing pain as something acute, a specific symptom for instance, rather than something more ongoing. She also alludes to the biological model being more apt to address the former, while the psychodynamic has the potential to dig deeper and get at suffering. Dr. Nelson also clearly identifies herself as a medical doctor; her job is to diagnose and to assuage whatever pain possible. In doing so, the role of an initial diagnosis is important, but it is not the whole picture:

I know in the back of my mind that I’m gonna write some kind of diagnosis, but I don’t feel like I necessarily have to know what it is after one meeting, so mostly I’m trying to get the story and figure out what’s going on and what does the person need. If a diagnosis easily pops up the first time, I will put it in the chart...I mean I take a good history and I take a family history. I review a list of symptoms

\(^2\) Refer to Chapter 2 for a more extensive discussion.
to see if they do fit together in a diagnosis. You know a medical history and drugs, substances all. I do a medical as well as a psychiatric evaluation.

Though she does not use a standard check-list, by diagnosis Dr. Nelson means thinking of the DSM symptoms a patient has and how those symptoms might fit into a diagnostic category. On the role of DSM more specifically, she says:

I think it is important to label what we see both because of using medications and in terms of picking therapies, as therapies start to get tested for certain diagnoses. But the fine tuning of, you know, whether someone has one form of anxiety or another - I don’t usually bother with very much... I really see it as a tool to help us talk to each other and label what we see...my goal is not to try to use it... I think it’s, it probably is a good thing to continue to develop but it’s just not something I’m interested in focusing on. I mean I’m glad it’s there and I think it’s a good endeavor and should be continued and that over time it will better approximate, I hope, what in fact these syndromes are...

She takes a distant approach to DSM, making sure to note that she really has little interest in it at all. Of course, because of the nature of Dr. Nelson’s practice, she does not need to fill out insurance forms for most of her patients, thus allowing for a more peripheral role of diagnostic codes than practitioners for whom insurance reimbursement is much more a of a concern. Throughout her comments above, she chuckled, as if indicating the useless, silly nature of DSM, but was also careful to point out that while DSM is not very useful and plays only a peripheral role in her practice, the medical model itself is central. Seeing the ironic nature of her own critique of DSM and simultaneously strong adherence to the medical model, she laughs as she says, “the categories [in DSM] and like the long lists don’t feel like the way I’d approach it so much, but I think it is a medical model tool and probably not that far off from what I said I do use.” In other words, she comes full circle from saying DSM has little role to
acknowledging that, while she may seldom use DSM itself, the categories are probably quite similar to the diagnostic categories she has readily available in her mind when she assesses a patient.\(^3\)

Perhaps the clearest indication of how Dr. Nelson thinks about treatment is in her description of etiology. In describing what causes psychiatric symptoms she implies a solution:

> I mean I’m sort of bio-psycho-social...I’m a firm believer in biology. I think there are people who grow up in horrific developmental situations and come out way ahead, and people who can’t and that a lot of it is biological. And genetic. And then I think that you know I’m a firm believer in the developmental theory of how we become who we are - all kinds of theories that our social and economic environment also play a huge role.

Showing her biodynamic colors, Dr. Nelson describes biology as the most salient of three overlapping etiological concerns - the “bio”, the “psycho”, and the “social.” But she also believes psychological resilience and environment plays a significant role. In noting that there are multiple causal factors in the development of mental illness, Dr. Nelson reaffirms her identity as both biological and psychodynamic practitioner, which allows the biological contributions to etiology to not cause her problems in practicing psychoanalysis, and the psychological and environmental factors responsible for symptoms to not keep her from prescribing medications.

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\(^3\) Disparaging DSM categories and thinking of DSM as something peripheral to practice, even though it is in fact highly influential, is something I turn to much more directly in Chapter 3.
In this chapter I have offered portraits of four of my interviewees and focused on their thoughts about the central issues in their practice and in their field. In this chapter and the one before it I have alluded to some of the tensions that exist between the biological and psychodynamic models. I turn now to a more specific discussion of some of these central issues by focusing on the psychodynamic and biodynamic practitioners, whose narratives show that, while the two models are not nearly as irreconcilable as they once were, there are significant incompatibilities at the level of theory and in interpersonal interactions with other practitioners. Though I occasionally reference the biological group from here on out, I do so mostly as a comparison, since biological psychiatrists are only trained in one model and very rarely think about the psychodynamic model.
CHAPTER FOUR

The Tensions between Meaning-making and Medicalization

The biomedical and psychodynamic approaches nurture two very different moral instincts by shaping differently the fundamental categories that are the tools of the ways we reason about our responsibilities in caring for those in pain: who is a person (not an obvious question), what constitutes that person’s pain, who are we to intervene, what intervention is good. These two approaches teach their practitioners to look at people differently. They have different contradictions and different bottom lines. Both have their strengths and their weaknesses. Each changes the way doctors perceive patients, the way society perceives patients, and the way patients perceive themselves. (T. M. Luhrmann, 2001:23)

As is evident in the description above, researchers often assume there is a strict boundary between the psychodynamic and biological models in psychiatry. Strauss (1981) explains that these “different moral instincts” embodied by practitioners stem from the ideologies upheld by these two approaches. My data confirm the tensions Luhrmann and others describe between these paradigms, and that practitioners are aware of them. Further, in this chapter I show that it is not just the approaches to treatment, to seeing people, or suffering that diverge, but the way in which practitioners who operate in those opposing models see their work and their colleagues, who may have some but not all of the same professional training as they do. The clashes and complementary aspects of the two models manifest in different ways for practitioners in the biodynamic and psychodynamic groups as they face different kinds and intensities of professional tensions.
Given that the biodynamic practitioners are trained in both the psychodynamic and biological paradigm, there is a potential for internal, cognitive tensions in negotiating between one treatment model that advocates meaning-making in order to uncover deeply-rooted psychological conflicts, and another that advocates medicinal treatments. The biodynamic group, then, presumably embodies the contradictions we have seen throughout this project. The psychodynamic group is also in a position to experience the tensions associated with having been trained in the psychodynamic model, but encountering psychiatrists who are trained very differently, both when referring patients for medicines as well as in psychoanalytic training, where psychiatrists make up a significant percentage of their cohort. Because of this psychologists too must navigate between the psychodynamic and biological models to the extent that one does not refer ones patients for medications without at least a basic belief in biological etiology.

The potential tensions for the biodynamic group exist on two levels: as possible cognitive conflicts between meaning-making and medicalizing practices, and as interpersonal tensions when encountering non-analytically trained psychiatrists. The former are the most important for the biodynamic group, as they are much less likely than the psychodynamic group to require professional relationships with non-analysts. Because they refer patients for medications, the psychodynamic group has little choice but to encounter psychiatrists. In short, the psychodynamic group must rely on psychiatrists to a certain extent to help their patients, but the biodynamic group, who can prescribe medicines for their own patients, need not depend on anyone else except
in unusual circumstances. Thus, for the biodynamic group, the majority of the tension comes from their own training and is cognitive in nature, whereas for the psychodynamic group the tensions are not only cognitive but also interpersonal. Psychodynamic psychologists experience tensions as the result of external professional constraints.

Cohort is hugely important for the biodynamic group. The psychodynamic model is much more entrenched in the thinking of the more senior members of the biodynamic group; since they trained during the psychodynamic heyday, their role as medical doctor is something that was scarcely called upon until the 1980s, when it became necessary (for the array of reasons discussed in chapter two) for them to prescribe medications as well as to practice talk therapy. Therefore, the biodynamic group is somewhat heterogeneous when it comes to the extent to which they experience the tensions between the psychodynamic and biological models.

While training in psychoanalysis diminishes some of the differences between psychiatrists and psychologists by the end of the five years (especially since the biodynamic group comes to see talk therapy though an entirely new lens and psychodynamic practitioners are more pressured than ever to refer for medications), the relationship between the two paradigms remains complex and there are tensions between the two models as well as between the two groups. Some of these tensions extend beyond a clash between the biological and psychodynamic models to professional competition and power struggles between those with medical degrees and those who are doctors of philosophy.
Why Exclude the Biological Group?

In this chapter I leave behind the biological group to focus on the psychodynamic and biodynamic groups. I do so because tensions are irrelevant for the biological group, since they practice within one model. Therefore they are not as concerned with how other frameworks are employed in practice, nor do they need to think about the use of more than one kind of treatment in their own work. Even when biological psychiatrists practice what they describe as “talk therapy,” it is not psychodynamic. Rather, biological psychiatrists use principles of a range of behavioral therapies and generally consider the discussion of progress or side effects from medicines to be a significant part of the therapy they provide. Further, they do not need to practice talk therapy. In fact, at least two of the biological psychiatrists I interviewed said that psychoanalytic training is a waste of time and not necessary to practice psychiatry today, though they waited for me to turn the recorder off before saying so.

For the most part the biological group is not hostile toward talk therapy, dynamic or otherwise. In fact, sometimes they recommend it. Mostly they just do not think much about it; it was not a part of their training, so they do not offer it. Recall, for instance, Dr. Sutter’s description in chapter three of the patients who could go with either medication or talk therapy. She says:

...someone who has panic attacks, someone who has phobia of planes, for instance, you can give them medicine. But also, my officemate...does amazing cognitive behavioral therapy with anxiety disorders. I say to [patients], “there’s a treatment. It works really well. It’s not drugs. You will get cured and you could do that.
In other words, she is somewhat neutral about non-medication therapy – you can take drugs or try therapy. Of course, for more severe conditions Dr. Sutter would not be as quick to recommend a non-biological treatment, and dynamic psychotherapy never even came up in our discussion. Similarly, Dr. Hart (biological) told me:

I don’t feel that there should be sort of a cookie-cutter treatment imposed upon people based on the treater’s discipline. That, I don’t think – I don’t think that’s good treatment, but I think that if somebody is evaluated, and if in fact they have a condition that might best respond to psychotherapy, for example, and if there’s no acuity, no need for medicine, therapy without meds is perfectly reasonable. What really scares me is that I think there are a lot of people out there, not so much psychiatrists, but I think social workers and so forth, who are treating some very sick people and sometimes that isn’t the appropriate – sometimes therapy alone is not appropriate for that. On the flip side of it, I think psychiatrists do people a tremendous injustice if they’re just, “take Prozac and call me in a week.” I don’t think that’s good treatment.

Though biological practitioners may be open to their patients using talk therapy along with medications, and they may even see the good elements of discussing underlying causes for the symptoms they treat with medicines, they often point out that talk therapy without medication can be dangerous.

On the whole, the biological group has little reason to face the kinds of tensions that the biodynamic psychiatrists and psychodynamic psychologists in my sample reported experiencing. This is largely because it will not impede their practice if a patient is in talk therapy with another practitioner or if they do some basic supportive therapy with a patient who is taking medicines. They will not engage in in-depth talk therapy, and their interactions with practitioners from the biodynamic and psychodynamic group are focused solely on medicines. Thus, the biological group does
not need to think about the implications of medicines for their patient’s talk therapy
treatment in the ways the biodynamic and psychodynamic practitioners must. For this
reason, I focus on the biodynamic and psychodynamic groups in the final two chapters.

Age-old Tensions Between the Psychodynamic and Biological Models

Practitioners have long been aware of and even concerned by the contradictions
in their field between the biological and psychodynamic models, and between doctors
who identify strictly with one or the other of these paradigms. In 1966 the prominent
psychiatrist, Lawrence Kubie, noted profound changes on the horizon for his field.
Acknowledging vehement opposition between practitioners trained as Freudian
psychoanalysts and those wedded to the organic or biological approach, he called the
former “organophobic” (fearful of biological thinking), while he identified the latter as
“psychophobic” (afraid of any validity of the psychoanalytic tradition). Kubie notes of
psychiatrists of his time that:

    Some are so dedicated to the organic approach that they are terrified lest their
    fragment of truth not contain all the answers and they thereby be lost. Out of
    such terror come furious and poison-penned attacks on all psychological
    considerations and methods. The same terror assails some of those who
    approach psychiatric disorders from an exclusively psychological basis. They too
    live in terror lest a drug come along to destroy their life’s work and hopes; and
    they too react with rage. (Falck 1980:pg missing)

In fact it is not just psychiatry and the field of mental health more broadly that
experience these kinds of philosophical and methodological tensions, but all fields that
have subspecialties and in which members of these sometimes-disparate groups vie for
power and prestige. Psychiatry is but one of many professions in which subgroup
tensions have driven intense debate and even hatred of other members of the field. I turn to this subject more fully in the conclusion. As I have explained in the first three chapters of this dissertation, just a decade after Kubie’s essay, new medicines would be developed and new scientific theories would be seen as the “truth” in psychiatry, mostly confirming the fears of the “organophobe.” Tensions and uncertainties had psychiatry in the state of turmoil that characterized the liminal period of the late 1960s and 1970s, in which Freudian theories were losing ground and biologically minded psychiatrists ushered in an era of evidence-based medicine.

These tensions are still relevant in a profession (and a society for that matter) that largely accepts biological theories and solutions to mental illness. The tensions Kubie describes still exist today, although they are hardly at the level of “phobia.” Instead, these tensions manifests as an underlying contradiction between psychodynamic and biological practitioners and as certain irreconcilable differences between the models themselves.

As I described in detail in chapter one, not long ago psychiatric patients spent long sessions several times a week, often lying on analysts’ couches describing the intimate details of everything from their childhood experiences to adult relationships, as psychiatrists sat behind them, silent in every way except for the sound of pen on paper. Medication had little to no role in this kind of therapeutic practice. This is clearly no longer true. In this chapter I describe the tensions that exist for psychiatrists who remain interested in psychoanalytic treatment, and for psychologists who train as psychoanalysts in an institute that is dominated by medical doctors and a society that
favors biological treatment. Both groups are, therefore, presumably caught between two competing treatment paradigms, though as we shall see, each in different ways.

It is really only when my interviewees were in psychoanalytic training that these tensions came to the fore. The biodynamic group only became dynamic in this training – until this time they were biological (barring the more senior analysts who trained before the 1980s), and the psychodynamic group trained for the first time with medical doctors (though many of them had encounters with MDs when referring patients for medication consultations before this training). In analytic training psychiatrists encounter non-MDs who they must learn to listen to. Further, they must be open to new theoretical models and treatment approaches. This is complicated since their primary socialization is into a rigid way of seeing patients in terms of their symptoms and in solving problems with medicines. Psychoanalytic training in part re-socializes psychiatrists; though they retain their medical thinking, and their psychiatric-mindedness is still the dominant lens through which they see the world, psychoanalytic training challenges the way they think about and react to their patients.

Dr. Nelson’s description of using the two models together highlights the primary role of the medical model and the secondary status of psychoanalysis. However, she has five psychoanalytic patients, which make up ten percent of her practice, one of the highest percentages of any of the analysts, especially of practitioners under the age of sixty. She says, “I think [psychoanalysis is] very difficult to integrate with the medical model. And since I see the medical model as my bible, it’s always challenging for me to be an analyst because I’m constantly going in the other direction when I do analysis.”
In the end, training in psychoanalysis may not change the shape of a psychiatrist’s practice very dramatically. This is clear in the sense that only a handful of these psychiatrists have practices in which even as little as five percent is made up of analytic patients. In fact, the number of analytic patients is really not the best indicator that a psychiatrist engages in meaning-making practice. After all, very few of the psychologists see more than a handful of analytic patients either. It is simply not financially feasible for the practitioner or the patient. But analytic training does change the content of the session and the way practitioners think about patients; it adds new dimensions to their understanding of the patient. For example, Dr. Nelson (biodynamic) describes being able to offer the “deepest treatment experience” only after she trained in psychoanalysis. All the biodynamic psychiatrists report that the importance of subconscious thought and the meaning of symptoms are key lessons of psychoanalytic training.

Psychologists are also influenced by the new theories in psychoanalytic training—certainly, their background in dynamic therapy is reinforced. What is most striking, however, is that the psychodynamic group, who has little exposure to lessons in diagnosis and medication, comes into contact with MDs as both mentors and colleagues, and are influenced by their theories about etiology and treatment. It is the biodynamic group that is the most changed by analytic training, because they are introduced to an entirely new model of treatment and way of thinking about people, their motivations, their troubles, and their behavior. Even though a propensity for philosophical thinking and an interest in the psyche are what generally trigger a desire
to enter psychoanalytic training in the first place, the training itself is what provides psychiatrists with a new paradigm. In moving from being a biological psychiatrist to a biodynamic psychiatrist, practitioners learn to recognize new things about their patients – that the relationship they have with their patients, along with a deep exploration of the psyche, can change the way patients experience the world and influence the symptoms, which they were once taught were the result of chemical imbalances that should be treated with medicines.

Ultimately, as Zerubavel (1997) reminds us, “[b]y simply shifting our mental gaze, we may thus come to ‘see’ things we have never noticed before, even in extremely familiar environments...” (p. 26). The consequence of this is what Strauss et al (1981:371) describe as turning points that alter career trajectories and more general professional perspectives. Aside from the handful of biodynamic psychiatrists who trained before the 1980s and were exposed to a great deal of psychodynamic training in residency, psychiatrists enter psychoanalytic training largely as biologically minded practitioners seeking another set of tools to aid them in practicing talk therapy. If these psychiatrists want practices oriented toward in-depth talk therapy, they need more training.

On the other hand, training in psychoanalysis for psychodynamic psychologists is, as Dr. Kent describes, “continuous,” which she qualifies by adding: “I’m not really

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1 It is important to note that even after psychoanalytic training, psychiatrists’ practice may not necessarily change all that dramatically. The way they think about their patients may be different, but they still treat using medications because it is their primary training, because the medical model is more culturally acceptable, patients ask for medicines, and insurance companies reimburse for evidence-based practices alone.
doing something very different from what I did when I started graduate school. It’s
different in that I know a lot more and I’m better at it, but it seems like the same kind of
thing.” However, of the biodynamic group, she says, “for them, it feels very
discontinuous and so they all seem like someone who in some way changed careers or
something.” After psychoanalytic training, biodynamic practitioners wind up with a
practice that is radically different than that of their biological counterparts. This is clear
in looking at how many more patients the biological group see, on average, than the
biodynamic group.

In other words, in psychoanalytic training most of the biological practitioners in
my sample come to learn what traditional talk therapy really is – which is something
much more complicated than what they learned in what they describe as insufficient
lessons during their medical training. Talk therapy changes from something vague and
barely known to something with a specific technique aimed at understanding patients’
wishes, early experiences and general style of thinking. After all, most psychiatry
programs only teach residents how to ask standard questions pertaining to how long a
symptom has persisted or whether a patient feels suicidal. Even simple questions like
“what does that mean to you?” are not necessarily a part of training in psychiatry today.
In fact, even the most prominent psychiatry programs can fall short of teaching
residents how to successfully interview a patient. McWilliams (2005) describes an
occasion where she interviewed two patients on an inpatient unit in the presence of
two young psychiatrists. Afterwards, she overheard the two doctors discussing her
performance. She recounts:
...I overheard one young doctor comment to another, ‘that’s a great line she uses! I’m gonna use that line myself!’ Curious, I asked the resident which ‘line’ of mine he was appropriating. His response was, ‘It was your question, ‘Can you say more about that?’’ He had been trained to ask questions like ‘Has it been more than two weeks or less than two weeks?’ and to check off the relevant criterion in the [DSM]. (P.142)

This interchange took place at a well-respected training hospital in New York City. Psychiatry residents are simply no longer trained to make meaning of their patients’ experiences.

For the psychodynamic group, training is continuous since they were all trained in dynamic principles prior to entering psychoanalytic training; in fact, they enroll in analytic training as a way to further skills they already have. Still, psychodynamic practitioners experience tension of a different kind in this training. It is not because their professional ideology and identity is challenged, but rather because they encounter MDs, often for the first time, in a classroom setting. Previously, their graduate experience was with other psychologists. Psychoanalytic training, which involves some lessons on diagnosis and disease (typical only of training in the last several decades), is often their first exposure to the way psychiatrists are trained to think about the symptoms they treat. Again, the exception to this is the more senior analysts in the sample, who reminded me often that “psychoanalysis was obvious” as a specialty when they were in training and they would never have been encouraged to think medically or diagnostically when they trained, even in psychiatry residencies.

*Biodynamic Tensions: The Boundaries Between Meaning-making and Medicalization*
I turn now to the tensions that exist for the biodynamic group, which are largely caused by conflicts that result because of conflicting worldviews. Given the literature on the inconsistencies and tensions between the biological and psychoanalytic models, one would expect to hear of these in biodynamic psychiatrists’ narratives. Indeed, biodynamic psychiatrists recognize these tensions when they are prompted to think about the theories that underlie the two models and, often, in encounters with non-analytically trained psychiatrists.

*Analytic Training is about being a Better Psychiatrist; the Models should be Integrated*

When asked about why they became analysts and whether there have any difficulties in practicing analysis and biological psychiatry together, biodynamic psychiatrists immediately point to problems in integrating the two approaches. Dr. Warren (biodynamic) explains that psychiatrists often undertake psychoanalytic training precisely to be able to integrate dynamic practice more fully into their treatments, but then find themselves stuck between two competing camps:

The analytic training for me was about being a better dynamic therapist. I think it is a hugely helpful thing in my work on a day-to-day basis, but the complicated part is often in talking to colleagues who haven’t had the training and, when I’m at [Institute] doing analytic stuff I can sort of speak in one way and if I’m talking to child psychiatrists I’m gonna not go into too much detail about the dynamics... if you split it off too much then the people who don’t have the analytic training don’t learn anything in that regard and the people who think too analytically don’t get challenged about the medical part, so you try to kinda bring both in but it’s sometimes, it can be exhausting for one thing.
In her interaction with other psychiatrists who are not trained, in her opinion, as thoroughly as she is, Dr. Warren feels tensions. She conveys her wish for integration and her frustration in confrontations with mainstream psychiatrists.

Dr. Nelson, perhaps most directly, explains the general desire for more fluid movement between the dynamic and biological approaches: “I think it would be nice to integrate these different ways that we think. You know, I do think it’s very helpful to look at patients’ defensive structure\(^2\) and that really does affect treatment decisions…” She explains that the psychodynamic approach provides information for the psychiatrist about the patient’s personality organization, something central to dynamic theory. A practitioner would want to understand which type of treatment would be best for the patient, not just based on symptoms, but on a much more complete picture of who the patient is. Without the psychodynamic elements of treatment Dr. Nelson clearly feels the patient is at a disadvantage. In describing a desire for psychiatrists to more fully integrate these perspectives, she reinforces the idea that they are not often used in tandem – certainly not by those without psychoanalytic training. All of the biodynamic group, especially the more senior analysts, feel that psychiatry residents are not currently afforded a comprehensive repertoire of treatment techniques due to the lack of dynamic training. This is most evident in child psychiatry residencies, as Dr. Sullivan (biodynamic) explains:

\(^2\) This is the way in which people consciously and unconsciously respond to emotionally laden stimuli – i.e. conscious and unconscious coping mechanisms. A focus on this is central to psychodynamic theory and treatment.
The residents [in child psychiatry] who I worked with this past year have really suffered and struggled with the absence of any of that kind of [dynamic] input... People want to understand even when they’re medicating their patients, why they’re compliant\(^3\) or not compliant and what’s going on in the room.

Here Dr. Sullivan describes the desire for integration of dynamic principles into mainstream psychiatry, and the hope that residency programs will realize the benefits for their students of psychodynamic theory. The current lack of integration underscores the divide between analysts and other psychiatrists who have a different schema for understanding and language for discussing patients. Dr. Halsey explains the tension she feels in speaking with mainstream psychiatrists, whose thinking is rigidly diagnostic, when he says, “the adult psychiatrists I deal with who are not analysts I find just very hard to deal with. It’s almost as if I [am speaking] with an internist. I have to be very straight to the point, very concrete: these are the symptoms.” Dr. Halsey highlights the scientific, medical nature of conversations with psychiatrists, which often does not extend beyond symptomatology.

Some biodynamic psychiatrists feel that there is an unpleasant, almost confrontational exchange between mainstream psychiatrists and analysts. According to Dr. Mill, being a member of both the psychoanalytic and psychiatric communities can be trying:

I certainly wish [moving between the analytic community and the psychiatric community] was something we could all fluidly navigate and I fear it is not. In child psychiatry there’s no relationship at all. In fact, if you’re an analyst you’re sort of dismissed and rejected.

\(^3\) Compliance refers to patients who adhere to a treatment plan (e.g. they take prescribed medications as directed).
We can begin to see a trend where the tension is external to the biodynamic practitioner, and involves the relegation of psychoanalysis to secondary status in the psychiatric world. Some of this is certainly about professional competition, but the heart of it is really about the lack of awareness of and training in the dynamic model in psychiatry. When non-analysts and analysts interact there are fundamentally different ways of understanding what drives their patients to engage in certain behavior and how to conceptualize the causes of their troubles. Psychoanalytic principles still influence the field, but practitioners who specialize in psychoanalytic therapy often feel as though they are regarded by other psychiatrists as less serious or capable doctors. Though she feels it is less of a problem given her location in New York City, Dr. Taylor [biodynamic] says that being a psychoanalyst “can be problematic.”

I live in a city where there’s relatively greater acceptance of psychoanalysis. In the program that I trained in, psychoanalysts were very respected so I’ve not found it to be particularly problematic among psychiatrists. But I do believe that people elsewhere have problems with that feeling that their views - perfectly valid views - are kind of dismissed based on a bias against psychoanalysis. They maybe would be less likely to get referred a patient, a patient who might benefit from that approach because of a bias against it, but I actually don’t experience it that much.

In some cases, analysts describe being seen as relics from an antiquated era of psychiatric thought, even though they completed the same rigorous medical training as their peers as well as an additional five years of training in psychoanalysis.

*Interactions with Non-analysts*
Even for psychiatrists who did not report feeling tensions when interacting with mainstream practitioners, conflicts were often embodied in decisions to keep their patients from being treated by practitioners who are unsympathetic to psychoanalysis. This is why, on the rare occasions when biodynamic psychiatrists refer patients for psychopharmacology\(^4\) consultations, they prefer to send patients to doctors who have some understanding of dynamic theory. For the most part it is only the more senior analysts, those who did not train extensively in medication treatment, who refer their patients to other doctors, though when there is a complicated medicine question or a patient who is particularly difficult to treat with medication, referral might be necessary. Dr. Elliot explains: “...the people I try to use are people who are either themselves psychoanalysts or have some education and openness to the psychological in a person ...” Biological psychiatrists might focus solely on symptoms and disease and consequently not see the patient holistically. Referrals affect the psychodynamic group even more, as I explain shortly. Dr. Linden (biodynamic), perhaps most directly, explains the difficulties in professional relationships when she says:

> I think amongst some people it [being a part of both the psychoanalytic and mainstream psychiatric worlds] can feel very polarizing ...and I think there’s still certainly that group within psychiatry that feels that many injustices and things were done poorly by psychoanalysts\(^5\), but also people...have, I think, legitimate

\(^4\) While all psychiatrists are able to prescribe medications, a psychopharmacological consultation refers to one in which medicine is the sole focus. This might happen, for instance, for a second opinion about the biological part of a treatment, especially with a difficult case.

\(^5\) This is a reference to the accusations of biological psychiatrists that psychoanalysts were narrow-minded and too quick to ignore the benefits of medications, perhaps to the detriment of their patients.
complaints for those who only see people as moving molecules, which is obviously not the case...

She reiterates the sense that analysts are being held accountable (by the biological group) for all the stereotypes about their field and practitioners in it. For instance, that they are elitist and rigid, and that they are against treatment with medication and biological thinking (c.f. McWilliams 2000). Dr. Linden also points out that the biological group is critiqued as “pigeon-holing” their patients, rather than seeing them as unique cases. Clearly practitioners in each camp see the faults of the other model.

**The DSM Debate: What the Dynamic and Biological Models Should and Should Not Do**

Despite recognizing that dynamic training would be useful for mainstream psychiatrists, many interviewees are not sure it would be feasible to coherently fuse the two approaches. There would be positives (such as less tension in psychiatry and more standardization for treatment) and negatives (for instance, the further disordering of conditions once thought of as issues of the human condition). Dr. Park (biodynamic) captures both sides of the issue when he says, “I think [DSM researchers] oughta keep their grubby hands off all the important stuff and stick with what they do well...” However, his uncertainty is clear as he immediately follows this statement with the following: “I could answer just the opposite and say they left out neurosis⁶. They should

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⁶ Neurosis is a central concept in psychoanalytic theory. As I described in Chapter 1, Freud distinguished between neurotic and psychotic conditions. The former are less severe (a normal part of life), while the later include severe symptoms such as delusions or hallucinations. Dr. Park’s use of neurosis here is as a synonym for dynamic principles rather than the classic definition.
get back to that, but I actually think DSM is very valuable and it should stick to what it’s good at and should get rid of post-traumatic stress syndrome and dissociation\(^7\) and leave that to us people.” Dr. Park feels that DSM researchers should not step outside the bounds of categorization for statistical and diagnostic purposes, but he also recognizes the utility of the manual.

For the biodynamic practitioner there is tremendous uncertainty about where to draw the line between what should be treated through dynamic and what through medical practice, and there is both a desire and a fear regarding changing the standards. Dr. Park’s genuine confusion and trepidation in predicting what might happen if the standards were changed is widespread among my interviewees, who report that, though there are significant flaws in the manual, its uses are innumerable. This concern is particularly acute among the biodynamic group; the psychodynamic group share these concerns, though they feel DSM is more of a problem for psychiatry than for their own field, and the biological group report far fewer concerns because they think much less about the dynamic side of treatment. The manual offers a certain amount of reliability and the ability to neatly classify messy thoughts, emotions and behaviors, but it also makes, in Dr. Park’s words, “neurosis” and other Freudian conceptualizations of illness peripheral at best. There is very little use for DSM in the practice of meaning-making. This uncertainly of what role DSM should have underlies the general tensions surrounding DSM as a standard for the discipline.

\(^7\) Conditions correlated with situations, therefore not rooted solely in biology.
When they think about how they might change the manual, psychoanalysts go back and forth between expressing a desire to see psychoanalytic principles taken into account in DSM and thinking that those issues should be left to the psychoanalytic community and, as Dr. Park candidly explains, that researchers should “keep their grubby hands off” everything but the basic categorizations. In other words, interviewees debate whether or not DSM should concern itself with etiology at all. As it stands, DSM-IV (APA 2000) makes no etiological assumptions – the APA claims that it is atheoretical, in fact. Consider this paragraph from the introduction to DSM IV-tr in which the APA cautions use of DSM in forensic work:

...a diagnosis does not carry any necessary implications regarding the causes of the individual’s mental disorder or its associated impairments. Inclusion of a disorder in the Classification (as in medicine generally) does not require that there be knowledge about its etiology. Moreover, the fact that an individual’s presentation meets the criteria for a DSM-IV diagnosis does not carry any necessary implication regarding the individual’s degree of control over the behaviors that may be associated with the disorder. (APA 2000: xxxiii).

Despite this claim of theoretical neutrality, DSM is used to diagnose conditions for reimbursement from insurance companies (which generally must be biological in order to warrant full treatment reimbursement) and for prescribing medications (which presumably treat underlying neurochemical imbalances). Whether it is itself a source of biological thinking is largely irrelevant in my study, because in practice it is used as such. My interviewees are clear that it is a tool of biological psychiatry. Indeed, when you look at the difference between the classification of anxiety in DSM II and DSM III (see Chapter One), it is clear that Freudian language has been removed and that disorders have been situated in theoretically neutral language that allows practitioners trained in the
biological model to imbue it with a link between disorder categories and biological etiology. In addition, the DSM III (and versions thereafter) classifications are specifically designed to look much more like descriptions of illnesses of the body (see Chapter One). The APA is also clear in DSM IV-tr that “…a distinction between ‘mental’ disorders and ‘physical’ disorders…is a reductionist anachronism of mind/body dualism” (p.xxx). In fact, the use of DSM as a tool of biological psychiatry is part of what drove prominent psychoanalytically oriented practitioners to devise The Psychodynamic Diagnostic Manual (2006) (PDM). The PDM is an attempt to bring psychodynamic language back into diagnosis, to educate practitioners who are coming of age in an era where DSM is all they know, and to show that there are alternative frameworks for looking at symptoms. The PDM is introduced with the following:

The goal of the PDM is to compliment the DSM and ICD\(^8\) efforts of the past 30 years by explicating the broad range of mental functioning...Mental health comprises more than simply the absence of symptoms. It involves a person’s overall mental functioning including relationships; emotional depth, range and regulation; coping capacities; and self-observing abilities. Just as healthy cardiac functioning cannot be defined simply as an absence of chest pain, healthy mental functioning is more than the absence of observable symptoms of psychopathology. It involves the full range of human cognitive, emotional and behavioral capacities...That a comprehensive conceptualization of health is the foundation for describing disorder may seem self-evident, yet the mental health field has not developed its diagnostic procedures accordingly. In the last two decades, there has been an increasing tendency to define mental problems primarily on the basis of observable symptoms, behavior, and traits, with overall personality functioning and levels of adaptation noted only secondarily. (P.13)

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\(^8\) ICD (International Classification of Diseases) is the World Health Organization’s (WHO) measurement for illness around the world.
Yet devising a second classificatory system does not solve the problem of what DSM misses, since the PDM is not now nor is it likely ever to be as widely used as DSM. However, this passage certainly reinforces the notion that the medical model and the dynamic model oppose one another, even if the PDM is ostensibly an attempt to integrate dynamic principles into mainstream mental health practice. It is also important to note that the differences between the use of DSM and PDM are conceptually similar to training differences; all psychoanalysts have formal medical training, but most psychiatrists are not trained in psychoanalysis.

*Irreconcilable Differences*

Despite operating in multiple treatment frameworks, biodynamic psychiatrists see the paradigms as difficult to assimilate at the level of theory, and many are not certain integration is even a possibility. Dr. Nelson elaborates on her explanation that having both models available (a frequently cited benefit for practice, as we will see in the chapter to follow) creates difficulty when she thinks about whether they are reconcilable:

I think [psychoanalysis is] very difficult to integrate with the medical model. And since I see the medical model as my bible, it’s always challenging for me to be an analyst because I’m constantly going in the other direction when I do analysis. So the hard thing for me is that medicine, being a doctor, is very much focused around alleviating suffering and helping people rise to function and analysis is much more about digging up and uncovering and opening up material that’s deep and that it doesn’t always immediately in the short run make people feel better. So I see a lot of contradictions in integrating it.
There are certain elements of the biological and psychodynamic models that practitioners describe as theoretically irreconcilable. Even though Dr. Nelson is one of only a few of the biodynamic practitioners to mention that it is challenging to be trained in both frameworks, when she speaks of her practice, it seems to cause her no tangible problems. The biological model offers the best hope for immediate symptom relief, while the psychodynamic seeks long-term solutions to deeply entrenched psychic conflicts. It is for this reason that practitioners with dual training recommend using medicines to get symptoms under control early in a treatment, and then engaging in longer-term psychodynamic treatment. Psychologists also try to sort out whether or not to use medicines early on so that they can move on with the talk therapy part of the treatment.

For the psychodynamic group there is an attention to current symptomatology only in so far as it is necessary to alleviate severe symptoms so that in-depth therapeutic work can begin; this is evident in the descriptions of the use of medication in Chapter Two. For the biodynamic group, assuaging the intensity of present symptoms and eliminating as much discomfort as possible is a crucial starting point, but is also likely to be a precursor to a longer-term treatment. However, for the strictly biological practitioner the alleviation of symptoms is the main and possibly the only focus. This helps to explain another source of tension between the psychodynamic and biological models: different temporal orientations toward treatment. Whereas the psychodynamic group is mostly oriented toward the past in order to uncover the source of current
problematic symptoms, the biological model is focused on the present, with an orientation toward possible dangerous future outcomes if symptoms are not alleviated.

Though all the biodynamic psychiatrists in my sample were attuned to the formal tensions between the biological and dynamic parts of their training and between the models themselves, they did not indicate that their practice was affected by these tensions in any negative way; we will see how this is possible in the chapter to follow.

Psychodynamic Tensions: Meaning-making in a Medical Field

For psychodynamic psychologists, the tensions are much more tangible; they are less cognitive and more interpersonal. Biodynamic psychiatrists have to operate within two paradigms in their own practice (i.e., write a prescription and analyze patients’ narratives in the same session), but psychodynamic practitioners face different constraints on their practice than their biodynamic and biological counterparts; they cannot not prescribe medications and do not have extensive training in the biological paradigm. However, given that many patients want and/or need medicines, there are a lot of pressures on psychodynamic psychologists to refer their patients for medications.

The tensions described by the psychodynamic group therefore come much more from external sources rather than any internal conflict of being trained in two models, as is the case for the biodynamic practitioners. Further, biodynamic psychiatrists dominate psychoanalytic training. This means that the medical thinking of their colleagues influences the psychodynamic group during this training. Because it is five years long, the analytic program allows for prolonged exposure to psychiatrists in both
professional and personal settings. Psychodynamic practitioners learn from, work with, and befriend psychiatrists, and this changes their perspective on illness and treatment. They retain their allegiance to the psychodynamic model, but we can see the influence of the medical model on their practice simply by looking at the significant percentage of patients treated by the psychodynamic group who are taking medications for their troubles (see chapter three). The psychodynamic practitioner has little choice but to encounter the psychiatrist who prescribes the medications, and possibly (though in rare cases) even experiences a power struggle, whereas the biodynamic practitioner can treat the patient in talk therapy and prescribe medicines herself. Referrals create an ongoing tension for the psychodynamic practitioner. Consider the following interchange I had with Dr. Butler about whom she refers patients to for medication:

Dr. Butler: I send most of my patients to a colleague who’s a close friend of mine who is a psychiatrist and an analyst, and so is sophisticated about therapy and analysis and so on. And we know each other very well so she knows – you know, some psychiatrists are very interfering and condescending. I think you have to find one you really get along with or a few that you really get along with who will do their job without trying to interfere with treatment.

DS: Condescending in the sense that?

Dr. Butler: That they think they know best and I generally don’t run across that because I have a choice of who I refer to, and I know them well, but occasionally it happens. I do some work for the student health service [at two NYC Universities] and there the psychiatrist is provided by the student health service. And I remember there was one occasion where the psychiatrist was so intolerably controlling and interfering that I said I would never accept a case medicated by that person again because it was just impossible to – I mean, essentially, she was doing a sort of parallel psychotherapy, and it was extremely annoying, and I talked to her about it, and she completely didn’t see that you know she was totally
unapologetic and she knew best. Luckily the patient moved to another state and the situation was over.

Though Dr. Butler chuckled as she described the patient moving away, indicating the absurdity that it took something so drastic to resolve the tension between her and this biological psychiatrist, she was clearly quite annoyed and upset while describing this experience. Her professional authority, her allegiance to the patient, and her relationship with the patient were all challenged by having to deal with this outside interference in her treatment.

Whatever tensions the biodynamic psychiatrist might experience, there are even greater strains for the psychodynamic psychologist. Given the fact that the biodynamic group is the only group that is actually trained fully in two models, it seems more likely that they would face the greatest tensions. However great the potential tensions are, the psychodynamic group experiences much more tension in navigating the psychodynamic and biological models than the biodynamic practitioners do. In the following sections I explain why this is the case.

*You Don’t Always Quite Belong; Too Steeped in Psychodynamic Theory to Fit In*

At a basic level, for the psychodynamic group, analytic training itself is a much more consistent movement from graduate training than it is for the biodynamic group, most of whom never experienced much training in psychodynamic ideas during their medical school years. Of their choice to train in psychoanalysis, the psychodynamic practitioners describe their affinity for the perspective, as I have discussed in the
previous chapters. For instance, Dr. Kent says, “My PhD program was analytically oriented and many of the supervisors were analysts ...and I was in analysis during graduate school.” Dr. Butler provides a more detailed and personalized answer:

I guess because it was intellectually interesting to me. I mean I never like to deal with just the surface of a problem and while I think behavioral techniques can be useful, it just, as a humanistic endeavor, it struck me as far more interesting. And I was interested in art and literature and so on and the psychoanalytic applications to that always fascinated me but it was never really a question. I always assumed that psychoanalysis was something I would do and I knew I had to first do a doctoral training of some sort, but analytic training was always on the horizon. Another factor that was kind of fortuitous is I ended up marrying a man whom I’d met at [an east coast university] and his parents were analysts in New York, and so I was kind of steeped in that.

In my sample all the psychologists reported graduate training that was heavily psychodynamic (as opposed to behavioral), which means they come into psychoanalytic training with more of a theoretical background in psychoanalysis than their MD counterparts (this is part of the self-selection associated with psychoanalytic training; both psychologists and psychiatrists who train in psychoanalysis have some allegiance to in-depth talk therapy, otherwise they would not undergo five years of training and their own course of analysis). However, they describe the feeling of being the odd woman out; because the institute is affiliated with a medical program, the psychiatrists come into the training knowing other trainees and also likely knowing some of the faculty. Dr. Livingston explains this experience:

...you're in the minority and it's compounded by the fact that a lot of the MDs that they draw from [for the psychoanalytic training] come from the same pool of people who did their residency training either here or [at another medical program in the area]. So they all kind of knew each other in some form or many
of them knew each other through their medical school training. So they’re already kind of a cohesive group by the time they get to psychoanalytic training and then the sort of infrequent psychologist who comes on board is not part of that - is doubly outside because one, they’re not MDs and two, they’re not from that training culture where they got to know each other already. So it creates some sense that you don’t always quite belong and there’s explicit attempts to kind of like move away from that, but you just notice it and it’s part of the air you breathe.

Though most of my psychodynamic interviewees make mention of efforts on the part of the program directors to reduce and even eliminate these kinds of social tensions for the psychologists at the psychoanalytic institute, they are all clear that, while less prevalent than they once were, these problems have not been entirely resolved. Further, because the training is five years long, and the tensions are, as Dr. Livingston explains, “part of the air you breathe,” means psychologists are steeped in this atmosphere consistently over several years.

Dr. Butler, who was one of the earliest psychologists to train at her institute, told me that “there was tension when I applied for analytic training, but that was because it had only been just opened up to psychologists... and they were kind of reeling ‘cause they didn’t know how to assess psychologists’ background, training and expertise, and they were early in the process of figuring these things out.” Dr. Butler was definitive in her feeling that this has changed greatly since she trained, and she cited the desperation of psychoanalytic institutes for trainees these days as a reason the elitism of analytic training has dissipated. Also, as an increasing number of psychologists have moved into positions of leadership at the institute, the tensions have been somewhat alleviated.
The balance of power, as some interviewees describe it, has shifted, though it is certainly still more concentrated in the hands of the MDs.

The Dangers of Working with Psychiatrists

Most of the psychodynamic practitioners alluded to feeling that the MDs who trained with them considered themselves to be at the top of the hierarchy at the outset of the training, but that they were more skilled in talking to patients. It took the MDs time to accept that they were not as skilled at talk therapy as the psychodynamic group. Dr. Brighton succinctly describes the majority of the tensions mentioned by the psychodynamic group in the following. When I asked her if she could describe any tensions between psychologists and psychiatrist analysts, she replied:

I’ll give you the broad general tensions that exist. Between the groups - and psychologists complain and you know of course it varies enormously with your own individual experience with people - but psychologists will complain that MDs will see themselves as the Gods who know it all and diminish or look down upon all, talk down to the psychologists, and the psychologists not understanding the medications when they have to deal with psychiatrists often play into that view. That’s how psychologists view the psychiatrists as superior, playing God, diminishing them. …Many psychologists feel that they get dismissed as not knowing anything, they get overridden, their treatments can get taken over. They’ll send someone for a [medication] consultation - I don’t work with anybody who does this - I have my own people who I feel close to who work collaboratively, but the complaints tend to be that the psychiatrists can dominate and take over the treatment. I don’t know how it’s seen from the other side.

Dr. Brighton also suggests the need for psychologists to be careful about whom they send their patients to for medication consultations, a topic I turn to much more fully in
the following chapter. As an addendum to her description above Dr. Brighton added the following: “What I hear is almost like if a black person were here – ‘oh no, some of my best friends are psychologists, they’re so smart and they make the best candidates, we love them.’ We know what that means.” Clearly, at the very minimum, Dr. Brighton feels that psychologists are looked down upon by their MD counterparts and kept at arm’s length. I asked Dr. Livingston if this created tensions for her in the training experience, to which she replied:

I think there's tension on many levels: there's tensions at the institutional levels where still, even though we accept psychologists and social workers now, they're still kind of a minority, especially in New York. And that most of the people from social work and psychology go to other institutes that are more free standing, so you've got that level. I think a lot of people who trained at an American they don't even see those other people as "real" analysts. So, there's that level of tension, but even if you go to a place where there are more social workers and psychologists, and get your training, it's still relatively new in a lot of people's minds, especially the more senior people and I think they still have a lot of skepticism about whether you can really do analytic work. I just had an experience - I gave a talk last weekend about transference-focused psychotherapy at a conference for clinicians that also presented cognitive behavioral treatments and medication treatments and during one of the breaks a more senior woman came and said she was an analyst and said she really appreciated my talk. And then she mentioned something about the show on HBO called "In Treatment" where there's a therapist who's kind of psychodynamic but he's a psychologist and he doesn't seem to be doing classic psychoanalysis. He's doing some loose version of psychodynamic psychotherapy. And she made some kind of dismissive comment, "Oh, he's just a psychologist so that's why he's acting that way. And since we're analysts we wouldn't do that." It was like she didn't realize I was a psychologist, and I said, "Well, you know, you can be both." And she looked at me a little puzzled, like she hadn't reconciled

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9 Free-standing refers to an institute that is not affiliated with a hospital that trains psychiatrists.
10 Institute affiliated with the American Psychoanalytic Association – these are considered the most prestigious institutes at which to train.
those two things yet. So that's the kind of attitude you sometimes bump into with more senior people sometimes.

This example of the senior analyst who did not even consider that Dr. Livingston might be a psychologist is not uncommon. Senior analysts in my sample are all MDs because no one else could train with MDs in psychoanalytic programs prior to the 1990s. Therefore, they tend to slip into the pattern of assuming that analysts are medically trained much more so than younger analysts.

Psychodynamic practitioners also talk about biodynamic psychiatrists, colleagues and often friends of theirs, who launch into discussions of medications, which is something the psychodynamic group knows little about. For instance, Dr. Haman told me that in seminars “there were discussions, not that many, but sometimes there would be discussions that would come up that would have a relevance for psychiatrists that would have a very different or non-relevance for a psychologist. And it wasn’t acknowledged that there was anybody in the room who didn’t have medical training.” This, they say, can make psychologists feel left out or even as though psychiatrists are being condescending, and it happens both during and long after training. Though many of them feel that the starkest tensions between the psychiatrists and psychologists at the training institute have dissipated (a few even say they do not exist anymore between the trainees), they still describe these experiences with the more senior people in the program. They certainly recognize that the legitimacy of their training (that their PhD is a marker of sufficient training to be a psychoanalyst) is questioned by at least a percentage of the MDs in their program. Many do report that this is less of a problem as
they get to know the biodynamic psychiatrists better (and as the biodynamic group become less biological and more dynamic), but this tension is always present on some level.

*Referrals*

Beyond training, the time when psychologists experience the greatest tensions with their psychiatric counterparts is in sending patients for medication referrals. As Dr. Livingston explains:

Since I work with a lot of people with personality disorders, it's good to have psychopharmacologists who are - who know how to work with those people because it can be really dicey and there's a lot of placebo responding and there’s a tendency to overmedicate because they only have partial response to medications so you just keep adding and adding and before you know it, the person's on like five medications and none of them are doing anything. Ultimately you're - you want to work with people who know about - a lot of them are like my old supervisors and people who I know, have trained [in psychoanalysis] so we have a similar mindset around medications.

In other words, Dr. Livingston feels she must be sure that the doctor to whom she sends her patients for medicines has an awareness of the person *as a person*, not just as a body incubating an illness, which Kleinman (1988) reminds us is the major downside of the modern medical approach. Especially for patients who have personality disorders that might lead them to respond in unpredictable ways to medications (regardless of what the actual effects of the drugs are), it is very important to Dr. Livingston that the psychopharmacologist have an awareness of the patient’s personality, psychological
functioning, atypical reactions to medications, and the possibility that a single diagnosis is not an accurate enough way to classify human emotion.

Different Orientations; The Psychodynamic and Biological as Different Worldviews

Most of the psychodynamic group point out that there is a stark difference between psychologists and psychiatrists based in their training. Consider the following response from Dr. Brighton when I asked for her thoughts about her medical colleagues using DSM as the bible of psychiatry. She recounts many of the troubles the psychodynamic psychologists face in interacting with biological psychiatrists, issues they must face given the high demand for medications today. Dr. Brighton explains:

One type of training is trying to categorize, coming out of the medical model: what’s the illness, what’s the disease, what kind of pills are we gonna give them? They have four years of training in those pills. That’s heavy duty training. That’s what residency is. Psychologists are coming at it with who is the whole person? You can’t quickly categorize that. And you wanna have a dynamic formulation, you wanna have an understanding of how this person has been put together. It’s a different orientation.

In responding to my question about the centrality of DSM and diagnostic thinking in psychiatry today, Dr. Brighton was clear that it may not be easy for psychiatrists to get away from the medical model because of how central it is to their medical training: “It’s their bible, but I think it can be extremely limiting and what I see in teaching psychiatrists who are now psychoanalysts it’s very interesting to see them try to get out of their bible.” Dr. Brighton teaches psychiatrists at the psychoanalytic institute, so she sees first hand the MDs struggle to be open to analytic training – to go beyond their psychiatry lens that taught them diagnosis is of primary importance.
In presenting her work to non-analyst audiences, Dr. Sutton explains that she used to experience heavy critique, though now she avoids those meetings altogether. As a seasoned analyst she says, “Twenty years ago, yes, I had to do that, and I did it. But you know, for example, I know that if I go to certain meetings, if I present my work, I will be attacked. I don’t do it. I don’t have to do it. This is my freedom. This is my freedom.”

Dr. Sutton, who largely treats children and adolescents, says that with clinical experience she has learned to avoid certain situations where she knows she might be attacked for her ideas, specifically her psychoanalytic ideas. She continues, categorizing her encounters with people (biological psychiatrists and even psychologists who are not psychoanalysts) who are not friendly to psychoanalytic treatments:

Let’s say I present a child case, how I work, and what I do. I have a strong theoretical base. But I use a lot of my clinical experience, so I work with metaphors. I work with play a lot, and when people ask me do you have the proof of what you are doing, I can explain, of course, but there are some limits about explaining the proof. You have to work with the imagination of people...then I can explain what is the symbolic functioning of playing and all that stuff. But there’s always a limit [on proof]. “What you’re doing is bullshit. You know? It doesn’t make any sense. There is no immediate goal. You don’t tell the child anything.” No, I never tell a child what he has to change...so it’s a very different clinical experience.

In describing the avoidance of these possible tensions by abstaining from conferences other than those hosted by the American Psychoanalytic Association, she is clear that these tensions still exist and are palpable. Further, Dr. Sutton highlights that the current emphasis placed on evidence-based medicine underlies the critiques and even hostility toward the dynamic model and the practitioners who employ it. Most of the biodynamic practitioners also report abstaining from mainstream psychiatric conferences for the
same reason, though it is a less contentious situation for the biodynamic group as they are less likely to be singled out as different because of their medical degree. The biodynamic and psychodynamic are most similar in the tensions they face when dealing with biological psychiatrists. Here it is a matter of degree, where the psychodynamic practitioners are more likely to feel hostility, but both can certainly be challenged.

Discussion

At the most basic level, medical and psychological training yield different thinking. Biodynamic and psychodynamic practitioners encounter one another and new perspectives in psychoanalytic training, which brings these tensions to the fore. However, the effect is not the same for the two groups, since the biodynamic group has a higher status in the mental health profession. For the psychodynamic group, being accepted by the psychiatrists in psychoanalytic training (those who become their friends later on) presents a tension. The biodynamic group may come to realize over time that they can learn from their psychodynamic colleagues, and they certainly want to be accepted by the psychoanalytic community, but they will rarely rely on psychologists for referrals\textsuperscript{11}, which generally come from psychologists and go to psychiatrists. Therefore, the psychodynamic group needs the approval and acceptance of the biodynamic group much more than the biodynamic needs the psychodynamic practitioners to approve of.

\textsuperscript{11} Psychiatrists refer patients to psychologists only in rare cases where a psychologist specializes in a niche treatment. For instance, a psychologist might specialize in treating women who are victims of sexual violence or in educational testing for children. In these cases, the referral trajectory might be from psychiatrist to psychologist, but it is predominantly the other way around.
their decisions. In terms of sheer numbers, psychologists are in the minority in my interviewees’ psychoanalytic program and that means that, in order to fit in, they are likely to want the respect of the psychiatrists.

The tension for the biodynamic group is much more about learning to be a good analyst with the medical model as their primary professional lens. This tension comes directly from psychoanalytic training – prior to it, the dynamic piece is not relevant enough to cause tensions. The psychodynamic group does not have to alter their perspective in psychoanalytic training, which means there are less cognitive conflicts for them. Rather, tensions that already exist between them and psychiatrists, and those that come from being a psychologist in a field dominated by medical practice are enhanced in this training. It is also clear that psychoanalysis and psychodynamic theory (and therefore all practitioners who employ it) are under fire for lack of scientific and measurable progress from biological and other evidence-based practitioners. Regardless of the extent to which this is true, it is perceived and felt by all the psychoanalysts in my sample, and experienced as a tension with other doctors.

Though it is the same tension (between the biological and psychodynamic perspectives and techniques), the experience of it is quite different for the biodynamic and psychodynamic groups. For the former, there are potential tensions between them and their non-analyst counterparts, who do not see the symptoms, suffering, and treatment of their patients in the same way. The clash between competing models of what it means to be a good practitioner comes alive for psychiatrists during their psychoanalytic training -- the psychoanalyst is seen as the “wise wizard of insight” and
the diagnostician as “fearless investigator of [scientific] truth,” and each implies a quite different lens (Luhrmann 2001:158). If psychiatrists take on a role as the former, they risk losing their legitimacy as the latter. Biodynamic psychiatrists are able to consider the tensions between their psychiatric and psychoanalytic training at the level of theory; they recognize that the two paradigms each have very different goals and methods of assisting patients. For the psychodynamic group, there certainly are tensions with other practitioners and, as is the case with the biodynamic group, this is often in encountering practitioners who are not friends of psychoanalysis. However, the interpersonal tensions are much more pronounced for the psychodynamic group: 1) because PhDs perceive that they are looked down upon by MDs, they face tensions both from biodynamic and biological practitioners, whereas the biodynamic group experience tension from the biological alone; 2) because PhDs must rely on MDs to prescribe their patients medicines, psychologists are vulnerable to psychiatrists taking over or at the very least influencing their practices in ways they did not intend – and they have little choice but to deal with this tension.

The consequences of these tensions are strikingly different for the two groups. In fact, the tensions experienced by the biodynamic group are reduced enough (if not eliminated entirely) so that they do not ever reach a level that would impede practice. The majority of the tension the biodynamic group actually faces is strictly related to interpersonal interaction with other professionals, but even this can be mostly avoided; there is professional power and legitimacy at play here, but this need not enter the everyday practice of the biodynamic psychiatrist, as we shall see in the following
chapter. For the psychodynamic practitioner, on the other hand, it is much more difficult to keep the tensions out of practice since they rely on outside sources to intervene when medical treatment is necessary. Again, while the psychodynamic practitioner must rely often on the biodynamic group (or risk relying on the biological group), there are few circumstances in which the roles are reversed and the biodynamic practitioner is genuinely in need of a psychodynamic psychologist. Biodynamic psychiatrists do refer potential patients to psychodynamic practitioners if their practice is full or if they think a colleague might be a good fit for a patient, but it is generally not because they need a particular service for one of their own patients – and certainly not a service that will challenge their perspective on etiology or treatment.

Both groups have mechanisms for keeping the tensions between the models at bay and for allowing the use of both, even though they are difficult to reconcile as complementary models. However, they key difference between the biological and the psychodynamic practitioner is that the process of negotiating these tensions is much more active and conscious for the psychodynamic psychologist than it is for the biodynamic psychiatrist. The biodynamic group is able to use a set of routines in their practice to combine the two models, whereas the psychodynamic group is only able to practice the psychodynamic model and must rely on other practitioners if a patient needs medicinal treatment. The psychodynamic group is also much more often reminded of their lesser-than status when compared with MDs, which also makes fluid navigation of the two paradigms less likely for them than for the biodynamic group, who are a subset of psychiatry at large.
In sum, the psychodynamic practitioners do not face nearly as much cognitive tension because they do not practice both the psychodynamic and biological models. Of course there is some of this tension for the psychodynamic group, because they must also accept that medications are useful for talk-therapy in order to feel comfortable referring patients for medicine. In general, because they cannot prescribe, they face much more external tension or tension coming from peers and encounters with unknown colleagues. Consider the following interchange with Dr. Haman (psychodynamic):

DS: Do you ever feel any tension between being a psychologist and being a psychoanalyst?
Dr. Haman: My experience of the tension was more when I was in training...maybe it has a little bit less of this now; I think they’re trying to work to make it less...All these people are coming out of their psychiatry residency and going into the analytic training. So coming in as a psychologist, I felt like not quite a part of the whole thing. It took a long time to feel like I belonged there, in a way.

DS: So the tension you feel is really between psychiatrists, or the medical people, and yourself?
Dr. Haman: Yeah, it’s not an internal tension.

Where Do the Tensions Come From?

These tensions exist precisely because psychiatrists and psychologists are taught to see through particular sociomental lenses (Zerubavel 1997:31) and are socialized into using different conceptual frameworks or schemas with which they understand the kinds of troubles their patient experiences. The binary character of these psychiatric paradigms, which Luhrmann describes in the passage at the beginning of this chapter, is the result
of psychiatric training in two different optical traditions that results in some irreconcilable differences between paradigms. Even after analytic training, it is hard for the biodynamic group to see beyond this – much more so than for the psychodynamic. This may be because the biological schema is long established when the biodynamic group train in psychoanalysis. Therefore, any new information they process in psychoanalytic training is still filtered through the more general treatment schema that they acquired in medical training.

The practitioners in my sample may have one largely un-conflicted perspective on illness, as in the case of the biological psychiatrist, or they may, as in the case of the psychodynamic psychiatrist, have one lens that is constantly challenged by a more powerful perspective that is considered to be more legitimate and more scientific than their own. It is also possible that they may have multiple lenses that compete with one another, as in the case of psychiatrists who train in psychoanalysis. The dominance of the medical lens means it will likely win out over the less prestigious and seemingly less scientific psychodynamic one, especially since there are more situations in which the medical lens will be invoked, since so many patients request medications today. Even after psychoanalytic training many psychiatrists remain wedded to the medical model, which can be understood in terms of the difference between primary and secondary socialization. The psychodynamic perspective comes from secondary professional socialization. For the psychiatrists, this means that their medical training, which is their primary and therefore more salient lens or schema for interpreting the symptoms of their patients, is more likely to be their default model. The medical model provides the
first professional schema for psychiatrists, which makes it difficult for them to incorporate new, psychodynamic information that is in many ways discrepant to the psychiatric model. The salience of the medical model actually protects practitioners from the danger that their medical training might be challenged or even undermined by their new psychodynamic training, which might also cause professional identity tensions (Berger and Luckmann 1966:140).

However, for the psychologists the psychoanalytic training is much more fluid, as they experience an alignment of the newly acquired psychoanalytic perspective with an already taken-for-granted reality; their graduate training prepares them for the psychoanalytic lens. The biodynamic group may become more dynamic by the end of the psychoanalytic training, but they are restricted by their medical socialization and by their medical practice. Recall Rosenberg’s recognition that “...professional life becomes then a compromise defined by the sometimes consistent and sometimes conflicting demands of his discipline and the conditions of his employment” (Kohler 1982:2).

People wind up in psychiatrists’ offices because they seek medications. Therefore, the biodynamic psychiatrist’s practice may not represent the extent to which she actually thinks dynamically and would ideally want to work in that fashion. This can lead to conflicts with patients, which is a topic I do not address here, as it was not a central focus of my interviews\textsuperscript{12}. Most patients who wind up in biodynamic psychiatrists’ offices are there primarily because another practitioner, who purposely chose someone with

\textsuperscript{12} If a patient wants medication and comes to a psychiatrist seeking them, but the psychiatrist does not concur that the patient needs them, then conflicts with patients can arise.
analytic training, referred them; most patients do not end up with analysts if they are simply looking for a prescription. Given that, it is striking how many analysts’ patients are taking medicines.

Returning to Strauss et al (1981), it is clear that other professionals are certainly important in the socialization of psychoanalysts. In particular, biodynamic psychiatrists make the psychodynamic psychologists more medically minded than they were when they entered psychoanalytic training. The biodynamic group is also affected by the dynamic perspective of their psychologist counterparts, possibly even more so. In terms of theory and practice principles, the biodynamic group learns more in psychoanalytic training because they know so much less than the psychodynamic group when they come in, but the psychodynamic group feels much more pressure to conform at least somewhat to medical practice – certainly when it comes to referring patients to psychiatrists for medications – than the biodynamic group do.

For the biodynamic group there is a potential internal tension that could be experienced because of practicing with two competing models at once. If this tension were to come to fruition it would present serious consequences for the functionality of their practice. In turning to the final chapter I show that, strikingly, despite the conflict between the biological and psychodynamic paradigms at the level of theory, at the level of practice very little conflict exists for the biodynamic group. This finding is somewhat unpredicted, even by other analysts. For instance, Dr. Haman (psychodynamic) says of her biodynamic colleagues that:

I think about certain things that I don’t have to wrestle with in the same way that a psychiatrist might, like, the whole medication issue. I mean, if I’m referring
somebody who’s in analysis for medication, I have to think about the transference to the psychopharmacologist, but I don’t have to think about, now, should I prescribe it myself? Or should I have somebody else do that? I think there’s a lot of confusion for psychiatrists about those dual roles when they’re doing an analysis, and maybe even when they’re doing psychotherapy.

Yet, interestingly, this is not the case. In fact, both groups work to assuage tensions that arise because of the meeting of biological and psychological ideas and treatments, though using different mechanisms. As I detail in the following chapter, it is the psychodynamic group that must work more intensely to assuage these tensions, yet are less successful than the biodynamic group, who are largely able to avoid experiencing any tension between the two models. In the following chapter I describe how practitioners navigate the potential and actual tensions in their practices, and in doing so show how the biological model remains so salient in the work of biodynamic psychiatrists even after they undergo psychoanalytic training.
CHAPTER FIVE

Resolving Tension through Practice:
Blurring the Boundaries Between Meaning-making and Medicalization

If thought styles are very different, their isolation can be preserved even in one and the same person... The conflict between closely allied thought styles make their coexistence within the individual impossible and sentences the person involved either to lack of productivity or to the creation of a special style on the borderline of the field. This incompatibility between allied thought styles within an individual has nothing to do with the delineation of the problems toward which such thinking is directed. Very different thought styles are used for one and the same problem more often than they are very closely related ones. (Fleck 1935:110)

The data presented throughout this project reveal stark contrasts between the biological and psychodynamic models – some at the level of theory, and some that loom as potential impediments to practice. Despite the contradictions, psychodynamic and biodynamic practitioners do not use these models in binary ways and as we have seen, largely agree on issues such as when to use medications. Yet the biodynamic group is comprised of medical doctors, while the psychodynamic group practices meaning-making in a professional world dominated by medical treatment. Thus, the experience of practice is not the same for these two types of mental health practitioners largely because the kind of work they are primarily trained to do involves different conceptualizations of the mind and brain and how to treat problems that arise therein. Though they arrive in psychoanalytic training programs from disparate professional backgrounds, both the biodynamic and psychodynamic groups share a five-year-long experience in intensive meaning-making training. The result, however, is that both
groups face potential and lived tensions that come along with training in analysis in a world dominated by biomedical conceptualizations of illness and suffering.

In this chapter, I focus on how the biodynamic and psychodynamic groups manage the tensions between these two contradictory models. As in the previous chapter, I leave aside the biological psychiatrists since they are unlikely to employ psychodynamic principles in their practice and therefore do not face the tensions the other two groups encounter. Because their practice aligns with dominant cultural and professional ideas about etiology and treatment, they do not need worry about negotiating tensions in practice. The boundaries between meaning making and medicalization, then, are strict – the biological group never crosses the line between the two. Conversely, for psychoanalysts, the boundaries are much more porous and therefore, their practice is much more complicated. In this chapter, I explore the ways in which the biodynamic and psychodynamic bridge these seemingly irreconcilable paradigms – sometimes fluidly and sometimes with great effort.

In chapter four I explained that biodynamic psychiatrists face potential tensions between the two parts of their own professional training – one part that advocates biological treatment and the other that strives to uncover the dynamic roots of psychic pain. They also describe tension and even outright clashes in dealing with psychiatrists who reject the legitimacy of or who are untrained in psychodynamic principles. In encountering these biological psychiatrists, biodynamic practitioners describe frustration or even feel denigrated. Yet the biodynamic group has found ways to make sure that these potential cognitive and interpersonal clashes rarely come to the fore. I
find that practitioners in the biodynamic group are able to turn their psychoanalytic training into a strength rather than a problem by seeing themselves as super-psychiatrists. Thus, they see their biological colleagues as less capable and in need of coaching from the wiser, more intellectual biodynamic practitioner.

The more pressing threat is the one to practice, however, and it is a result of the potential tension between the biological and dynamic models in terms of their basic operating principles. Much like the interpersonal situation, the biodynamic group is able to avoid the actual experience of tension here as well by using what the routines Berg (1992) describes as essential to medical practice. They are invoked relatively automatically and require little conscious thought and therefore make fluid practice possible. For instance, when a biodynamic psychiatrist sees a patient for the first time, she need not deliberate about a course of treatment because it is appropriate to start with the medical model and proceed from there. In order to understand why they are so effective, the most important characteristic of routines to keep in mind is that they are summoned “...without explicitly reflecting on or legitimating the actions involved” (170). In this case, biodynamic psychiatrists resolve the potential tensions between their two competing treatment paradigms without much (in some cases any) focused effort. These routines are therefore crucial for effective practice; successful treatment of patients simply would not be possible without them.

For the psychodynamic psychologists, as we saw in the previous chapter, the greatest tensions are found in interactions with biological psychiatrists, much more so than they are for the biodynamic group. This is largely because psychodynamic
psychologists have no choice but to send patients to psychiatrists if they are referred for medication; the psychodynamic group will necessarily encounter psychiatrists, whereas the biodynamic group has much more control over encounters with biological psychiatrists because they are able to prescribe medicines for their own patients. Even if a psychodynamic psychologist refers her patients to a biodynamic psychiatrist who would presumably be less likely to see the patient through a drastically different lens than she would, the fact that the psychodynamic practitioner must rely on someone else to handle this part of the treatment means that there is no choice but to bring a second perspective into a treatment.

Thus, the door is open to potential interpersonal tensions. When psychodynamic psychologists encounter biological psychiatrists (and even sometimes with biodynamic psychiatrists) they perceive that they are not taken seriously both because of their psychoanalytic perspective and because they are not medical doctors. They feel there is still a significant prejudice toward them in both the mainstream psychiatric world, and among the analytic community (as a remnant of an era when psychologists were not allowed to train in psychoanalysis). Some biodynamic psychiatrists still treat the psychodynamic group as if they are not as qualified to practice. Unlike the biodynamic group, psychodynamic practitioners are unable to significantly diminish the tensions; they are able to use some less effective routines when referring patients, but cannot protect themselves from the interpersonal tensions in the same way the biodynamic group is able to.
Equally difficult to manage is the strain that comes from adopting a belief in biological etiology that runs counter to their training in psychodynamic theory. This belief is a necessary precursor to sending patients for medications in the first place. However, unlike the biodynamic group, the psychodynamic psychologists are only able to curb their misgivings about the central role of medication in psychiatric (and their own) treatment. Unlike the biodynamic group, they are not able to do this neatly and there is consequently much more residual tension for the psychodynamic group. This is because the kinds of tensions they face are much more difficult to assuage and therefore require conscious, purposeful, and often contentious work at the cognitive and interpersonal levels. Psychodynamic psychologists must realign their thoughts in a way so that their support of the biological model does not contradict their psychodynamic practice, and so that they are able to work with psychiatrists. Thus, to reduce the tensions faced by the psychodynamic group (described in chapter four) requires much more intensive work than does the tension that arises from being trained in two competing paradigms and practicing with a foot in both camps. For both groups of analysts, then, there are cognitive and interpersonal tensions, though the psychodynamic group is less able to assuage these tensions, especially those that arise at the interpersonal level.

Both the biodynamic and psychodynamic group must find ways to resolve the inconsistencies between the biological and psychodynamic models or else they would not be able to practice without constant tension. The biodynamic group must be able to prescribe medications to patients to whom they also provide talk therapy. The
psychodynamic group must, too, find ways to feel comfortable working with patients whom they treat with psychodynamic therapy but who are also taking medicines. Further, they must find ways to explain their participation in an analytic training program that introduced to them ideas about the biological model and altered their thinking about etiology and treatment. The psychodynamic and biodynamic groups each require different mechanisms to assuage (or avoid) the different kinds of tensions they could potentially experience. Through practice, for the biodynamic group, tensions are resolved with the use of a set of routines that largely privilege the biological model. Thus, the potential tensions between the psychodynamic and biological models never come to fruition. These psychiatrists are able to practice effectively even though these tensions loom as potentialities and are described as present in both interpersonal interactions and when actively thinking about the theory that underlies treatment.

The key difference between the biodynamic and psychodynamic practitioners in terms of their success at resolving tension is that the ways in which the psychodynamic group navigate the boundaries between the models is through goal-oriented, problem-focused, deliberative thought and action. This means the psychodynamic group is often aware that they are actively bridging the biological and dynamic models. On the other hand, the more tacit, subconscious routines that the biodynamic practitioners invoke are often so automatic and natural that they are able to preclude the experience of tension all together.

I should note that psychologists have important routines in their practice as well. For instance, psychologists have a course of action they follow with patients and
psychiatrists have to invoke all sorts of less routine explanations when things go wrong with a treatment or when other problems arise. Yet, when it comes to resolving the tension between the biological and psychodynamic paradigms, routines are much more present for the biodynamic group and basic explanations much more so for the psychodynamic.

*Routines of the biodynamic psychiatrist: Creating the Super-Psychiatrist Mentality*

*Treat symptoms medically first; it is the obligation of a medical doctor*

*Medication*

Medication was simply not a tool of the classic psychoanalyt. Of course, part of the reason for this is that medicines were new and seen as an endeavor separate from the kind of work that analysts engaged in. Largely, abstaining from the use of psychotropic medicines was a result of analysts’ worries that treating people with medicines might undermine their work to uncover the roots of neurotic symptoms. However, medicine is a central instrument of modern psychiatry. Biodynamic practitioners frequently reminded me that a doctor has a responsibility to think medically and diagnostically, so as not to “miss something,” and to provide the most thorough care. This means practitioners who are otherwise wedded to the dynamic approach usually perceive patients through the biological lens (at least early on in treatment), and this also means that certain indicators, as I discussed earlier (severity and duration), automatically lead to medical interventions. For the psychodynamic group, this is clearly not the same, as they are not medical doctors and cannot prescribe medicines. However, it is remarkable
to what extent the idea that the alleviation of symptoms through medical means has seeped into the language of the psychodynamic practitioner as well.

Interviewees defer to the biological model, especially when patients’ symptoms are severe. Dr. Mill explains the role of medication in practice:

I think medication...is just another one of the tools we have. It’s no worse and no better than some of the other tools but it is one of them and if it can be helpful I think it should be recommended. It’s always up to a patient to accept it or maybe reject it but if we don’t recommend it when we know it can be useful then I think we’re not doing our job. Since I’ve treated a lot of children and adults who could have ADHD ... I feel it’s my job to tell them and to tell them that the treatment of choice is medicine. I also think the treatment of choice for a serious depression or a serious anxiety disorder includes the medication. I usually recommend combination treatments of medicine plus therapy and I don’t know my own statistics but I’d like to think I rarely treat people with medicine alone.

For Dr. Mill, who reports that two thirds of his approximately fifty regular patients are on medication, the biological model plays a central role in treatment. He is careful to point out that medication is only part of a treatment plan. All but two of my twenty biodynamic interviewees reported that at least half of their patients were on some type of psychotropic medicine. In fact, about half of the psychiatrists in this sample report the use of medicines with over sixty percent of their patients. Though the biodynamic group reported treating patients with medication alone less than twenty-five percent of the time, psychoanalysis is rarely the primary mode of treatment. Instead of having to choose, the biodynamic practitioner defaults to the medical model because that is what a good doctor does.
Dr. Park captures the widely shared sentiment that a doctor treats pain first and foremost, and that there is no point in allowing patients to suffer given the alternative. He says,

If somebody has, even if it’s a psychodynamically determined, meaningful headache, I’m very much in favor of aspirin, narcotics, anything. I’m not worried about treating the physical side of suffering. I don’t think it detracts from motivation [to participate in talk-therapy] in 99% of circumstances. Someone’s interested in meaning and soul and mind, we’re gonna get there and there’s no particular advantage in having them writhing around with treatable pain.

While pain or suffering can motivate people to seek treatment, Dr. Park feels there is little merit in prolonging medically treatable symptoms. Citing Parsons’s (1951) study of uncertainty in medicine, Gerrity et al (1992:1025) note that he:

...recognized that scientific medicine ups the ante for doctors because it places on them the full burden of diagnosis, effective treatment, and the control of social disruptions caused by illness...Yet "the physician's responsibility is to 'do everything possible' to forward the complete, early and painless recovery of his patients.

In psychiatry, the fastest way to offer alleviation of symptoms and to control the uncertain outcome of psychoanalytic treatment is to privilege the medical model. In this sense, alleviating symptoms also increases the chances that the psychiatrist will feel doctorly. Dr. King expresses a similar sentiment:

If somebody is in pain and we have a treatment for that, like a medicine, we should help...yeah, pain is sometimes useful in that it you know, can force people to look at things, but I think we have to be very respectful of that because we also want people to not be in pain. And I think that when people realize that we’re helping them with their pain, our alliance gets better and we can probably do better analysis.
Seeking immediate alleviation of suffering departs drastically from classic psychoanalytic understandings of psychic pain as a useful element of treatment. Part of the reason for this is that psychic pain in the biological era is described in physical terms – today it is rare that any pain is not thought of as an illness of the body. The current assumption is patients will be able to talk towards the root of a problem once symptoms are alleviated, and perhaps even more easily without acute pain. This allows the biodynamic psychiatrist to feel they are both a good medical doctor and a good psychoanalyst.

DSM

While the use of medication highlights the centrality of the medical model, so too does the reliance on diagnostic categories. Dr. Park explains that it is his “responsibility to make a diagnosis assessment recommendation.” That, he says, “comes first” and that he feels he, “owe[s] to the patient.” However, he quickly adds, “Am I guided by their desires and fantasies? Sure, but that’s my responsibility to give them my best advice.” In sum, personality is important, but a responsible physician diagnoses; the “advice” Dr. Park speaks of here is clinical, medical advice. After that, years of meaning-making might follow, but first, symptoms must be addressed. For most of my respondents, diagnosis is necessary in order to feel they are appropriately treating patients. Luhrmann (2001) reports a similar finding with her psychiatry residents: “prescribing medication makes them feel as if they are doing something to relive the body’s pain, to act against the venom of disease within the body” (50). This is clearly something that is only enhanced as doctors spend more time in the field – and it is especially true for the biodynamic group.
While the biological psychiatrists prescribe the most medication, it is the biodynamic group that describes prescribing as this “responsibility.” It is striking, in fact, that the biological group never use this language, but it is of no concern to them since they are always medical – there is no alternative model. The biodynamic group needs this routine in order to feel they are acting doctorly enough. Perhaps most forcefully, Dr. Nelson claims: “if someone fits into a DSM diagnosis that medicine treats I basically feel like it’s an obligation as a physician to offer it up.” While all interviewees expressed curiosity about information beyond standard DSM criteria (often referred to as the patient’s “dynamics”), this comes after identifying symptoms using diagnostic tools. In fact, in many cases where symptoms are interfering with functioning, medicine is seen as a pre-requisite to useful dynamic therapy.

There is an interest in what Dr. Park explains as “other stuff in addition to DSM diagnosis, something about their culture, their intelligence, their psychological mindedness, their ability to play with language...”, but the role as medical doctor precedes in-depth exploration of the psyche, even where that is the ultimate goal. Dr. Dean powerfully summarizes the “doctor-first” mentality when she says, “... people ask me what I am and I say I’m a physician first and a psychiatrist second and a psychoanalyst third.” While some of my interviewees might not consider “physician” and “psychiatrist” to be separate identity categories, they all share the sentiment that their first obligation is to medically treat suffering, thereby placing their identity as psychiatrists before their identification with psychoanalysis. Dr. Warren explains that
being a doctor first allows for a clear interpretation of a patient without “clouding” the picture with thinking about the patient’s dynamics at the outset.

I think for me there’s always a sense that I’m first a doctor or a psychiatrist because I guess I really feel that diagnosis is really important. I think it’s really important to look at the situation and really kind of have a clear understanding of who you’re treating first. Because I guess I feel that psychoanalysis has sometimes clouded that...

Part of this routine involves abiding by the stereotype that psychoanalysis is messy and could muck up a diagnosis. Dr. Warren continued by telling me that patients with severe conditions such as OCD are much more likely to invoke her doctorly, diagnostic mentality than a patient who presents with, for instance, problems in going off to college and separating from his family. She reinforces once again that the severity of the patient’s symptoms influence whether she is a doctor or psychoanalyst first, though she is always concerned with diagnosis so as to do her doctorly duty to the patient.

By privileging the medical first, the psychiatrist not only fulfills her role as medical doctor, but also settles on an initial course of action so as not to feel overly burdened by decision-making at the outset of treatment. Berg (1992) describes the need for this kind of tunnel vision:

A problem is solvable when the doctor is able to propose a disposal: a limited set of actions which she perceives to be a sufficient answer (at this time and place) to a specific patient problem (‘a prescription of aspirin’, ‘referral to a urologist’ or 'advice'). This does not necessarily imply that the patient’s problem is relieved: what matters is that the physician knows what to do next. The physician makes a patient problem solvable by reducing the infinite array of possible actions to just one disposal.” (Berg 1992: 155-156)
If not for putting the medical model first, the problem might seem less solvable and open the door to thinking about appropriate treatments and which to choose for whom. Allowing this level of uncertainty into practice is dangerous and unnecessary. Merely having to make the choice opens the door to cognitive conflicts, but defaulting to the medical makes this much less likely. Classic social psychological explanations such as Brehm’s (1956) contribution to the study of cognitive dissonance suggest that simply having to choose one course of action over another allows for potential regret; in choosing, we necessarily deprive ourselves of the “good” parts of the option we leave behind and are forced to take on the “bad parts” of the option we select.

Of course, there are also considerations of dangers for the patient if the medical model is not used early on in a treatment and the doctor-first mentality allows psychiatrists to feel as though they are protecting the patient to the greatest extent possible. I do not mean to insinuate that this is not a genuine effort, but rather that the medical model is only one way to do this, though the biodynamic group see it as the most appropriate way. For instance, when I asked her if it is important to get at the meaning of a patient’s symptoms early on in a treatment, Dr. Mill responded:

I think it may reflect my medical training. The fact that I come to this from the MD point of view, which is I do, I am thinking about symptoms and diagnoses. Maybe ahead of meaning. Like if I’m forced in the first session, I kind of feel like it’s first important to get a handle on whether they’re psychotic or suicidal or ya know in some sort of danger. If those aren’t problems we can quickly move on to the meaning question.

The safety of the patient is a central consideration in a medical diagnosis, which includes an assessment about whether the patient is a danger to herself or to others, though
certainly any mental health practitioner, not just MDs, would check to make sure a patient is safe enough to continue treatment without an immediate use of medications or a hospitalization. This does not need to be a DSM diagnosis in order to capture this, but psychiatrists tend to frame it this way, again, which makes their use of the medical model make sense.

**Use Medications First, but in Combination with Talk Therapy**

Medication is a central part of the psychiatrist-first mentality described in chapter 2; it is the main medical tool of the psychiatrist. The ability to prescribe medications sets this group of psychiatrists apart from others, and more generally sets psychiatrists apart from all other mental health practitioners (psychologists, and social workers). Conventional psychoanalytic wisdom claimed practice would be compromised if patients’ neuroses and/or symptoms were treated medicinally. If symptoms are no longer troublesome, how can they be accurately addressed though psychodynamic treatment? This mostly antiquated line of inquiry potentially leaves patients to suffer unnecessarily if medical methods can intervene. Further, if the alleviation of suffering actually allows patients to talk more freely, then combining the two would be more effective. The biodynamic psychiatrists report that medication is conducive to talk therapy; psychoanalysts are no longer as rigid about keeping psychoanalytic patients away from medication. Dr. Madison explains:

> In a practical sense...fifteen years ago, you know if a patient was on medication, they were thought maybe to not be analyzable and we don’t think that way anymore. I see it on a continuum, as a dimensional thing, between psychiatry
and psychoanalysis and where you are with a particular patient on that dimensional scale changes with a patient over time...

The dimensional scale, however, may tilt more evenly toward the psychodynamic model at later points in the treatment, but medicines stay the course to keep symptoms at bay and facilitate talking. Though Dr. Madison reports that some analysts still feel as though medication interferes with dynamic treatment, all twenty biodynamic psychiatrists reported using medication and dynamic therapy together. Dr. Elliot pithily explains the rationale: “There are plenty of people who take pills where that doesn’t solve their problems; though there are people that if they don’t take pills they can’t solve their problems either.” Even the senior analysts in my sample who are not fond of using medication do so at the very least because it is standard psychiatric practice and simply because patients ask for it. In fact, patient requests for medicines are one of the greatest predictors of prescribing for psychotropic medications (Sleath et al 1997). In fact, patients with higher incomes, the group most of the patients who see my interviewees fall into, are much more likely than those with low incomes to receive medications because they ask for them (Sleath et al 1997). Of course, these studies are done in primary care settings where doctors have less expertise in psychotropic medicines than psychiatrists do. Nonetheless, according to Conrad (2005:4-5), patients are, today, patient-consumers and medications are another product that Americans seek out. Conrad explains that the treatment decisions patients make are “…not whether to have talking or pharmaceutical therapy but rather which brand of drug should be prescribed” (5).
There is a sentiment among all three groups that when patients are in pain, their ability to make use of talk therapy is stifled; medication reduces symptoms, and thereby fosters dynamic therapy. Dr. Warren describes researchers at her psychoanalytic institute, who systematically measure whether medication interferes with dynamic treatment:

They’re looking at the percentage of their patients on medication and why are they on medication and how is that fitting in? Because the reality is there’s a significant percentage [of people in dynamic treatment] on medication now and I think there was a feeling in the field a long time ago that you didn’t put someone on an anti-depressant if they were in analysis because it interfered with their analysis and that’s pretty much out the door at this point.

This once again reinforces the idea that the medical doctor role is of primary utility, but also propels the notion that combining dynamic and biological treatment is the most responsible and effective conduct. As Dr. Madison explains, “people can actually be more thoughtful, more reflective when they’re not so miserable.” Dr. Sullivan explains this when she describes a “two-fold” purpose of medicine:

One [purpose] is to reduce the symptom and then, for example, an anxiety symptom is reduced enough that the patient is calm enough to do dynamic work to get through, for example, a block in being satisfied in a relationship or pursuing more what they want at work. It can facilitate that process.

The discussion of medication as an aid to the therapeutic process is a recent and unconventional mode of thinking about both medicine and psychoanalysis, as it combines swift symptom relief with talk therapy. If a psychoanalyst prescribed medicine before the 1980s, she would likely have experienced guilt, and possibly even actual alienation from the psychoanalytic community. Now, in fact, the opposite is true and it
must be if a psychiatrist in the world today will be able to be an analyst as all psychiatrists are biological after medical school and a psychiatry residency.

The medicines first, therapy after mentality is also representative of a fusion between the biological model that is geared much more toward treating pain, versus meaning-making practices that are aimed much more at uncovering the roots of suffering. For instance, Dr. Elliot explains the temporal distinction in reference to her mention of pain throughout the interview:

They clearly overlap and I was speaking of pain concretely - physical pain and psychic pain. Suffering has a different connotation to me in that it has a time frame to it; it has to do with a longer time frame. And how that then gets metabolized in the person. I mean I think psychic pain can occur with an acute episode, but if a person has a lifetime of pains, suffering comes in there.

In order, then, to get at suffering, which Dr. Elliot distinguishes as something of longer duration and as a cumulative condition built of various interwoven pains, the psychodynamic model is more appropriate. It tracks patients over time and opens up past experience in order to facilitate an understanding of the present and hopefully a less painful movement into the future. In order to do so with more efficacy, biodynamic psychiatrists reminded me often that first, you treat the immediate source of pain.

As I reported in chapter two, the evidence is equivocal as to the efficacy of both medicines and talk therapy, but the vast majority now says that both medications and talk therapy work with some success. This is certainly corroborated by explanations of the use of combined treatments as the most humane and most effective approach to treatment. Dr. Halsey explains the use of medications with his child patients:
There is a moment in which if a kid has a problem, either depression or psychosis or mood instability that does not allow them to do therapy, by giving them medicine you diminish the intensity of that problem. I mean you don’t cure it, it is not a magical pill, but you decrease the intensity and then they’re more willing to think about things, reflect on things, hear what you have to say, whereas if they are so stuck in being upset and angry that they’re just overwhelmed you can’t do any therapy, so they do work hand-in-hand.

Consider this similar interchange I had with Dr. Carroll after I noticed her repeated mentions that the medical model is useful as a precursor to dynamic therapy:

D.S.: I just want to make sure that I’m getting this right. It seems like what you’re saying is that the medical perspective and medicine is useful for preparing people to be in some sort of psychodynamic or possibly psychoanalytic treatment?
Dr. C: Well, it facilitates. I mean, if someone is in a major depression, all you hear is, “oh, I’m terrible, I caused WWII or whatever it is, and I’ve ruined my children, I’ve ruined my family, and I’m no good.” And that’s all you hear. You can’t get to any psychological roots, so when that calms down, that obsessional kind of self-recrimination, self-hatred, and it calms down through medication, then you can get to the psychological content.

In sum, using medications may enhance talk therapy rather than detracting from it, as classic psychoanalysts decried. This understanding is effective in keeping the psychoanalytic and biological models from colliding because they are in need of one another – primarily the psychodynamic model is in need of assistance from the medical model.

In fact, when I asked biodynamic practitioners about how they conceptualize pain and suffering or whether they see themselves as people who treat pain and/or suffering they almost unequivocally conceptualized my question as one about the
difference between pain of the body and suffering of the mind. In fact, most seemed confused and asked me what I meant by pain in my question, or they asked for clarifications: “Physical pain or mental pain?” or “by pain, you mean psychic pain?” to which I responded that I would like them to talk about however it is that they conceptualize it. Once we sorted out the confusion, most biodynamic psychiatrists responded similarly to Dr. Sterling who says, “I mean I definitely think pain is more associated with physical pain and suffering seems like something that more has a component of suffering through something that you’re experiencing.” Dr. Taylor also explains this clearly when she says “pain I associate more with the body, like body, physical pain, but if you’re - is there a psychological version of pain? I would call it suffering. Or maybe suffering is the result of pain.”

After relaying that she thinks psychoanalysis is geared toward understanding suffering, but that people who engage in psychoanalysis are not necessarily in pain, I asked Dr. Brown if she sees pain and/or suffering as being pathological. She told me, “I think the analytic model is more oriented toward seeing people as human, you know, and suffering and pain as part of the human condition. From a medical perspective, I look at it as pathological. I’m not sure from a psychodynamic point of view – it’s part of life.” If pain is pathological, it becomes much more likely that a psychiatrist will treat it with medications, as it is then seen as something more serious, more in need of medical care. If the dynamic and biological models are used together, then a psychiatrist is able to treat both pain and suffering, without having to sacrifice the treatment of one for the other.
Both Nature and Nurture Produce Symptoms; Address Both Possible Sources of Suffering

The notion that the cause of mental illness is “bio-psycho-social” allows psychiatrists to feel at home using both the dynamic (which would presumably address the psychological and some social roots) and the biological model (which should intervene on the chemical or biological issues). Using this logic, it is necessary to treat all possible causes of symptoms. Thus, both psychoanalytic and medical training are vital. The biodynamic psychiatrist, then, becomes the super-psychiatrist who can treat all sources of symptomatology. From this perspective, being trained in dynamic therapy and medication treatment does not create conflict, but rather consistency. Dr. Ferris explains her philosophy on etiology:

Well, first you start with genes...Then, under certain circumstances, growing up in certain families or being exposed to traumatic experiences or growing up in a family with parents or siblings who can tolerate more things and contain it, someone would be more or less vulnerable if they have the genes...And you know maybe some people, if they grow up with enough resourcefulness can kind of counterbalance what may sway another person into becoming deeply depressed about something. But I think...so much of it is just in the genes and the chromosomes.

Though nature (represented above as genetics) is assigned primacy, if both environment and heritable neurochemistry are important, then so are both psychoanalytic and medical treatments.

The same sentiment is clear in Dr. Warren’s description of etiology:

There’s a huge genetic component to a lot of things. I would say that’s a very important part...obviously environmental components play a role. It’s not that I
don’t think they do and certain kids have had more traumas and more parental deprivation and more inconsistent parenting and all of that plays a big role, but I certainly think that a kid’s either genetic endowment or the way they come into this world plays a huge role too.

There is a general sentiment that environment and genes are both responsible for either normal or pathological functioning in later life. When asked “how do you think about the etiology of psychiatric conditions?” the majority of my interviewees explained that they would “not have a very interesting answer to that question,” or that their answer “will probably not sound very different from everyone else’s.” Indeed, all twenty biodynamic psychiatrists explained that psychiatric conditions stem from a combination of social and innate characteristics, which is indicative of training in the “bio-psycho-social” model.

This particular stance on etiology – that psychiatric conditions are born of a vaguely defined combination of biological, psychological and social factors - provides a service for doctors: it allows them to bridge the dynamic and biological models. It also allows them to feel useful and unique because only they can do that. Of course, there are multiple plausible explanations for the etiology of mental illness, so this is not just about training, but also about anecdotal experiences with patients and professional experience that leads practitioners to note that their treatments are more successful when they recognize etiology at the bio, psycho, and social level.

The majority of respondents were also quick to admit that despite being taught in medical programs that there are multiple influences on etiology, biology was the one most discussed and thought to be most important. Though practitioners were quick to
respond with what they alluded to as the medical-school-party-line of multiple causal factors, they still cite biology as the central etiological concern. Training in psychoanalysis, genuine attachments to and belief in psychoanalytic theories and witnessing the character growth and personal understanding possible with the use of talk-therapy, leads the dynamic approach to maintain a central role in the majority of these psychiatrists’ professional lives. However, much like their descriptions of etiology privilege biological explanations so does favoring medication and diagnostic thinking early on in a treatment.

**A practitioner must Address the Strengths and Weaknesses of both the Biological and Dynamic Models to Design the Best Treatment**

Biodynamic practitioners praise and criticize both the dynamic and biological approach. They present each paradigm as important, but incomplete, and thus in need of the other. The most common claims are that the biological approach is overly general and that the dynamic model lacks quick, more certain odds for symptom relief. For instance, Dr. Park criticizes DSM for its lack of specificity, pointing to the utility of dynamic theory in understanding everything beyond initial diagnosis:

> [DSM] is a diagnostic statistical manual. It’s precisely useful...for grouping people not for looking at aspects of concern that are necessarily N of 1. So all sorts of things like meaning, character, personality, the soul, the mind and how it works are not involved in DSM. DSM is explicitly and purposely non-etiological...DSM is not concerned with origins. Psychoanalysis and meaning, I would say, has a drive toward the notion of origins, origin of symptoms, the origin of human experience in childhood, in trauma...
It is because of contentions such as these that doctors often report using what Whooley (2010) calls DSM “workarounds” wherein they take some autonomy back from the diagnostic system. For instance, pointing to DSM’s lack of attention to meaning allows doctors to do things like give a patient the least stigmatizing code (e.g. depression instead of borderline personality disorder). This serves the doctor’s need to feel intellectually superior to the DSM model – she knows better than the manual because of her training in meaning-making. She can understand what effect a certain code might have on a patient’s self-concept, for instance. Additionally, these workarounds that often involve imbuing meaning into diagnostic categories that are, as Dr. Park describes, “purposely non-etiologic” is a way for psychiatrists to maintain their autonomy. As I described earlier, the ability of the seasoned practitioner to go without a strict use of DSM and make her own interpretations is a sign of control over the treatment. Finally, when biodynamic psychiatrists point out how incomplete DSM is, it reinforces how important it is that they have training in psychodynamics; their knowledge fills in the gaps left behind by a DSM diagnosis alone.

On the other hand, Dr. Park is equally willing to point out problems with psychoanalysis in terms of symptom relief. He continues:

[Psychoanalysis] is a slow process. It’s an uncertain process unlike medication. You come in with a panic disorder and you’ve got an 80% chance of responding and psychoanalysis I tell people it’s gonna be burdensome in terms of time and money and uncertain in terms of results. Freud advertised psychoanalysis at the end of the last chapter in Studies in Hysteria. The goal of it was to achieve everyday unhappiness. It should be a hard sell alright.
Having the medical paradigm to fall back on is crucial because of the general concern that psychoanalysis is, as Dr. Park describes it, “as a clinical endeavor, in practice, limited to a very few people.” Psychoanalysis cannot abate psychotic symptoms, help a child with severe attention difficulties or quickly alleviate extreme sadness or anxiety, but medication generally can, and usually within a few weeks.

Most criticisms of the diagnostic approach are focused on its lack of ability to accurately describe personality disorders¹, which are a central area of explication in dynamic theory and something analysts feel expert at dealing with. Beyond this specific criticism, interviewees consider the overarching problem with DSM and the medical model to be that complex human beings do not fit neatly into categories. This is evident in Dr. Sullivan’s description of problems with DSM:

Personality isn’t just a list of traits. It’s how they all fit together and motivations and how those all weave together and I don’t see how the DSM IV could ever really capture that. I mean it [DSM] doesn’t contain everything. It doesn’t capture everything about a person. I don’t think that the personality disorders section, for example, is especially useful because there are certain personality styles that aren’t really in there like masochism or sort of depressive personalities. I think of it as a tool and I think of it as something sort of plastic, meaning that I can use it the way I want to.

The lack of depth in diagnostic descriptions of personality disorders leads biodynamic practitioners to feel they must be discerning in their use of DSM. Because they are especially likely to see patients with personality disorders (unlike biological

¹ A personality disorder is “an enduring pattern of inner experience and behavior that deviates markedly from the expectation of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment” (American Psychiatric Association 2000:685).
psychiatrists), they come face to face with shortcomings of DSM much more regularly. As discussed in chapter three, discussing DSM in this way provides practitioners with a sense of autonomy and skill, but this ability to use DSM as they choose is something they can do even more extensively now that they have been trained psychoanalytically. Nearly all doctors in my sample find utility in DSM descriptions of Axis I disorders (overarching biological conditions, e.g. depression) but assess Axis II categorizations (deeply entrenched personality/character problems, e.g. narcissism) as unsatisfactory. Thus, the biodynamic psychiatrist uses the medical model, but makes deeper assessments of patients than identification of symptoms and disorders. The super-psychiatrist is able to do what those who are only medically or only dynamically trained cannot; because of their dual training, biodynamic psychiatrists have more tools and therefore allude to being more thorough and even more useful than other practitioners. It also allows them to feel somewhat free of the constraints of both models.

Dr. Elliot explains that elements of both the diagnostic and dynamic are necessary factors in an overall treatment equation:

The psychiatric community at large as is the psychoanalytic community is always influenced by fads, what’s popular...for example, let’s say sexuality’s gone out of style, but the fact is that it is a window into the psyche and it also can be very important and also, taking the other line, let’s say underlying moods, irritability, that kind of thing is very important and sometimes is very difficult to influence purely psychically so that somebody who’s sort of depressed and closed off and guarded may not be able to listen and think about their problems. Unless their mood is lifted, they cannot work on those problems.

The implication here is that both the psychoanalytic and the biological model should be used, as each provides distinctive benefits for the patient. Dr. Elliot realizes there are
both valuable and ineffectual elements of each theory, but she feels well prepared to
treat patients precisely because she can draw from elements of each paradigm. Further,
the biodynamic psychiatrist feels she benefits (as do her patients) from the
multiplicative effect of using both biological and dynamic treatments together.

Dr. Lewis explains that, among other reasons, it is often difficult to tell whether
the talk therapy or the medication is helping the patient. Despite seeing the patient
multiple times per week, it can be complicated to parse out which treatment modality is
the most effective.

I have a severe borderline patient who underwent ECT\(^2\) and all kinds of stuff. A
complicated case. And nothing helped and no medications helped and I put her
on another medication really without any expectation that this medication will
do much else and about a month after that medication was started she took a
turn but I will never be able to tell you what got her to take the turn. In fact, I
think it’s not the medication because she’s going back to her old ways. I think it’s
been more the systematic interpretation and the work we’ve been doing but you
will never be able to purify it and I think [the] way to see it will be if down the
road a lot of her symptoms will be really gone for a really long time like a year or
two years as opposed to two months or six weeks. So, if I were a pharmacologist
I would say she’s responding to this medication. I would happily discharge her. I
would happily just consult her once and then never see her again and have a
conviction that this medication is wonderful for borderlines. Or if she were in a
research study she would be considered a responder and the study would be
over there, and they wouldn’t know that the same woman two months from
now or eight is struggling with the same stuff and eventually through the therapy
she will actually climb out of it. And I don’t know, maybe this [the therapy and
medication together] is the miracle bullet.

Though she giggles as she says the phrase “miracle bullet,” she is quite serious that her
patient would have suffered without a combined treatment. Rather than settling on one

\(^2\) Electro Convulsive Therapy or “Shock therapy”
or the other, Dr. Lewis ultimately resolves that it is likely the overall treatment using both psychodynamic and medicinal treatment that has made the difference for her patient.

Dr. Linden diverges from those of most other biodynamic interviewees since she describes privileging the dynamic model at the beginning of her treatment. However, she does do a standard DSM diagnosis and would not wait very long to prescribe medicines if symptoms were severe enough. What is particularly telling here is that her response nonetheless indicates recognition of the strengths and weaknesses of each model and she, too, uses medication and talk-therapy together. She tells us that patients should never be regarded as just “moving molecules,” and that it would be ridiculous to attend only to the biological factors. When asked more directly what her experience was like being trained in both of these worlds, Dr. Linden responded:

My internal experience is that it’s part of one identity. It feels very cohesive. I feel like I can move back and forth. It’s not even moving back and forth. I don’t split off my psychiatric understanding and knowledge from my analytic...Until a patient feels that I’ve understood their experience I’m not gonna introduce medicine even if I think they need it...If somebody’s whole self-experience is about being optimistic and they’re in the midst of a depression, taking anti-depressants can be filled with humiliating feelings or failure or things like that...

Dr. Linden denigrates the process of prescribing without understanding the patient’s experience, which highlights the weakness of the strictly biological model. She also expresses the oft overlooked idea that even medicine is tied to feelings. This recognition of context is one of the strong suits of the dynamic approach. For Dr. Linden, meaning-making does not challenge medical practice, but rather facilitates the feeling that she can counter any negatives of either approach with the use of the other.
In an interchange with Dr. Plymouth, she explains that being an analyst sets her on the periphery of mainstream psychiatry, but instead of experiencing this as a tension, she sees this as a benefit precisely because she can offer both perspectives. She says, of her dual training:

It makes me a minority in the psychiatric community, which is something that I kind of like. I’m not sort of being a mainstream psychiatrist, and it means I have something to offer in psychiatry that not so many other people have to offer. In psychoanalysis - you know, I became a psychiatrist because I thought there were advantages to being a psychiatrist and then becoming a psychoanalyst. I still think it conveys certain advantages and I like that I’m a psychiatrist rather than trained differently. As much as I value other sorts of training in psychoanalysis as well. It brings a certain biological perspective to psychoanalysis and I feel like I understand the medical orientation in psychoanalysis and that’s important within the community of American psychoanalysis just because it’s what dominates American psychoanalysis...there are two different sets of advantages. There’s this kind of biological and clinical kind of value and then there’s also - because I think that understanding people from a non-psychological perspective is very useful in psychoanalysis. But then also administratively, organizationally, politically within psychoanalysis, the American Psychoanalytic Association as a whole, I think being a psychiatrist confers certain advantages in terms of understanding how people approach things.

Dr. Halsey explains that she has something to offer the psychiatrists who do not know that much about medications (especially more senior analysts); because she is a psychoanalyst, she can communicate with therapists who think dynamically, but she can add something to their knowledge base that she feels is lacking:

I move within child psychiatry and child psychiatrists are, it’s very hard to be a child psychiatrist and not believe in the psychodynamic model. I think that you can be an adult psychiatrist and believe that everything is neurotransmitters and everything is very biological, but when you’re dealing with children, I think it’s either part of the training or because of the work, there is no way that you don’t believe in some kind of a dynamic model even if it’s not the Freudian model. So
that when I talk with child psychiatrists, they’re interested [in dynamics]. Even some of them who only do the psychopharm piece, they’re interested in – of course mom has an influence on a 7, 6, 8 year old. How could they not have it? I mean, they live in the same house. They’re interested in hearing about that...The people I get along with, the other child psychiatrists work with the same models that I work with. And that’s why we get along and have dialogues. Child psychiatrists who only do medication, I feel that they’re not very happy doing it, and in general it’s not very gratifying work, and they complain about it, and they need a lot of patients so they have 300 patients and they’re overwhelmed, and the people who are doing therapy and doing medication have less patients so we know them better so we feel it’s more gratifying. I think people are happier and we talk about that experience. What is more common [in her practice, compared with finding child psychiatrists who are not amenable to psychoanalytic perspectives] is talking with older child psychiatrists who do not know very much about or a lot of psychopharm, and being that I trained recently, I know a lot more. So they end up asking me a lot about psychopharm, like: how high do you get on this medicine? So that’s how I get along with them.

Even though Dr. Halsey explained earlier that she feels great tensions in talking with biological psychiatrists, her niche, a psychoanalytic perspective in child psychiatry, allows her to feel as though she has something to offer the older child psychiatrists who were trained in the dynamic era and may not know as much about the biological piece as she does. She clearly also believes that being able to understand both the medical and psychodynamic side of treatment makes a psychiatrist’s practice more fulfilling.

These descriptions again yield a sense that my interviewees think of themselves as super-psychiatrists; they are capable of handling any kind of psychiatric problem that comes their way. They are capable not only of treating all kinds of problems, but of educating other psychiatrists in how important it is to practice with both the medical and dynamic models in mind. Though their identities are to a certain extent dependent on being analysts (good meaning-makers), it is more so on being medical doctors (good
psychiatrists) and since their practice is very much dependent on the former, that part of their identity tends to be invoked more often. None of this is much of a problem, however, because the routines described here flip these potential tensions into useful attributes.

In the remarkably similar narratives of biodynamic psychiatrists, it is clear that these routines are both guided by and perpetuate particular ideologies; these are not idiosyncratic creations of individual practitioners, but rather come from socialization particularly into the biological model. Training provides the blueprint for constructing a treatment plan, but psychiatrists are the engineers, rather than the architects; these routines are not their invention, but rather learned in training, as is evident in their nearly identical descriptions. This also protects doctors from feeling as though they made a mistake, chose the wrong treatment plan, or caused a problematic outcome when patients report troubles with treatment; Experiencing that level of blame could be crippling and negatively impact future practice.

**Active Decision-making of the Psychodynamic Psychologist: Negotiating Tense Interactions with the Biological Model**

Unlike the more automatic routines available to the biodynamic psychiatrist, the psychodynamic psychologist must engage in much more active problem solving techniques in order to reduce tensions between her own world (the psychodynamic) and the biological model. As we have seen throughout this project, the psychodynamic psychologists do consider biological influences, believe that medications are important
and helpful, and even think in diagnostic ways more than might be expected of them. However, unlike the biodynamic group, here the biological model creates unavoidable, tangible, interpersonal and cognitive tensions.

Whereas the biodynamic practitioner can avoid interacting with doctors who are different than them if they so choose, the psychodynamic practitioner is much less able to do so. She needs someone with a medical degree to prescribe medications for her patients. This also causes tensions at the cognitive level in that the use of biological treatments for the psychodynamic psychologist involves more strategizing and more conscious thought. The biodynamic practitioner has been trained to use both in her own practice and so very rarely does she have to think rationally about whom to send their patients to for medications. Even amongst analysts, the psychodynamic practitioners are constantly reminded of their lack of a medical degree. Often, they sense that biodynamic practitioners find them inferior, but sometimes it is simply because the institute is dominated by psychiatrists and psychologists are simply trained differently.

In sum, though the psychodynamic group is able to routinize their practice to a certain extent, the interpersonal and cognitive tensions they face cannot be resolved though using routine to the same extent for the psychodynamic group as they can be for the biodynamic group. And yet, if the tensions were too great, if their sense of professional legitimacy was too threatened, they would not be able to do their job effectively. Therefore, the central question I seek to answer in this section is: how do the psychodynamic practitioners avoid the potential risks associated with being a meaning-maker in a medical world?
The Biological Piece is often Necessary for “Good Psychotherapy”

Most indicative of their involvement with the biological model and with medical doctors is that all of the psychodynamic practitioners refer their patients for medications, and, on average, about half of their patients are prescribed psychotropic medicines by a psychiatrist. There is quite a range, however. For instance, Dr. Kane reports that only three of her twenty patients take medicines, whereas Dr. Kent reports that nine of her twelve patients do. This largely depends on the kinds of symptoms patients report. On average, patients with the most severe symptoms are more likely to wind up in the offices of psychiatrists than psychologists for logistical reasons, so it also makes logical sense that psychologists’ patients are less medicated than psychiatrists’.

The rationale behind sending patients for referrals keeps the psychodynamic group in a constant state of tension. In order to justify sending patients for referrals, they must in some way believe that the biological piece of treatment is necessary. But because of that, they must face the tension of deciding whether or not to send patients to a psychiatrist and then rely on psychiatrists, who often have differing opinions and lenses for understanding the patient, to help them address that element of the treatment.

On the reasons to use medication in combination with psychodynamic treatment, the psychodynamic group sound strikingly like their biodynamic counterparts, even if they are not doing the prescribing themselves. Dr. Brighton, for instance, explains:
If their pain is very high and they’re into tremendous self-damning, depressive thinking, they actually can’t do treatment because every insight leads to what a schmuck I am, ya know. And you have to lift that enough so it opens up the thinking and in the opening up of the thinking is typically better capacity to do a good psychotherapy. And that’s true for anti-anxiety medication, OCD medication. The less crippled the patient is with the symptoms, the more able they are to look at their overall behavior...

We can see here a resounding similarity to the biodynamic psychiatrists when they describe why medicines are useful and what role they play in treatment. However, the utility of these explanations is different for the psychodynamic group than it is for the biodynamic. While both groups do, in fact, believe that biology underlies mental illness, and therefore that medication is a useful tool in combating symptoms, there is something much more tacit at play here for both groups. For the biodynamic, as we have seen, this is about privileging the medical model as a course of action that allows for fluid practice and reinforces the feeling of being a good doctor. For the psychodynamic group, describing the medical model as necessary justifies their sending patients for medication consultations and not feeling as though that detracts from the dynamic side of the treatment. This also serves the purpose of allowing psychodynamic practitioners to align themselves with their biodynamic counterparts and not feel as extreme a tension as they might otherwise.

“I’m more likely to think like an MD Analyst”; Aligning with the Biodynamic Group

When I asked the psychodynamic practitioners how they succeed at being both a psychoanalyst and psychologist, and how they see themselves in relationship to the biodynamic group, the consensus is that they feel more like a biodynamic practitioner
than a psychologist once they have analytic training. For instance, Dr. Kane responds to a question about what differences there are between her and the biodynamic group:

I don’t think there’s a huge difference in thinking. I think that there are around the periphery - like an MD psychoanalyst might jump in more towards medical or DSM diagnostic explanations for things, there may be more of a tendency and psychologist analysts may be a little more, a little less prone to pigeon-hole, more open to the broader phenomenon of the patient cause our training is not so diagnostically and bodily. Bodily in a literal way. So I think that’s around the periphery, but I think for the most part I’m more likely to think like an MD psychoanalyst than a psychologist, than the average psychologist who’s not an analyst.

Dr. Brighton, for instance, sounded similar to the biodynamic group when they described leaving the psychiatric community behind in favor of the psychoanalytic. She told me:

Well, you know, I’m not even sure that I’m even part of the psychology community. I’m not even sure what that is anymore. I mean I know psychologists but...I went to a heavily medical [analytic] program so most of my colleagues are psychiatrists in fact. But I don’t really think of myself as a psychologist or a psychoanalyst. I tend not to pigeon-hole at least not in this stage of my career.

Also common is this deflection of the question, which comes in the last part of her statement – she does not want to choose between the two, even though here and elsewhere she clearly identifies more with the psychoanalytic community than with any other. In identifying as an analyst, the psychodynamic group narrows their perception of difference between themselves and the biodynamic group – though elsewhere they are clear about the boundaries between themselves and the biodynamic psychiatrists.

*I Only Refer to People with a Sense of Psychodynamics*
As I described earlier, all the psychodynamic psychologists in my sample refer patients for medicines. Specifically, all of them prefer to refer only to practitioners who they know have training in psychodynamic theory. While most of them would prefer to refer to fellow analysts, this is not always an option, so the next best thing is someone who has a background in psychodynamic treatment. First, they all report that this is the best thing for the patient, but it also resolves having to deal with psychiatrists who are too medical and might introduce the risk of taking over the treatment or overmedicating the patient. This also reinforces the notion that there is something special about the psychoanalytic training – that their colleagues, the ones who they trust and feel most like, are the only ones they would want to refer their patients to. Finally, if they do not refer to very biologically oriented people, then it is not as hard to assimilate the psychiatrist’s suggestions into their notions of etiology.

When I asked psychodynamic psychologists who they prefer to refer patients for medication, the response was unanimously “psychoanalyst psychiatrists.” One reason this is possible is that psychodynamic psychologists are rarely in insurance networks; some patients who see these practitioners will be reimbursed for a portion of an out-of-network visit, but the majority of the patients who see psychoanalysts in general are not relying entirely on insurance to pay for their visits. This means the psychodynamic group has a great deal of leeway in terms of who they send their patients to for psychopharm referrals. Dr. Adams explains:

I refer to this one guy who’s an analyst and he works collaboratively with me. He calls me - well, there’s actually two, a man and a woman, but what I value about both of them is that they work collaboratively with me. They respect that even
though I’m a lowly psychologist, that I do important work and they report in to me. I call them. We talk about the case.

Dr. Adams, here, resolves the potential conflict that could arise between herself and an overly medically-minded practitioner. Dr. Coffrey, who worked in a department of psychiatry for a long time and therefore has an understanding of medications, says:

...if I had my absolute choice, it’s a psychoanalytically informed or psychoanalytic psychiatrist. And not because they know necessarily more...I might actually know a lot in the sense of what could help the person or various things. Then I can say, “Well, but you have to actually go to person X to get the medications.” And then I worry when it goes to psychiatrist X that that person has got to have a sophisticated understanding, or otherwise, we’re going to be at logger’s head because they’re gonna overmedicate, which is usually what happens, and/or skew things with that patient.

The same fears are evident here about what might happen to the treatment, but specifically, Dr. Adams introduces the idea that (even if they don’t know more about the medicines – and they likely do not since biological psychiatrists usually have the most specific knowledge about medication) a psychoanalyst has a more sophisticated understanding of patients. In that sense, she avoids the potential problems in dealing with any other kind of psychiatrist, and she also reinforces her own identity as a practitioner who is interested in deep thinking. She says, quite plainly, that she knows a lot about the medicines and almost alludes to the fact that she could do just as good a job of prescribing them as an MD, but legally, she cannot.

Dr. Haman presents a complication to the referral process and explains why it is sometimes not possible to refer to a psychoanalyst, in which case psychodynamic psychologists must settle for someone who has basic psychodynamic training. She says,
The people who are psychoanalysts are not so keen on doing psychopharm, so even though in some ways there’s something appealing to me about referring to them, they don’t see themselves, their forte, as being psychopharm, so that probably isn’t the greatest referral, but it does help to have them have some kind of sense of psychodynamics.

Many of the biodynamic practitioners, as we saw earlier, had to give up some of their psychopharmacological specialization to become really good at psychoanalytic therapy. Therefore, they may not make the best referrals when a psychodynamic psychologist is looking for someone who specializes in medications. The psychodynamic group must be careful then that the psychiatrist who prescribes their patients’ medications knows enough about dynamic principles not to “ruin” their treatment. Unfortunately, that is not always clear at the outset. This opens the door for potential complications between the referring psychologist and the psychiatrist to whom the patient is referred.

Dr. Kent is most forthright about needing to feel a sense of allegiance to the psychiatrists she sends her patients to:

I have my people...I mean I’m still looking for the perfect one, but I look for people who are not like the many that I’ve encountered who have no interest in having a discussion about the patient and don’t really understand the idea of the therapy and often kind of impinge on the therapy. So, people who are more psychodynamically oriented, but it depends because if it’s a very complicated case in medical terms, my first priority is that it’s somebody who’s very skilled with that disorder, like bipolar disorder or something and I’ll work around that.

Again, Dr. Kent is clear that, for cases of depression or anxiety – disorders that are considered to be straightforward and rather mundane in the world of psychopharmacology – she will send patients to her biodynamic colleagues. However, she reinforces the notion expressed by Dr. Haman, above, and those stated earlier by
the biodynamic group, that a psychoanalyst is not always the right referral because they are not the best-trained psychopharmacologists. If a patient needs a more specialized psychopharmacological consultation, this can cause problems for the psychologist who has no choice, then, but to deal with a more biologically-oriented psychiatrist. Despite their best efforts, no explanation will remove this tension. It must be dealt with and psychodynamic practitioners will sacrifice their own comfort to find the best possible person to treat their patient, as Dr. Kent explains. When I asked who she refers her patients to, she told me:

People who are more psychodynamically oriented, but it depends because if it’s a very complicated case in medical terms, my first priority is that it’s somebody who’s very skilled with that disorder, like bipolar disorder or something and I’ll work around that.

There are cases when psychodynamic psychologists cannot get around the potentiality that tensions or outright clashes with a more biologically oriented practitioner might arise. In this case, the notion that they are doing the best thing for their patient is an explanation that allows for a referral to a non-analyst, but it does not actually succeed in avoiding the tension in the first place. For psychologists, it is simply not always possible to avoid tensions.

_Psychoanalytic Training is Easier and Makes More Sense for Us_

When it comes to resolving the tension between themselves and the biodynamic group, the psychodynamic group all allude to their own acceptance that the psychiatrists may think of themselves as better practitioners, but that it is in fact the opposite. They do so
in describing psychoanalytic training as being easier for them than for the biodynamic group, since it is more continuous from their graduate training than it is from psychiatric training. In separating themselves from psychiatrists in this way, they reinforce their own expertise and thus are able to feel more at ease referring many patients for meds. Dr. Kent says of her experience in psychoanalytic training that it was “very continuous.”

She continues:

“I’m not really doing something very different from what I did when I started graduate school. It’s different in that I know a lot more and I’m better at it, but it seems like the same kind of thing, whereas for them [the MDs] it feels very discontinuous and so they all seem like someone who in some way changed careers or something.

As I have described earlier it is in fact much like they have changed careers, especially for the most junior biodynamic psychiatrists in the sample, who were almost entirely trained in the biological model.

The biodynamic come into the analytic training knowing next to nothing about psychodynamic psychotherapy and they leave with an allegiance to it but it is a long process and often, as their earlier descriptions show, a contentious one. For Dr. Kent, referencing that she and her other psychodynamic colleagues came into the analytic training with the kind of knowledge and experience similar to that which is presented in psychoanalytic training provides her with a sense of mastery and even superiority that combats some of the super-psychiatrist mentality of the biodynamic group. She says, further:

Psychologists tend to come to analytic training with much more experience...and a psychoanalytic point of view, whereas the MDs don’t tend to. I think that really washes out over time, so that with colleagues that are my cohort now [several
years beyond training] I don’t sense that it’s that different. I’m sort of hesitating cause I’m not sure. I do feel like there’s something about being an MD that feels different inside them, but I’m not sure quite how. I mean cause there’s all kinds of funny slightly competitive issues...

Dr. Kent seems torn, here, between saying the differences between the biodynamic and psychodynamic practitioners are somewhat dissipated after analytic training and saying that the biodynamic group still feel like they have something over the psychologists.

Certainly, she corroborates that there is tension and even competition between the two groups in the institute because of the different kinds of training backgrounds, but she also clearly thinks that the analytic training, even if it does not entirely alter the treatment and thinking of the biodynamic group (which it does not) definitely does change the way they see patients, and also the way they see their psychologist counterparts.

Dr. Brighton explains the multiple issues perhaps most thoroughly when she says:

I think we’re trained very differently. The MDs and the PhDs are different kinds of people and have different kinds of training. PhDs are trained in philosophy and they are more broadly read in theory. It’s a certain kind of person who comes to psychology and it’s a different kind of person who becomes a doctor. What brings them together is psychoanalysis. Certainly, by the time they come into psychoanalytic training, they’re both interested in the mind and the brain and analytic theory, but the kind of people, they think differently. I find that very interesting. I find that very stimulating. The doctors, the psychiatrists tend to be very cut through the data, cut through the detail; they have wonderful memories, they gobble up articles in 5 minutes, the speed of learning is amazing, but the psychologists tend to be, they’re better clinicians. They have a better grasp of - very often they have a less didactic and rigid - the medical model, something about the way the medical model trains psychiatrists with diagnosis and symptoms is a little bit antithetical [to psychoanalysis]. I mean, Freud said
it's something antithetical to a philosophical grasp of the whole patient. And I think the psychologists get it by and large better.

What we can really see here is a description of the psychologist as more suited for the psychoanalytic training and of the psychiatrists as practitioners who struggle with psychodynamically oriented thinking, at least early on.

For instance, Dr. Livingston explains:

Because I went to a graduate school that was already so psychodynamic, I actually had learned a lot before...so in a way I felt like I started off a little bit ahead in terms of my theoretical knowledge, and to some degree my clinical experience because most of the psychiatrists who come in come in really right after residency or they've had maybe a couple longer term cases that lasted a little while or they had a supervisor who was psychodynamic, but other than that they don't really have that much knowledge and experience. So, it's funny cause you're starting off, in a weird way, ahead in terms of some of your knowledge, so it's kind of like comparing apples and oranges cause it's people who are at two stages of learning. Now my experience in the course of the training, you know, they pick it up and they're very facile by the time [they finish] their training...

Dr. Livingston is also clear that primary professional training – for the biodynamic group, medical school and for the psychodynamic group, graduate school in psychology – result in practitioners with two different schemas for understanding and treating patients. She continues:

So, in terms of attitude towards training, I wonder if psychologists are a little bit- because we're trained in psychology where, at least in my graduate school and I think in most, you're taught to be critical. You're taught to not take what's being taught to you at face value, but many professors encourage you - it's your job to critique these theories and come up with alternate theories and to test them and test their limits out and see what they can and can't explain. My sense is that physicians and psychiatrists don't always have that attitude toward theory. It's more received wisdom that - not always, but sometimes you get that sense that once they find kind of an approach that's aesthetically pleasing to them and
they've had some success with presentations or that their supervisor or their analyst seems to be in accord with, it's kind of like they're locked in and that's it. I mean, this is a broad generalization, but I've sensed that before and it can happen with psychologists too, but I just sense a little bit more tendency to be openly critical, to challenge, to not accept at face value certain things, which actually I think makes over time for a little bit better clinical work because you don't get blinded by an etiological position and you can be a little bit more flexible with your patients.

Schemas, as I detailed in the introduction to this project, are cognitive structures that organize the way we perceive stimuli in the world around us. Dr. Livingston explains that psychodynamic psychologists and biodynamic psychiatrists come to psychoanalytic training with very different organizational structures; whereas graduate training encourages students to question accepted knowledge, medical training encourages the memorization and models.

Though she says she thinks analysts have much more in common with each other than they do differences (especially after the analytic training), Dr. Willow reports a similar sentiment about being better prepared than physicians are for analytic training. She says, in talking to medical doctors, that they “tell me they have to unlearn more than psychologists, social workers, pastoral counselors, psychiatric nurses because they get trained ‘you're the doctor and you are the authority’...” According to Dr. Willow, being a medical doctor makes the biodynamic group think of themselves differently than the psychodynamic psychologists, but it also makes it strikingly more challenging for them to assimilate dynamic principles into their approach to treatment. Even though it often takes the biodynamic group more time and more effort to be good at psychoanalysis, the psychodynamic group still seems to need to explain their place in
analytic treatment and to prove that they belong in a group that was once reserved only for MDs.

Dr. Adams, however, describes that this is changing somewhat. MDs, she says, have come to realize that they have less training in talk therapy and theoretical thinking than the PhDs. She suggests that this may get better over time, since PhDs have not been in the training programs for that long. They may just be in the process of accepting that the kind of training they receive in medical programs does not prepare them for psychoanalytic training as well as psychologists. She says:

Psychiatrists have come to recognize that they have less therapy training when they come to psychoanalytic training than psychologists do, so I think a psychiatrist who’s willing to go look for psychoanalytic [training] already has to have a certain kind of humility because they’re exposing themselves to psychologists and social workers who know much more about therapy than they do.

In sum, the way the psychodynamic practitioners deal with tensions is to play up how much better they are at talk therapy, critique the overly medical practitioner, and be very, very careful about who they send their patients to. However, unlike the biodynamic practitioners who are much more in control of how much tension they experience (little to none), the psychodynamic group face many more constraints from the outside, making them more likely to actually experience these tensions rather than just have them as an unlikely potentiality.

**Discussion**

When it comes to resolving the tensions (potential or actual) described in chapter 4, the process is quite different for the biodynamic and psychodynamic practitioners. In this
chapter I have shown that both groups manage to find ways to bridge the biological and psychodynamic models to allow for effective clinical practice, but that the biodynamic group are much more successful than their psychodynamic counterparts. The internal tensions that I described in chapter four are resolved using routines. That the psychodynamic group is less able to routinize their practice and much more likely to encounter external tensions is what makes their practice much more tenuous.

The biological group faces less tension because this does not pose a problem since their model coincides with those treatment expectations and the dominant conceptualization of etiology and appropriate treatment within their field. On the other hand, practitioners in the biodynamic and psychodynamic groups who are schooled in psychodynamic theory and heavily influenced by their psychoanalytic training to think deeply about patients and their problems, face potential tensions in operating within a biological framework. This is embodied in interaction between practitioners who work in these two different camps and in the ways they talk about their own allegiances to biological and/or psychodynamic practice. Among psychoanalysts, the stereotypical model of the Freudian or biological psychiatrist (based on real practitioners in the middle to late 20th Century who did fall into these binary categories) does not exist anymore.

For the psychodynamic group, there are external constraints upon them - namely that they must keep medicines and psychiatric diagnoses in mind (their patients are taking medicines and they do think biology is important), but they cannot merge
these perspectives as neatly as the biodynamic group because they do not prescribe medicines. Further, they do not have medical training in their background.

For the psychodynamic group, there are more real, tangible boundaries between the meaning-making and medical paradigms, making it much more complicated to feel at home in both models and certainly to interact with psychiatrists, especially those without analytic training. Therefore, they must engage in much more active problem solving in order to practice effectively, whereas the biodynamic group are able to use a set of routines that they learn in training in order to avoid the actual experience, most of which push them toward favoring the medical model.

Further, there are external pressures on the psychodynamic psychologist to interact with the medical model – and even to accept it. For the biodynamic practitioner, the training in medicine clearly influences the way in which talk-therapy is used as a secondary method to medical treatment. Psychologists are not thoroughly trained in diagnosis and certainly not in medications, which they are not allowed to prescribe. In fact, many (especially younger) psychodynamic practitioners report choosing psychology over psychiatry precisely because they did not want to engage in prescribing or devote any portion of their practice to medicine. Some even say that because they always knew they wanted to practice talk therapy or even psychoanalysis, there would have been little point in going to medical school. Many of them feel that prescribing is and should be a separate job to their own – they talk to the patients, they get at the deep meaning and uncover the roots of symptoms. Someone else is responsible for handling drug treatment and that is how they prefer to practice. This, in
some ways, allows them to feel as though their talk therapy practice is superior to the biodynamic group and some are critical of treatments in which the same doctor provides both talk therapy and medications.

Having been in analytic training with many psychiatrists and also having been schooled in diagnosis and medicines during that training, there are pressures for the psychodynamic psychologist especially after forming friendships with psychiatrists. There is an interpersonal pressure to think medically and refer patients both during and beyond psychoanalytic training. Of course, psychologists refer patients for medicines before they are trained as analysts, but because of other pressures (patients want them, insurance will pay for them – with kids, schools and parents want them, etc.). It is ironic that since psychoanalytic training is ostensibly about dynamic practice, psychologists wind up thinking more diagnostically and even medically than before. Finally, though this was less often mentioned, there certainly is a legal and ethical consideration for psychologists. Today, it is considered negligent to treat someone with severe depression, panic attacks, and certainly bipolar disorder, without medicines. If something were to happen to a patient who had been diagnosed with one of these conditions and a psychologist had not referred that patient for medicines, she could be held accountable (even if not legally, by other practitioners, by patients’ families, etc.) for not treating the patient appropriately.

Primary and Secondary Socialization
For the biodynamic group, the biological model is their default and the psychodynamic perspective is what causes tensions when it is added to their primary, medical training. Whereas for the psychodynamic group, the dynamic model is their guiding framework and it is dealing with the biological model and practitioners trained in it that poses the problems. What is clear here is that, in order for these routines and explanations to be so present, something happens to these practitioners in psychoanalytic training that makes it necessary to manage potential and actual tensions. In analytic training, these routines and explanations become crucial for the analysts. Recall Strauss’s (1981) description of the importance of colleagues for professional socialization. While the biodynamic group learn much more about dynamic treatment than the psychodynamic group who start out fairly knowledgeable about that model already, it is striking the extent to which medical colleagues influence the psychologists during this training. Though the biodynamic group changes much more than the psychodynamic group in analytic training, when it comes to practice, no one is forcing them to use psychodynamic psychotherapy in their practice. They do so to the extent they wish. There is much more pressure on the psychodynamic clinician to refer and to think diagnostically than there is on the biodynamic to be psychoanalytic. There is also a difference in terms of the source of these tensions for the biodynamic and psychodynamic groups. While, for the former, the potential tensions between the two models arise mostly due to their analytic training, for the psychodynamic group, this is not entirely the case. Psychologists of all kinds must face tensions when referring patients for medications and from psychiatrists who do not believe psychologists are as
qualified as they are to practice. This is as much a professional tension as anything else and is not new for the psychodynamic group. However, they are much more regularly faced with medical training once they are analysts and that does increase the pressure to be more medical. The psychodynamic group has their primary socialization challenged much more in practice than the biodynamic group does.

The Necessity of Routines: what they do and Why Practice is More Difficult

Without Them

Routines are so necessary for the biodynamic practitioner because they prevent any of the potential tensions between the psychodynamic and biological models from rising to the surface and challenging a course of action in a treatment. Routines also guard the biodynamic practitioner’s identity as both a medical doctor and a psychoanalyst. It is equally important for psychodynamic psychologists to find ways to keep their professional identity in tact despite referring patients for medicines and to minimize the tensions between them and more medically minded practitioners, but it is much more difficult to do this.

In sum, the internal tension of being trained in two different treatment routines thoroughly and naturally washes away the tensions because they allow the biodynamic psychiatrist to feel in control and that she has made effective and appropriate decisions for the patient. This is why they only experience tension when they encounter biological psychiatrists, but they so rarely do because their colleagues and friends are generally analysts. As long as biodynamic psychiatrists can maintain separateness from the
mainstream psychiatric community, their contributions to the field are not devalued. Aside from their own students, who are not a threat because of the power difference, the biodynamic group is relatively unlikely to need to encounter biological psychiatrists. However, even when they do, they feel more like it is their duty to educate these non-analysts than to argue with them and they can turn the power dynamic on its head by thinking of themselves as less rigid, more highly trained doctors. Further, the psychodynamic psychologist will have more trouble washing away any tension involved in the use of the biological model since they have very little training in this perspective, whereas the biodynamic group does not even need to do this (save the most senior analysts in the sample). The work the psychodynamic group must do to be able to practice meaning-making in a medical world are active, whereas routines are much more tacit, even automatic.

Returning to the point at hand, the ideologies that underlie these routines are much like the institutional logics described by Friedland and Alford (1991) – proscribed ways of carrying out practice that are available for elaboration. It is striking that even the elaboration of these routines (and the explanations of the psychodynamic group for that matter) are fairly isomorphic across practitioners. For instance, the “workarounds” Whooley (2010) describes are not drastically different for each psychiatrist he interviewed, but rather there is a set of possible ways that practitioners navigate the restrictions of DSM. They may seem like individual variations on DSM use, but these, too, come from membership in a community and show how powerful their training is. Psychiatrists’ logics are rarely elaborated upon, particularly those that favor the medical
model because they provide them with a clear direction for practice and actually soften the boundary between the meaning-making and medical paradigms.

In many ways, actually, the biodynamic practitioners, in the face of more threatening potential tensions, wind up feeling like the super-psychiatrist - the psychoanalytic training gives them more tools instead of creating conflicts – doing both makes them feel their practice is better, and that they are a better practitioner. For instance, while the psychodynamic psychologists refer patients for medications to alleviate severe suffering as quickly as possible (and partly because patients want medications, and it is a culturally sanctioned response especially to severe psychiatric symptoms), the biodynamic group does this because it is, as Dr. Park explains “their obligation” as a medical doctor. It would seem that being obligated would lead to a greater sense of constraint, but in fact, it is the opposite. The sense of obligation takes away some of the burden of having to make a decision – the medical model is the default. For the psychodynamic group, they not only have to belabor the decision to refer patients (often because they may not believe a patient needs medicines), but then they have to deal with the tensions that arise in dealing with psychiatrists.

Conversely, feeling like the super-psychiatrist allows the biodynamic practitioner to see herself as a good doctor first and foremost, but also not to damage her psychoanalytic identity, which is crucial for the sense of being a super-psychiatrist. After all, to be a psychoanalyst – even though dynamic treatment has lost much of its allure – is still a badge of honor within the psychoanalytic community. It requires five extra years of training and is known to be a difficult process. The psychoanalytic identity, for all its
flaws, also connotes being wise, seasoned, and highly trained, even if it is in a paradigm that is seldom the training of preference for medical doctors. Rather ironically, when I asked Dr. Haman (psychodynamic) what she thinks is different about her job as an analyst versus analysts who are psychiatrists, she told me that she thinks it is more difficult for her biodynamic counterparts because they must negotiate two models:

I think about certain things that I don’t have to wrestle with in the same way that a psychiatrist might - like the whole medication issue. I mean, I have to think about if I’m referring somebody who’s in analysis for medication, I have to think about the transference to the psychopharmacologist, but I don’t have to think about, now, should I prescribe it myself or should I have somebody else do that. I think there’s a lot of confusion for psychiatrists about those dual roles when they’re doing an analysis, and maybe even when they’re doing psychotherapy.

Yet it is quite the opposite; the psychodynamic group actually must make the decision about whether to refer patients much more often than the biodynamic group who only do so in rare circumstances if they need someone who specializes in treating a certain disorder or if the medical side of their treatment is interfering with their ability to work with the patient in talk therapy.

The key difference between the psychodynamic and biodynamic groups is that the former cannot get rid of the interpersonal tensions. They can diminish them to a certain extent, for instance, by reminding themselves that they came into analytic training more prepared than their psychiatrist counterparts, but that does not change the actual situation. The biodynamic psychiatrists have two models (they can prescribe medications, and once they have been trained in psychoanalysis, also practice in-depth talk therapy). This means they have the ability to operate within both frameworks yet still be seen by medical colleagues as being on the same professional level. They do not,
for instance, have to reveal that they were psychoanalytically trained if they do not want to. Their degree remains medical, unchanged by five years in analytic training. But this also explains why psychiatrists might feel less tension than psychologists – they have more choice of what part of their identity to invoke when – they can be psychiatrist or psychoanalyst or some combination of the two depending on where they are and who they are with or what their patients’ symptoms are.

One way to understand this is that the biodynamic group face fewer conflicts when interacting with other practitioners because they can be flexible about when to invoke the psychoanalytic or medical parts of themselves. In Brekhus’s (2003) discussion of identity management by gay suburbanites, he shows that it is possible to identify as gay, suburbanite, or some combination of the two depending on the situation in which a gay suburbanite finds himself. Some of the men Brekhus describes as chameleons because, despite being members of two very different communities, each rigid about their values, the men are able to move between their two identities by metaphorically changing the color of their skin to blend into their environment. Biodynamic psychiatrists have this ability to move between professional identities in a way that the psychodynamic psychiatrist cannot. The biodynamic psychiatrist can actually benefit from the ability to be both dynamically and biologically oriented, given the appropriate contexts, and can use the biodynamic identity to feel like the super-doctor, as opposed to the psychodynamic practitioner who, more than anything else, must defend the psychoanalytic perspective.
The psychodynamic group, however, even if they are influenced by exposure to the medical model, mostly have one paradigm to fall back on, and it is the one that is rarely the training of the average psychiatrist and even most psychologists today. The psychodynamic group is much more likely to use to the psychodynamic model since it was their graduate and postgrad training, whereas the biodynamic practitioners were trained medically first and then in psychoanalysis. Being able to default to the medical model, especially early on in a treatment, while knowing the psychodynamic model is there for the long-term, in-depth work makes it so that the potential tension between the treatments is almost washed away for the biodynamic group. The medical model provides them with a neat sense of appropriate, medical action and the psychodynamic model allows them to maintain long-term relationships with patients in an attempt to uncover the cause of psychological problems, if and when they see fit. The psychodynamic group, too, has come to accept that medication is very helpful in reducing symptoms, but they cannot take care of that on their own, nor would most of them want to. Thus, they often have no choice but to introduce tension into their treatment and questions of whether to refer at all brings up many questions the biodynamic group does not have to answer. Of course, they manage this by choosing particular doctors for referrals and making certain to know whom they are dealing with to the best of their ability.

*Uncertainty in Mental Health Treatment*
Though these routines and explanations ostensibly reduce the tensions between the
two paradigms, and allow for more efficient practice (more successfully for the
biodynamic group), they also provide another mechanism: reducing the uncertainty of
practice. These routines of the biodynamic psychiatrist and even the explanations of the
psychodynamic psychologist function as standards of sorts – proscribed ways for dealing
with the symptoms patients present and the different potential treatment modalities
available to deal with those symptoms. For the biodynamic group, if the two paradigms
are more easily combined and in routine ways, then there is much less room for error,
and comfort in of a set of guidelines to fall back on.

It should never be ignored that psychiatry is an uncertain field. For the
psychodynamic group, the tensions can be mitigated at least somewhat through
explanations, which also allows for much more functional practice. After all, the kinds of
troubles presented to these practitioners can be confusing. The treatments are also
unpredictable, and psychoanalysts are scrutinized as to their scientific practice because
of the legacy in Freudian theory and the overarching medical notion that all treatments
should be evidence-based. Therefore, these routines really serve multiple purposes, the
most important of which is that they reduce tensions, but these routines can certainly
also be seen as important for providing a sense that there are overarching standards for
practice, thus reducing the overall need to question practice and get bogged down in
confusion. This is more central for the psychiatrists though the extent to which
psychologists are expected to refer makes it a relevant discussion for them too.
Cohort: The Increasingly Blurry Boundary between Psychoanalytic and Medicinal Treatment

Cohort is hugely important for the biodynamic group. The likelihood to privilege the biological model is much greater for younger biodynamic psychiatrists whose primary professional socialization in medical school and residency was in the biological model. The biodynamic practitioners in their 70s and 80s, who trained long before the biological revolution, use the routines described in this chapter, but are much more likely to use those that bridge the biological and psychodynamic models rather than those that privileging the biological; for instance, they tend to describe the use of medication for talk therapy more readily than the biological etiology of illness. They are much more wedded to the notion that the psycho and social are the primary influences on their patients – perhaps even more so than biology. Of course, that does not stop them from prescribing medications, though it is in part for reasons of pressure from both patients and other practitioners, much in the same way psychologists send their patients for psychopharm consultations.

In fact, the older biodynamic psychiatrists look much more like the psychodynamic group than they do the younger members of their own group, who tend to adhere much more closely to the biological model and prescribe medications mostly because of a genuine belief in biological etiology. Simply stated, older analysts do not experience that clashes in the same way because their primary allegiance was never to the biological. They are first and foremost analysts, not doctors or even psychiatrists; many of them only went to medical school to become analysts because it was the only
route to that goal when they trained. This also means that the more senior analysts must work harder to combine the two models, since their primary professional socialization was, even in medical training, into the psychodynamic model. The tension with using the biological is therefore greater for them, though the power of these routines may be most obvious with this group because they allow even more senior analysts to prescribe medications and think medically without feeling conflict, even though they are trained as classic analysts.

The use of these routines and explanations is a relatively new phenomenon because psychoanalysts, though they always have been medical doctors, were not until recently trained biologically. And psychologists until recently could not train in psychoanalysis with medical doctors. The two paradigms were therefore much more isolated in previous eras. The intensity of the tension between the models mostly kept them apart; most people who trained in the 1980s tell stories of biological and psychodynamic practitioners locked in a power struggle, the former sensing their emerging power and the latter afraid of their imminent demise. Now, there is much more a need for psychiatrists and psychologists alike to provide or facilitate hybrid treatments.

There are fewer and fewer of the more senior analysts as they age out of the profession, so this resolution of the once stark contrast is actually quite important to understand, given that it is incredibly rare for a psychiatrist to come out of residency with any significant psychotherapy training these days. This means that for those who train in psychoanalysis (though it is very few today), these routines are particularly
important. But these routines also provide an interesting insight into how psychodynamic principles could perhaps be integrated into medical training, since it is certainly possible for them to be more complementary than most theorists presume. If the junior biodynamic psychiatrists and psychodynamic psychologists experience less tensions with using the two models together than the older analysts, then it is clear that it is possible for the biological model and the psychological model to work in tandem, even if there are professional tensions that come along with this kind of combination treatment, and even if, thus far, the medical model dominates combined treatments.

*Opposing Paradigms can be Functional in Practice*

To return to Fleck’s statement that appears at the outset of this chapter -- there seems to be something about the stark difference (the almost irreconcilable theoretical positions) between the psychodynamic and biological models that makes it so they are actually not that difficult to use simultaneously. Further, in practice, they offer different treatment goals, different treatment methods, so they can both be used to help make the patient feel better without really being in conflict with one another. It is, in many ways, the fact that they are so different, that makes them compatible. On the other hand, two psychological theories or two different models of diagnosis would likely be much more difficult to reconcile because their goals and methods would overlap and compete with one another since they share much more similar treatment goals. I have shown in this chapter that the reason these disparate models are so easy to use together for the biodynamic group is in many ways because routines that bridge the two
models parse out when to use each model (almost always by favoring the biological first); in practice, then, the psychodynamic and biological model are in some ways so different that they are compatible, but only when these routines are in place.
CONCLUSION

Can Meaning-making Survive in a Medical World?

No one seems to know where psychiatry begins and ends; it suffers sizable difficulties in setting its own boundaries, delineate areas of knowledge and skill where it and it alone remains supreme, and because its boundaries appear vague, at least to outsiders...(Falck 1980:220)

The State of Practice; General Findings

As early as the 1950s, when psychotropic medications were first introduced, prominent psychiatrists suggested in mainstream psychiatric journals that the emerging biological model was in conflict with the entrenched psychodynamic approach (c.f. Armor and Klerman 1968). By the 1980s, with the release of the 3rd edition of the Diagnostic and Statistical Manual for mental disorders, the predominant perspective on the etiology of psychiatric symptoms was one in which symptoms were seen as manifestations of underlying illnesses. The focus of treatment rapidly shifted from the identification of the psychological and experiential sources of symptoms to the use of medicines that alter brain chemistry.

Talk therapy is still central to psychological and some psychiatric training programs in New York and other major cities in the US, and training in psychoanalysis is considered a right of passage among some individuals with the social and cultural capital to know it is an option and with the financial capital to afford it. Talk therapy is also still valued by cohorts of psychiatric residents that entered training before the biological takeover and who were socialized into their field in an era during which psychiatry was characterized by in-depth talking treatments. Even though they too have
incorporated elements of the biological model into their practice, their allegiance to the psychodynamic model remains. However, there is little debate that the biological model dominates the training of psychiatrists and even influences graduate training in psychology today.

The biological model in mental health treatment is what patients are most likely to encounter when seeking treatment for their symptoms and Americans do seek the help of psychiatrists at astonishing rates each year; in 1995, about forty-six percent of the American population had seen a mental health professional (Furedi 2004) and one study shows that between 1996 and 2005 only about a third of the office-based visits to a psychiatrist lasting longer than thirty minutes involved some form of talk therapy (Kaplan 2008). If my sample is any indication, it is likely that many of these talk therapy visits do not involve in-depth exploration of the psyche, but rather discussions of symptoms, medicines, and possibly cognitive behavioral treatment.

Though the influence of psychiatrists on patients and American culture more broadly is great, there is sparse research on the doctors who practice this brand of medicine and train new generations of mental health professionals. Particularly lacking is the kind of information I have provided in this dissertation -- about what happens once practitioners are many years out of formal training programs and the watchful eyes of supervisors are no longer a daily influence on thinking and treatment preferences. Researchers have explored the models that underlie training in both psychoanalytic and biological psychiatry, but we know little about how practitioners think about these models and their role in treatment.
In this project, my goal was to fill this void in the knowledge of mental health practice by starting with the professionals who employ these treatment models. In order to do this, I have detailed the history of the field of psychiatry, which culminated in the dominance of the biological model. I have explored the key issues in mental health practice today, as well as practitioners’ perceptions of the differences (and many similarities) between those who spend the majority of their time employing meaning-making practices and those who operate mostly within the medical model. Finally, for the biodynamic and psychodynamic practitioners, who each operate to a certain extent with a foot in both the biomedical and psychodynamic approaches, I described the methods by which my interviewees are able to practice despite the tensions between the biological and psychodynamic models.

I show that the biological model is a powerful force that often dominates practice even for psychiatrists trained intensively in the psychodynamic model. In fact, the biological model even influences the practice of the psychodynamic psychologists in my sample to the extent that they refer many of their patients for medicines and consider biological factors to be central forces in the development of mental illness. There are stark differences between the biologically and psychodynamically oriented groups; the former are more likely to support the use of medications, while the later are significantly more likely to engage in talk therapy. There are also significant within-group differences, particularly for the biodynamic group for which cohort is especially relevant to practitioners’ allegiances to the psychodynamic model; those who trained prior to the
1980s tend to be much less biologically oriented and more likely to have smaller practices that resemble those of the psychodynamic practitioners.

I have examined the trends in the use of talk therapy and medication in an attempt to both give insight into these practices and to show the benefit of investigating structural phenomena (in this case, the widespread use of mental health treatment, particularly biological treatment) from the ground up. It is in practice that we see the manifestations of treatment paradigms and, for instance, the reasons for which rates of prescribing psychototropic medications are so high. For example, in the routines biodynamic psychiatrists employ to avoid the potential tensions between the psychodynamic and biological models the extent to which the biological model is favored and the psychodynamic model is relegated to secondary status is clear.

In examining practice, we can see a process that is otherwise only documented in terms of prescribing patterns and trends in medication consumption. It is informative that the use of anti-depressants in the US tripled between 1988 and 2000, and that about ten percent of women and four percent of men use psychototropic medicines in a given month (Pear 2004). However, knowing how many people take psychotropic medication does not tell us about the processes involved in the decision to prescribe those medications; the rationale behind prescribing practices is important and largely overlooked. In the narratives of the practitioners in this study, the mentality that fuels the dominance of the biological treatment of mental illness is clear. In sum, the ways in
which practitioners make decisions about when to prescribe medications and if/when to use talk therapy are implicated in the trends in mental health treatment today\(^1\).

Thus, this dissertation calls for a sociological study of mental health professionals. Conversations with practitioners provide a wealth of information about the structural conditions of the field at large. In any field that is generally examined in terms of large-scale trends we should be able to gain the same kinds of insights from talking to practitioners. We know, for instance, about political trends, but how much do we know about how politicians think about their field and practice, upholding the will of American citizens, or about the decision they make on, for instance, the senate floor when a vote comes up. Researchers can glean valuable information about fields in medicine or science at large from the perspective of doctors or scientists, or the education system from the perspective of educators, or the political system from the perspective of politicians. This serves as a reminder of the crucial role for studies of *praxis* (Bourdieu 1977) to compliment those that highlight trends in various social realms. Insight into the world of the practitioner - the influences on and the consequences of her thinking and action - can inform what we know about various fields more broadly. A focus on the practitioner as the arbiter of practice allows insight into the ways in which training messages (such as those embedded in psychoanalytic training) are received and carried out.

**Biomedical Dominance**

\(^1\) It is important to note that much of the psychotropic prescribing in the US is by general practitioners rather than psychiatrists.
Gerald Maxmen, author of *The New Psychiatrists*, explains that “...the old psychiatry derives from theory, the new psychiatry from fact” (Kirk and Kutchins 1992:31). Maxmen’s statement is not a neutral observation, but rather an insight into his firm belief in the damaging nature of the un-scientific practice of psychoanalysis as well as his assumption that evidence-based medicine is more objective and true. From the early 1900s until the 1980s the psychoanalytic model dominated psychiatry in the United States; most practitioners believed that even the most troubling of psychiatric symptoms stemmed from trauma, childhood experiences, sexual repression, and psychological responses to key life figures and events. Practitioners in this tradition were focused on what Dr. Brighton [psychodynamic] describes as her fundamental question about her patients: “how has this person been put together?” This orientation toward understanding personhood and how that relates to symptomatology is drastically different from one that involves categorizing symptoms in order to provide evidence-based treatments.

As Cassell (2004) claims, “theories of medicine are exemplified by the actions of doctors” (p.vii). I provide evidence that the paradigm shift in the mental health field influences the thinking of and treatment provided by practitioners. I show that the biological model is highly influential even for the psychiatrists and psychologists who are the most trained in psychodynamic treatment in the country today. Given their location in and around New York City, where there is a patient population with the financial resources and enough interest in the field enough to engage in psychoanalytic treatments, as well as their five years of training in psychoanalytic theory, biodynamic
practitioners should be the most likely of any other psychiatrists in the country to engage in in-depth talk therapy. The biodynamic group, however, medicate more than half their patients, many of whom they see for medications alone, and describe mental illness as highly rooted in brains and bodies. This does not contradict their concern with minds and psyches as well. The psychodynamic group is clearly still mostly wedded to the psychoanalytic model as they have not attended medical school, but instead spent the majority of their career training in psychodynamic theory and practice. However, the fact that just under half of the psychodynamic practitioners’ patients are also taking psychotropic medications reveals a striking influence of the biomedical model on their practice as well.

That the medical model reigns supreme in psychiatry is not surprising. As Falck (1980) underscores: “Psychiatry is a specialty in medicine; it is not a profession itself” (p.220). In short, the central reason for the dominance of the medical model in psychiatry today is that -- though psychiatrists are stereotypically associated with analytic couches and images of bearded men smoking pipes as they listen to patients talk about childhood problems -- medical training is the primary professional socialization for these psychiatrists, regardless of future training in psychoanalysis. Medical schools inculcates doctors into the essential notion that they are responsible “to do good” or to “do no harm,” a relic of the Hippocratic Oath, which has been translated into modern medical ethics as “first, do no harm.” If a doctor medically treats pain, then she satisfies her moral obligations as a doctor. From this perspective, diagnosis and medication are the most powerful tools with which to help patients. Light
(1980) notes that “[l]earning how to diagnose is a skill which psychiatric residents must learn before all others...” (p.160). The identification of symptoms is a central element of psychiatric training and one of the first lessons learned in medical training.

Shifting Treatment Goals; From Understanding to Symptom Reduction

In the introduction to this dissertation I laid out a central goal of this project: to examine the standards of practice, how they change, and for whom they change things. In examining the shifting nature of treatment goals, we can see that the field of psychiatry is radically different today than it was in the Freudian era. Psychiatry retains the primary goal of treating patients even if what is considered to be the best, most effective means to achieve that goal may be radically different than it once was. What is considered effective and the consequences of that perspective rest largely on notions of what illness is and what it means to be ill.

Underlying the key differences between the psychodynamic and biological models are different notions of what treatment is and what it should do. This is clear in the narratives of my interviewees. Though the practitioners in all three groups -- the psychodynamic, biological and biodynamic -- share the common goal of caring for their patients by alleviating their troubling, painful and even debilitating symptoms, the immediate and long-term goals of treatment are at the heart of the differences between the three groups, an essential element of which is the temporal orientation of their treatments. With a focus on the present, the biological group is mostly concerned with controlling what are perceived to be dangerous symptoms and returning the patient to
normal functioning as quickly as possible. This is why diagnosis is so central to the model; it quickly categorizes patients’ symptoms and allows psychiatrists to feel as though they are living up to their role as medical doctors. On the other hand, the psychoanalytic perspective looks to the past in order to understand the present and allow the patient to function more easily in the near and distant future. In this tradition practitioners advocate the long-term use of meaning-making practices in order to uncover the roots of deep-seated neurotic tendencies that are believed to underlie symptomatology. The relief of symptoms is not necessarily the primary objective for a psychoanalyst, though it is a treatment goal in the long-term. As Dr. Park reminds us in chapter five, psychoanalysis may open up painful or traumatic experiences to be relived; though the ultimate goal is to understand those experiences and avoid similar situations in the future, the process of psychotherapy is messy and may allow for the experience of pain as a part of self reflection.

Recall that Dr. Park (biodynamic) says, “Freud advertised psychoanalysis at the end of the last chapter in Studies in Hysteria. The goal of it was to achieve everyday unhappiness. It should be a hard sell alright.” In part as a reaction to this, the biodynamic group treats symptoms early on with medicines and then attempts to uncover meaning and explore psychological functioning once those symptoms have been alleviated. Thus hope to relieve the worst symptoms in order to make psychoanalytic treatment tolerable. Because the biological model is dominant today, the goals in treatment for the field of mental health are much more focused on diagnosing and treating symptoms using medications than on the psychodynamic model and the
use of talk-therapy to understand the psychological and environmental factors in the development of symptoms.

Underlying the differences in treatment goals between the biological and psychodynamic models are different conceptualizations of what the appropriate duration of treatment should be. Because evidence-based practices push for the most efficient treatments possible, those with shorter duration are seen as the most effective and therefore preferable. Short duration is tied to notions of efficacy, which puts the psychoanalytic model at a disadvantage. As I describe in Chapter One, this is why some psychodynamic and biodynamic practitioners have pushed for short-term, evidence-based versions of psychodynamic treatments to match the kinds of trials used to determine medication efficacy. These trials usually last six weeks and clearly document the initial threshold of symptoms and any changes during the period in which a medication is administered. The accusation that treatments that continue for years are ineffective has badly damaged the image of psychoanalysis, which is not meant to be a short-term treatment, nor is it, in its classic form, set up to scientifically track patients’ progress over the course of treatment. In order to do so, it could take years. Psychoanalysis is also more concerned with the process of treatment than with a particular endpoint, while biological treatments focus much more on the ultimate goal of symptom reduction or elimination.

Again, a theme that runs throughout the narratives of all three groups is that, irrespective of particular treatment modality, practitioners’ goals are to make patients’ lives better. They do what they can to that end, and most of the time if they cannot
solve a patient’s problems or help them enough with their symptoms they will bring in a doctor working in another treatment modality, regardless of the cognitive or emotional cost. Especially for the psychodynamic group, the expense can be great. Some of the referral process and the decision about who should work with which patient with what kind of treatment has to do with the division of mental health labor; doctors essentially do whatever they feel most competent at. They largely engage in treatments they endorse philosophically, though they will push themselves to the limits (as in doctors whose alliances are mostly to psychoanalysis, but who frequently prescribe or refer patients to someone who can prescribe medicines) if it means helping a patient. A practitioner will even go beyond her comfort level and use a treatment she does not endorse philosophically in order to help a patient -- whether it is a senior biodynamic psychiatrist who does not feel comfortable with prescribing or a psychologist referring a patient to a non-analytically trained psychiatrist.

*Medicines as a Central Factor in the Shift toward Symptom Alleviation*

The main tool of the biological model is medications that alter brain chemicals and are thought to abate the symptoms of a range of mental illnesses. Today, it is not just biological psychiatry, but psychiatrists of all brands as well as other mental health practitioners (like the psychodynamic psychologists in my sample) who rely on medicines to assuage patients’ symptoms. This practice is fairly widespread, although a very small number of the older biodynamic psychiatrists and all the psychodynamic
psychologists do treat patients without medicines if their symptoms are not severe. Many of them, if not for external pressure would likely prescribe far less medicine.

A major difference between the biological group and the practitioners who are analytically trained is in the use of medication; the difference is largely about whether medicines will be one part of a treatment plan or the entire plan and the endpoint of the role of the practitioner in the patient’s treatment. In general, psychoanalysts reported using combined treatments, wherein medicines are prescribed when patients present with severe symptoms. Talk therapy follows once the patient is more capable of seeing beyond his or her immediate pain. However, the extent to which medicines are the primary focus of a treatment and the likelihood that they will be used early on in a treatment depend on primary professional socialization; the biological paradigm and treatment with medication is more salient for psychiatrists regardless of analytic training. In fact, relegating psychoanalysis to secondary status allows doctors to feel as though they are satisfying their professional responsibilities to alleviate pain as quickly and thoroughly as possible.

Medicines are a central part of treatment for all three groups. For the psychoanalytically trained groups medicines are commonly described as a prerequisite for psychodynamic treatment. They lessen the intensity of symptoms enough that patients who might otherwise be too distracted or incapacitated by their symptoms can engage more fruitfully in psychodynamically oriented therapy. However, for the biological practitioners, whether or not their patients are in talk therapy is largely irrelevant since that type of treatment takes place under the care of another doctor; the
biological group exclusively takes care of the medical piece of treatment. If patients are in talk therapy with another practitioner or if they wind up in talk therapy at a later date, it has nothing to do with the biological practitioner except that she may have to communicate with the talk therapist. As we have seen, this interaction may cause problems for the talk therapist, but the psychopharmacologist is largely free from these tensions; her responsibility for the treatment is over once the patient is stabilized on a medication.

The Overt and Tacit Influence of DSM Categories on Practice

The effective treatment of symptoms through the use of medications rests on a practitioner’s ability to accurately diagnose illness. In order to do this, DSM must play a central role, which represents another drastic shift in practice. Standardization and classification were scarcely considered in mainstream psychiatry prior to 1980s with the exception of the Kraepelinian model, though even for Kraepelin, the earliest proponent of psychiatric classification, the categories were more a heuristic tool than a practice guideline. Because psychologists are not allowed by law to prescribe medications, the psychodynamic group uses DSM much less than psychiatrists do. However, diagnostic thinking is at play in all three groups.

DSM is certainly more of a research tool than it is a clinical instrument and my interviewees describe its greatest utility as a tool for coding insurance forms. However, its use extends well beyond its necessary role in reimbursement. Its utility is twofold in practice: First, it helps organize practitioners’ thinking so they can get started on a
treatment, whether it is oriented biologically, psychodynamically, or toward some combination of the two; Second, it assists practitioners in their decisions about treatment. The diagnostic categories assist practitioners as they strive to determine the severity and duration of symptoms and to classify them in a way that supports further decisions, largely those surrounding whether medication is useful for a given patient. If a psychodynamic practitioner is going to send a patient for a medication referral or if a psychiatrist is going to write a prescription, she needs to know what condition she is dealing with and which medications are indicated (or contraindicated) for its treatment. Further, certain conditions such as those that are characterized by psychotic symptoms or very intense mood states will be more likely to lead to the recommendation of medications, whereas mild or moderate anxiety might not necessarily yield a prescription. The diagnosis is necessary to determine the type of treatment to follow.

It is for these reasons that I argue DSM is relevant to studies of psychiatric and psychological practice even if practitioners say it is peripheral to their work on a daily basis. Horwitz (2007: 216) warns that researchers must be careful not to fall into DSM’s trap of conflating “symptoms associated with stressors” and “symptoms that arise from internal dysfunctions” – essentially, not to over pathologize and/or biologicize symptoms. He is careful not to lump researchers and clinical practitioners together, as Karp (1996) reminds us that “patients who seek help are self-selected and typically have already decided that their conditions go beyond ordinary distress to warrant professional treatment (Horwitz: 216). In other words, if patients are in a mental health practitioner’s office, they likely have a good reason to be there. While it is clear from my
interviews that practitioners too recognize the dangers associated with DSM and some (mostly the psychodynamically trained doctors) are quite critical of it, they still use the categories for insurance purposes, for prescribing, and most strikingly, for organizing their thinking, which means the DSM model is ubiquitous at least in so far as it is ingrained in the minds of practitioners. Horwitz notes that:

Clinicians can ignore the official DSM criteria and substitute their own judgment when they decide they are dealing with conditions that are connected to social situations and are not mental disorders. Moreover, clinical treatment can sometimes relieve the distress of suffering people who might not have disorders, just as physicians often use anesthesia to numb the normal pain that stems from childbirth. The conflation of normal, distressing emotions and mental disorders, however, has had greater implications for the kinds of issues that sociologists are most interested in, including rates of mental illness in community populations, public policies toward the response to mental illness, and changing social norms about the nature of mental illness. (idem)

For a variety of reasons clinicians are able to be much more discerning than to simply apply DSM categories, including their own clinical experience and expertise, and their desire to be autonomous of the diagnostic model (c.f. Whooley 2010). And yet part of what I have shown in this dissertation is that the medical model, which involves heavy training in DSM categories and conceptualizations of illnesses as biological malfunctioning is so powerful (especially, according to my interviewees, for the current residents in psychiatry programs across the country) that these concerns are applicable to many clinicians as well. The danger, pointed out by McWilliams (2000) and others, is that residents are not trained to see beyond diagnosis -- this should concern mental health researchers and clinicians alike. Though DSM may not be central to practice in the way it is to research, it is certainly worth more consideration, not only as a practice
tool, but as the embodiment of models that, even without the manual, exist in practitioners’ minds.

For instance, in explaining that psychiatrists do not use DSM in monolithic ways, Whooley (2010) suggests that the power of DSM is in its use in practice. He shows that DSM is negotiated in practice – that psychiatrists are flexible with the categories and claim some autonomy for themselves and less stigma for their patients by using what he calls “workarounds.” While my interviews show that this is the case to a certain extent, training in DSM and diagnostic/biological psychiatry, I argue, makes the use of the categories less of a choice than it may appear.

While “workarounds” are certainly an important and very present phenomenon, it is also the case that DSM categories are not only represented by their overt use – it is not necessary to consult the manual or to literally fit someone into a category if this is how you see them in the first place. The official diagnosis is only one part of the importance of the categories, which are internalized lenses for seeing patients and symptoms without having to consult a manual – and they exist whether or not doctors write an official diagnosis on an insurance form. Where there is ultimate autonomy (as is the case with my practitioners who do not have to answer to anyone because most of their patients do not need reimbursement) DSM categories are present even if the manual itself is untouched on a day-to-day basis. Thus, there is little flexibility in whether one uses DSM, but there is somewhat greater autonomy in the manner and the extent to which it is employed. Of course innovation in use of DSM is constrained training schemas that make it more or less likely that a doctor might ‘choose’ to be
creative with her diagnoses. For instance, senior analysts, who trained before 1980 and
were not schooled in DSM diagnosis, are more likely to think flexibly about the
categories, whereas those who trained after the biological revolution were trained to
see the categories as real disease entities.

Psychoanalytic Training Doesn’t do what it Used To

Psychoanalytic training provides psychiatrists with a new definition of talk therapy. Prior
to this training, talk therapy connotes any meaningful interaction with patients, which is
evident in the way the biological group conceptualizes talk therapy. Analytic training
provides doctors with meaning-making skills that psychiatrists lack exposure to. The
extent to which the meaning of talk therapy changes for psychiatrists who participate in
analytic training underscores how unprepared psychiatrists are to practice talk therapy,
psychodynamic or otherwise, when they emerge from psychiatric training. While the
more senior members of my sample did not engage in psychoanalytic training in order
to bolster their talk therapy skills – for them it was a natural progression from psychiatry
training where they were trained mostly psychodynamic principles - the more junior
practitioners (age fifty and younger) perceived that they needed it desperately to be
good talk therapists.

For psychologists, analytic training exposes them, ironically, to the medical
model because they socialize with and are trained by MDs for the first time. This training
can be important and helpful for practitioners who do not have any exposure to the
biological model. Most practitioners today would agree that it is a loss not to have some
education in biological thinking (theories of etiology, diagnosis and medicinal treatment) given that the dominant conceptualization in the field is that biology is the factor most responsible for symptoms and that it is extremely helpful for many patients. However, this represents a radical alteration in psychoanalytic training from the days when analysts would not prescribe medications, let alone allow information about the medical model to be taught in their training programs.

Another important change is the result of psychoanalytic training for MDs. Ultimately, while analytic training changes their perspective, it may not change the decisions made in practice all that much, as Dr. Ferris (biodynamic) informs me:

If I had to say what my intellectual home was, I’d say you know the analytic institute and if I had to choose meetings to go to I’d probably prefer to go to an analytic meeting than psychiatric meetings. Even the way I think about the patients I see for medication -- while I have to keep up on medication like everyone else -- the questions I ask and the way I handle consultations with people who are coming for medication management is based on me as an analyst and I don’t think differently because I see a medication patient. I’m still an analyst. I may ask different questions at different times or do a different kind of consultation but the way I think about people and the way I ask them to talk about themselves comes really straight from my identification as an analyst.

Thus, when analysts describe the importance of psychodynamic training (especially for psychiatry residents who are no longer exposed to psychodynamic ideas in psychiatry training) it is not because analytic principles will radically alter practice, but rather because it entirely changes the practitioner’s approach to her patient and the kinds of questions she asks in an evaluation.

_Cohort Effects in Psychiatric Training_
Training and practice in psychiatry have shifted dramatically in the last three decades. Psychiatrists who entered into the profession before the 1980s went into analytic training because most of their peers were interested in Freudian theory and dynamic treatment at that time. Today, psychiatrists go into analytic training primarily if they hope to see some patients for in-depth talk therapy, which they no longer are trained for in residency. In other words, they do the training because they need the skills and, at least in part, because in New York psychoanalytic training still carries some prestige. Wanting the skills also means they are likely to have been exposed to psychoanalytic principles at some point, either by a supervisor during their training, or they may have gone into the field hoping to be a talk therapist from the outset and still need these skills after medical training. There certainly is some self-selection bias in terms of who enrolls in psychoanalytic training in the first place, but this irrelevant thirty years ago because everyone was exposed to dynamic principles. Psychoanalytic training would simply have been about gaining a deeper knowledge of those ideas and was much more common for all psychiatrists than it is today. The success of biological psychiatry is evident in the low enrollment in analytic training programs.

**Fueling the Biological Flames by Denying Uncertainty**

Many of the issues described above and throughout this project (especially the reliance on diagnostic categories) harken back to an age-old problem in treating psychological and/or psychiatric symptoms: uncertainty, unpredictability, a lack of knowledge about how the brain truly functions, and what causes and can likewise treat
the conditions mental health practitioners handle. For instance, Dr. Gold, one of the more senior biodynamic practitioners in my sample, explains that psychiatry should reinvest in training residents in psychodynamic principles. This is partly because she recognizes that no one paradigm has all the answers and because knowledge in any discipline is in flux at all times. Dr. Gold describes the gains psychiatry has made because of the biological model, but also says that throwing out the proverbial baby with the bathwater ignores the contributions that even outmoded models might offer. Thus, she believes that residents should be trained in a range of perspectives, though she is partial to the psychodynamic in her own work. When I asked her if she sees psychiatry moving in a positive direction, she seemed confused by the term “positive” and responded with the following:

There’s a play by George Bernard Shaw - I can’t remember which one, but there’s an old physician and some issues come up and this guy says “oh yeah, we had that idea fifty years ago.” So in psychiatry - I think the rest of medicine is moving progressively in their understanding of diseases - I’m not sure if psychiatry, I mean there’s more understanding of biological substrate of schizophrenia and manic depressive illness and so forth, so there is some progress going on, but not everything is going in one direction. It’s mixed.

Practitioners struggle with the uncertainty involved in the field of mental health, and with the indeterminate outcome of treatments, including the result of treatment in the evidence-based biological model; the majority of my interviewees express relief that there are medicines to help with severe symptoms, but also recognize that the troubling and sometimes intolerable side-effects of the medicines they prescribe are a reality for patients and vary so widely from one patient to the next that a practitioner can never know how a particular individual will respond without a trial. All the practitioners with
whom I spoke also note that medicines are not as effective as is desirable. In working with the available treatments, they do their best to find the most effective solutions to alleviate troubling or debilitating symptoms.

However, given the emphasis on evidence-based treatment and that there is so much uncertainty in theories of etiology and about what treatments will be the least problematic, standards have become increasingly important. There must be a way for doctors to make sense of (and even ignore) the uncertainty associated with their field if they are to be functional practitioners. If a desire to take ones own life, lengthy bouts of sleep disturbance, appetite changes and low self-esteem could not be classified as depression, a clear course of treatment could not be charted and thus psychiatry could not follow the medical model. DSM and the biological model provide a solution to some of this uncertainty. Cassell (2004) surmises, “...it would appear that the contemporary overuse of technology, or at least an increasing dependence on technology, and the continued concern with the disease to the exclusion of the sick person are methods of denying the inevitability of uncertainty” (p.215). Adhering to DSM categories (which aids in articulating which is the illness to be treated as well as how to treat it) makes it seem as though mental illness is a clear-cut entity, thus making the doctor’s job seem straightforward and doable (Fujimura 1987).

No matter the extent to which practitioners rely on diagnosis and the DSM model, psychiatry and psychology will always be disciplines plagued by the uncertainty of the human mind and body and the sometimes unexplainably ephemeral nature of symptomatology. No matter the extent to which practitioners rely on standardization in
order to make practice more manageable, the unpredictable quality of their work will lurk in the background. Patients sometimes do not get better despite the best intentions and the use of evidence-based practices. Medications sometimes produce side effects as bad as or worse than the original symptoms themselves. Changes in life situations yield either new symptoms or the sudden, unexplainable evaporation of long-standing problems that had previously been addressed using medicines and/or years of psychotherapy. The wish to deny uncertainty and to make psychiatry in particular (and psychology to a lesser extent) a more predictable field results in an overemphasis on categorization.

The attempts to control this uncertainty by relying increasingly on diagnosis and by sheltering the field of mental health under the umbrella of medical practice has meant that the dynamic principles that were the core of psychiatric practice not long ago have been left mostly by the wayside. The small group of practitioners who still practice psychoanalysis (especially the biodynamic group) give the biological model a significant place in their work. Most analysts in my sample do engage in some psychoanalysis, all practice psychodynamically informed therapy, and all “cherish the complex art” they practice (McWilliams 2000:372). However, the descriptions of etiology and the role of medication in practice make it clear that it is nearly impossible today to find a psychiatrist with a completely psychoanalytic practice. Members of the psychodynamic group are the closest to a traditional psychoanalyst that can be found today, though they too see a significant percentage of patients who take psychotropic medications. Psychiatrists are not alone in seeing biology as a key factor in the etiology
of mental illness, thus showing just how powerful the medical model has become; the notion that biology figures so centrally in the thinking of even non-medically trained practitioners is an important insight into the diffusion of the biological model beyond the boundaries of medical training.

The need to control uncertainty is a major part of what led to the crystallization of the biological model, though it is not the only reason. I have discussed many of the reasons why the biological model tends to play a more central role in practice than meaning-making does. It has as much to do with the economic unsustainability of a private practice that excludes biological practice as it does with a particular need to identify with the medical world. Psychiatry today is biologically oriented and it is not easy for practitioners to break out of that mold, nor would most of them want to. But, at a basic level of economic feasibility (for psychiatrists), practitioners can simply see more patients in less time when the appointments are centered on prescribing rather than dynamic therapy. Most patients cannot afford treatment if their insurance will not reimburse for it and managed care has made it more likely that patients wind up in a psychiatrist’s office for a medication evaluation than for any other kind of treatment. Further, the ubiquity of pharmaceutical treatments for everything from moderate depression to schizophrenia means that psychiatrists, who can prescribe those medicines, are likely to be called upon to do so, often at the expense of meaning-making practice. It is not just insurance companies or the pharmaceutical industry that pushes for the use of medications; patients themselves hope to leave doctors’ offices with a prescription that will solve their problems.
Concerns about the Shifting Nature of Treatment

I find that these much more porous boundaries between the meaning-making and medical models inspires excitement about the new possibilities for comprehensive treatment as well as anxiety about the perversion of paradigms that were once unlikely to be used in combination. Practitioners who practice and staunchly adhere to dynamic principles have much more to fear than those who are strictly biological practitioners. Critiques from theorists of medicalization support these fears and push psychiatrists to think critically about the dangers associated with over-medicalization (an important concern) (c.f. Horwitz and Wakefield’s 2007 work on the over-diagnosis of depression).

It is also important to note that the future of mental health treatment can be enhanced by the combination of the various perspectives on illness. As my interviewees report, there is a danger in treating illness solely as either a biological phenomenon (even the biological group agree with this in principle) or a psychological phenomenon (as classical analysts were known to do, at the expense of their patients). I find, as did Mojtabi and Olfson (Kaplan 2008:7), that the future of psychiatry will involve a struggle to integrate the psychodynamic and biological models. This is not just the case for psychiatrists, but for all mental health practitioners; even those who strictly focus on talk therapy are pressured to include biological treatments.

However, this struggle is currently and will likely continue to be experienced much less by the biological group. There is at the current time little need for them to think in any way other than in terms of the medical model. They are not pushed to think any further or act on anything but medical symptoms. This is another reason why the
Routines employed by the biodynamic group are so important to understand; the ways in which it is possible to integrate the psychodynamic and biological models could be useful to practitioners in terms of their ability to situate themselves professionally outside of just one model, and to integrate into practice some of the more useful elements of many different paradigms. Though it is true that as most fields evolve those who work within a profession become less doctrinaire in their thinking because they have more tools to draw on, this is not the case to the same extent for biological psychiatry. Whereas practitioners oriented toward talk-based treatments have been given the tools to integrate (or in some cases have been pushed toward) new models, those who train purely in the biological model are not challenged in the same way to incorporate talking treatments into their repertoire.

**Routines: Using Practice to Avoid Tensions Between the Dynamic and Biological Models**

One of the key findings of this dissertation is that paradigmic tensions (and likely cognitive tensions of all kinds) can be relatively easily avoided if an individual is able to engage in routine practice. Recall that Berg (1992) defines a routine as “a set of actions which is repetitively carried out with a certain 'automatism': habitually, without explicitly reflecting on or legitimating the actions involved”... that function as a “micro-sociological correlative of the concept 'paradigm’” (p.170-171). I have described the biodynamic group as one that is able to circumvent the real inconsistencies between the meaning-making and medical models by relying on practices that come to them automatically and require little thought, explanation, or active work. The avoidance of
these tensions is only possible because the routines described in Chapter Five arise automatically enough that they preclude the clash of the basic principles of the dynamic and biological models.

On the other hand, the psychodynamic group, without the possibility to invoke routines that neatly resolve the tensions between the models, must be deliberate in their thinking and their actions. In order to avoid the tensions between the biological and psychodynamic models they must navigate the significant external constraints upon them – namely that they are unable to prescribe medicines in a world where most people want them and where they are seen as appropriate treatment. Further, because they believe that medicines are useful and that biological etiology underlies the conditions they treat, they must explain away the contradictions with the psychodynamic approach. Thus, they must be active in the process of navigating the two models. The psychodynamic group therefore spends much more time questioning the use of the models together, and the irreconcilable aspects of the two approaches are much closer to the surface for them than for the biodynamic group, who are quite easily able to avoid actively making decisions or thinking too intensely about the incompatible parts of the models. Further, the necessity of bringing in outside practitioners for medications adds another layer of management that the biodynamic group need not allow into their treatment except in rare cases.

The ability (or inability) to reconcile these tensions has consequences for identity. While the biodynamic practitioners wind up feeling like super-psychiatrists in the face of potential tensions, the psychodynamic practitioners often report feeling
lesser than, as though they are second tier professionals in a world dominated by medical thinking. This provides fascinating insight into how crucial it is to resolve professional tensions in order to establish a sense of mastery and a feeling of legitimacy. This is not to say that psychodynamic psychologists feel insecure in their role as psychologists, but that they must question their role in the larger mental health community much more than a biodynamic psychiatrist does. Additionally, given the structure of reimbursement and referrals, psychoanalysts need the biological psychiatrists, but the opposite is generally not the case.

**Beyond Psychiatry; Professional Paradigms and the Struggle for Cognitive Consistency**

The case study I present in this project – the paradigm shift in psychiatry and the navigation of potentially incompatible models – is a unique case in professional socialization. Psychiatrists and psychologists approach the treatment of mental illness and psychic pain in different ways. Even within the field of psychoanalysis, practitioners begin their five-year training with disparate professional backgrounds; some are psychologists, some psychiatrists, and others are social workers (though I have not focused on them here). Even this subgroup, then, does not subscribe to a single, unified perspective on illness, treatment, the field at large, or their professional struggles.

Mental health practitioners differ as well in terms of the subject matter of their profession. The greatest difference between psychiatry (and medicine more broadly) and other fields is that psychiatry is one in which professionals’ actions have direct consequences on the immediate health and welfare of their patients. Mental health
practice is directed at helping people rise to functioning and to assuaging pain and suffering. Whereas in many professions the emotions and well-being of the “subject” of the profession are not at stake, training in the medical field cannot be relegated only to the thought process of the practitioner or the level of cognition; my respondents work in an explicitly emotional realm, which is much different than, for instance, working in investment banking or real-estate (though all fields have emotional components).

In other ways the themes in this project are highly generalizable. The formal elements of the tensions that arise from professional training (particularly the layering of training as is the case with the psychodynamic and biodynamic group) are somewhat isomorphic across fields. Lawyers who come from liberal arts backgrounds must learn to think linearly and to memorize codes and cases. This is also true of graduate students in the social sciences who majored in biology or physics.

_Shifting Professional Paradigms_

In looking at the more senior psychiatrists in my sample, one question that arises is how professionals adjust when the training and philosophies of their occupation undergo a major paradigm shift. While the more recent cohorts of psychiatry residents who train in psychoanalysis must find ways to reconcile their training in the psychodynamic model, they are much more able to privilege the biomedical model than their more senior counterparts. The more seasoned practitioners, who were trained first and foremost as psychiatrists in an era when psychiatry was not medical in the sense we understand today, cannot as easily fall back on their biological training as their junior counterparts can. We see that though they struggle against the medical paradigm,
ultimately not able to beat the medical model, they join in. They prescribe medications, and they invest themselves in the glimmers of hope on the horizon in neuroscience and bio-psychiatry.

Specifically the more senior biodynamic practitioners in my sample provide insight into the experience of being part of a field undergoing radical alterations. When professionals have invested the majority of their careers in something – in this case thirty or forty years in psychoanalytic practice – dealing with a radical change in the entire structure of the field engenders a need to join the crowd in some ways, but simultaneously to maintain their former ideological allegiances. For instance, senior psychoanalysts may discuss the benefits of medications, and they may even prescribe them (though many will not). A certain amount of acceptance of the new model is necessary in order not to perish in a changing field, but these analysts are hardly going to give up their psychoanalytic ideologies even if prescribing medicines may be the best and perhaps the only option in order to maintain a viable pool of patients.

The senior biodynamic psychiatrists are more dynamic than they are biological. In some ways they might more aptly be described as psychobiological psychiatrists in that, while they are hybrid practitioners, their identity and their practice is much more rooted in the psychodynamic world than in the biological. If there is any complication in a medication case they send patients to younger practitioners (often their own students) because they know their own knowledge of medications is not as substantial. However, in the majority of cases, senior biodynamic psychiatrists in my sample do prescribe medicines and are thus radically different from the psychoanalysts in pre-1980
psychiatry. Ultimately, the biodynamic group (both senior and junior members) is able to bridge the two models, sometimes by choice, and sometimes because of structural realities that push them to do so. Even the senior analysts found ways to adapt as their profession went through extensive upheaval.

One might predict that a member of any field during a major shift in thinking (whether a complete paradigm shift or something more localized) would have similar experiences of tensions between a practical and cognitive model to which one is habituated and a new model that forces the adoption of new practice and cognition. Medicine at large is the closest example to the one I provide in this dissertation since knowledge changes particularly rapidly with new discoveries. For instance, one small-scale example is that until recently it was widely accepted by doctors that antibiotics were the solution to even low-level infection. New studies that generated concerns about the body’s inability to fight infection on its own if dosed with antibiotics on a regular basis catalyzed a need for practitioners in the field to adjust their thinking and to account for their former, regular prescribing of antibiotics.

There are certainly parallels between the paradigm shift in psychiatry and, for instance, in the field of education. The push toward what we might call evidence-based models has meant that more seasoned primary and especially secondary teachers have had to adjust to a test-based model propelled by No Child Left Behind, wherein the creativity and autonomy of the teacher in her own classroom has been somewhat eroded by the need to make sure students are prepared for city, state, and nation-wide exams. Thus, we might imagine that more senior instructors, who have worked in the
education system since long before this model rose to prominence, would have to adjust to the new standards and the restrictions on their practice in the same way the more senior biodynamic psychiatrists do. We might then expect that junior faculty would be less likely to have problems with exam-focused teaching than those instructors who came of age in the 1960s and 1970s, when student creativity was at the center of the classroom and when teachers had much more control over their curriculums.

As in the mental health field, there are both advantages and drawbacks to the changes in education. In medicine there are patients who will benefit greatly from the use of a biological or diagnostic model, just as there are some students who will benefit from a more structured and rigid educational model. For practitioners, the limits on their autonomy and control over their practice, whether in a doctor’s office or a classroom, are largely experienced as restrictions, though one might imagine that newer generations of teachers could be comforted by a set curriculum and need to rigidly adhere to standards in the same way that psychiatry residents find DSM comforting and useful in organizing their thinking.

Alternative education models, like Montessori schools at the elementary level or high schools and colleges that do not assign standard grades (e.g. St. Ann’s in Brooklyn, New York or Hampshire College in Massachusetts) try to maintain the creativity that was once at the center of the classroom and avoid the competition that comes along with grading. Certainly, these models clash with the dominant test-based, grade-centric model and myriad structural constraints force most schools and educators to teach
within the confines of the current standards if there is to be any hope of their students progressing to the next grade or institution. We might also expect that in mainstream schooling, senior instructors would likely need routines to help them decide when to abide by their own allegiance to creativity in the classroom and when to teach to the test. Outside of medicine education is probably the closest parallel since it also involves a practice, the consequences of which effect other human beings and their potential to function in the world.

Of course there are other more imperfect examples in science at large, though these are much more about a need to assimilate new knowledge or facts, which was not the case with the paradigm shift in psychiatry in the 1980s, nor was it so with the alterations to the educational system. In the sciences there are several instances where a paradigm shift forced those inculcated in a model to radically adjust their thinking. Consider for instance the discovery of a new planet that challenges notions of where solar systems end or how many universes exist. Or consider Simpson’s (2006) work on the shift from thinking of diseases as the result of miasmas to germ theory; everything scientists and doctors believed about the transfer of illness had to be re-envisioned. Another similar shift occurred in the 1950s and 1960s as scientists came to believe in Plate Tectonics. Those who spent their career researching Continental Shift would likely have needed to radically alter their understanding of the creation of the continents. Any paradigm shift involves the need for established practitioners to find ways to compensate for their prior beliefs and practices in a new professional world. Likewise, all professionals encounter constraints that push them to favor the new model if they
hope to maintain funding for their work, prestige in their field, or a pool of patients that enables them to continue their practice.

Other practitioners in my sample trained solely in one paradigm (biological). From them we can see that the power of the biological model lies at least partly in its ability to eclipse other treatment modalities. Its dominance in the institution of medicine and in training programs is bound up with the power of the biomedical, scientific treatment schema. In DiMaggio’s (1997) summary of recent research in cognition he explains that people are “more likely perceive information that is germane to existing schemata” (p.270). He points to Zerubavel’s (1992) example of mapmakers’ resistance to sketching the new world and Fleck’s (1979) description of physicians’ misinterpretation of syphilis symptoms because of “archaic” medical practices (idem) as evidence of the rigidity and static nature of schemas. In this case, biological psychiatrists’ primary socialization is in the medical model and, as we can see with the younger members of the biodynamic group, it is difficult for them to shed their biological schema or the medical lens through which they learn to see their patients.

That the medical model is such a salient schema is precisely why biodynamic psychiatrists must learn to be flexible enough to chip away at that primary lens in psychoanalytic training – something that is often difficult for them. It takes a long time and even after analytic training, the biodynamic group largely returns to biological practice. This is, of course, not entirely a cognitive process and involves the many external (largely financial) constraints that have discussed throughout the project. It
does, however, highlight the importance of primary socialization – particularly when practitioners are socialized into a rigid model, schema can be difficult to unlearn.

_Routines and Rigidity; Maintaining the Power of the Biological Model_

The reliance on routines helps to highlight that schemas or lenses may be so entrenched that they are unlikely to change even after new information is assimilated. Thus, the widespread use of routines that favor the biological model may help explain why there is not more dissent in the psychiatric community about the dominance of the medical model. Berg (1992) reminds us that “…stepping out of the routine implies a deviation from the ‘safety of the norm’…” (p.171). Recall also that routines are tacit, subconscious, and generally automatic or taken for granted, so they make deviation much less likely. It is unlikely that a practitioner would question the biological norm if she favors that model in her own practice and employs it with little difficulty.

While the biological model was heavy critiqued by psychoanalysts and many other talk therapists when it first appeared in the 1980s, those criticisms have largely been silenced within the psychiatric community, in part because biological practitioners today only know the biological model and thus have no reason to see beyond it. Even the biodynamic group (the group we might expect to be the most likely to point to shortcomings of the biological model) is so able to practice fluidly using both models that they really have no need to be active voices in the dissent against the biological
model. Also, the biological model is considered effective and has been lauded as much more successful than its psychoanalytic predecessor. On the other hand, people outside the discipline – sociologists, psychologists, social workers, acupuncturists, herbalists, osteopaths, and many others -- express concern and even disdain for the biological model because it detracts from interest in, funding for, and basic attention to alternative conceptualizations and treatment of illness.

The result is that the biodynamic group practices little psychoanalysis (again, myriad factors, namely financial, also affect the likelihood of privileging the biological over the psychodynamic). A question for future inquiry then is whether psychodynamic psychologists are more flexible in their thinking about patients and illness than either the biological or biodynamic groups. As I have described, the rigidity of the medical model is part of what makes psychoanalytic training so difficult for psychiatrists, at least in their early psychoanalytic coursework.

**Limitations**

The greatest limitation of this study is that it is difficult to assess the extent to which the biological, psychodynamic and biodynamic groups in my sample are representative of the types of practitioners one would find in the wider community of mental health professionals. For instance, because of the small sample size and the single geographic

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2 There are myriad critiques of the medical model in psychiatry outside the discipline, as I discussed in some detail in the introduction to this dissertation, but very few from within the discipline, the most notable of which is David Healy’s work on the problematic relationship between the pharmaceutical industry and psychiatry (c.f. Healy 2004).
location, it is possible that my results represent subgroup characteristics that are not representative of, for instance, psychoanalytically trained psychiatrists (biodynamic) throughout the country; perhaps psychoanalysts trained at the Baltimore-Washington Institute or the Menninger Clinic do not think entirely like those who are trained at one of the institutes in New York. Further, analysts who are trained at institutes that are less dominated by MDs (e.g. The Freud Society in New York) or even exclusive to non-MDs (the legacy of the exclusion of non-psychiatrists from institutes until the 1990s) would likely have very different experiences.

Because the psychoanalysts in my sample trained at the same institute and thus associate with similar kinds of practitioners, it follows that their perspectives and even their word choice is similar. For instance, the tensions that the psychodynamic psychologists described throughout this project would likely be different if they had trained in an institute where the ratio of MDs to PhDs was more balanced or more skewed toward non-MDs. Concerning the biological group, my results likely downplay the extent to which mainstream psychiatrists think biologically and have practices that are dominated by psychopharmacological practice. Though the biological group was much more likely than their psychodynamic or biodynamic counterparts to report biological thinking and to have patients who are on medications, biological psychiatrists outside New York City, where there is much less influence of psychodynamic thought, are likely even more biologically oriented than those in my sample.

The atmosphere of psychotherapy in New York City affects even those practitioners who have mostly medical practices, so that they have some exposure to
the basic ideas that underlie the dynamic approach and therefore may be more likely to consider psychological factors than the average biological psychiatrist elsewhere in the United States. Even if only one or two psychiatrists per year from the various programs in New York City enter psychoanalytic training programs after their residencies, the likelihood that even practitioners who do not train in analysis have friends or colleagues who do is higher here than it is elsewhere. Those networks are likely to expose them to dynamic ideas. My results would have been different if I had interviewed psychopharmacologists, of which I had only two in the biological group. Another influence on the biological group in New York is the likelihood that they will have training in some other kind of therapy, such as CBT or DBT, which means that they are not the fifteen-minute in-and-out practitioners that characterize psychiatrists at large today. In fact, many practitioners in my sample pointed out to me that I would find more strictly biological people if I interviewed psychiatrists outside the New York City area.

Another factor that limits my sample is that practitioners’ perspectives on treatment are skewed toward experiences with mostly upper-middle class patients in New York City. The doctors themselves are also more likely to be financially well off and therefore less attuned to the problems associated with managed care and the experience of being less financially stable. These practitioners are at home treating mostly upper-middle class and wealthier individuals who are not at all representative of patients with mental illness across the US (or in general of people who experience the symptoms of illness, many of whom never seek treatment at all).
Finally, studying the mental health field from the ground up is complicated; it is sometimes difficult to tease out what effects have to do with practitioners’ own struggles for agency or control over their practice verses the structural influences that lead them to act in certain ways. For instance, when a practitioner says (as most do) that the advertising of medications directly to consumers has not changed the interaction she has with patients, is this in fact the case? Or does she not want/is she not able to see that an outside force could interfere with her agency in a treatment? Mental health practitioners, as do any professional (or person for that matter), err toward positive self-presentation and validation of their field, which may interfere in their ability to accurately assess the impact of outside forces, such as the motives of pharmaceutical companies or insurance limitations, on their practice. This desire for control over practice, which leads to mixed feelings about DSM, extends to decision-making in practice more broadly; practitioners vie for autonomy, making it perhaps impossible to isolate the effects of the desire for control, or to separate attempts to maintain professional prestige from structural constraints and feelings of professional obligation.

**Future Directions**

*Sample Composition and Size*

Though this project is based on a small sample, the general patterns found here would likely persist in the psychiatric and psychoanalytic professions at large. Though I provide some insight into practice, as I mention above, a more representative sample would be more informative. After all, doctors affect patients’ understanding of their psychiatric symptoms and how they see themselves as patients and as human beings more
generally. Especially when in in-depth talk therapy is involved, treatment may influence how people think of themselves beyond the realm of patienthood, in terms of personhood. It is therefore important that researchers continue to study psychiatric practice so that there may be more insight into it – overall, we know very little about the world of private practice.

My immediate goal for this project is to recruit new interviewees at psychoanalytic institutes where there are fewer MDs, and at those where there are more PhDs. For instance, there are analytic programs that were founded prior to the 1990s, when PhDs were allowed into the mainstream institutes; they remain dominated by non-MDs today and thus trainees should have a much different experience there than my interviewees did. In addition, I plan to interview practitioners outside the New York City area in order to determine if any of the aforementioned geographic variance is important for how practitioners think about the role of medicine and talk therapy in practice.

Training

In the future, I plan to look at training more directly, to examine the curriculum of psychiatric, psychoanalytic and psychological institutes; the particular course offerings influence practitioners’ perspectives and this would help address the link between training and practice. I also plan to ask more directly about experiences in training; in particular, I plan to ask MDs exactly how much course-work they did in residency that was dynamic.
Automatic and Deliberative Cognition

This project also has the potential to inform the extensive literature on automatic and deliberative cognitions. The former are highly schematized and therefore tacit and invoked with little effort, while the latter must be consciously and intentionally invoked and involve overriding automatic cognition (DiMaggio 1997). In this dissertation, I show that in the face of potential clashes between professional models, the deliberative cognition the psychodynamic group must use to manage tensions between the biological and psychodynamic models is much less likely to protect against cognitive conflicts than the generally automatically invoked routines available to the biodynamic psychiatrist.

Research begs the question of why automatic cognition - such as that invoked by the biodynamic group in order to resolve the potential tension between the psychodynamic and biological models - is so effective. For instance, DiMaggio (1997:271) points to studies in psychology that explain under what conditions deliberative cognitions might occur, one of which has to do with problem-oriented thinking. In attempts to deal with problems, people are often forced into deliberative mode, where they must be much more active and focus much more energy than when decisions can be made automatically. While a biodynamic psychiatrist can automatically move between the biological and psychodynamic approaches with the use of routines, the psychodynamic psychologist must be much more deliberative by bringing in an outside practitioner to whom her patients are referred for medications. The very decision as to whether or not to refer a patient for medication means a movement into
the realm of deliberation, which opens the door to the tensions between the two models to be experienced.

An important question for sociologists is under what structural conditions people are able to act automatically and when they are forced to be more deliberative; as I have shown, deliberative cognition is much less effective at reducing cognitive conflicts. This could aid in our understanding of many fields, from professions to studies of the stress process, which have shown that when people have less control (in particular over their decision-making), they are more likely to experience stress. In addition to briefly describing the utility of certain kinds of cognitions, I show that there are certain circumstances in which structure constrains whether automatic or deliberative cognition is possible, and what kind of action results from said cognitions. For instance, the psychodynamic psychologist is under a great deal of pressure to refer patients for medications. In the future, I will more fully address the extent to which structural constraints limit the level of control practitioners have over their work, and what the consequence of the availability (or unavailability) of routine practice is for professional identity and the fluidity of practice.

Identity

In future interviews I intend to focus much more on the identity work that is involved in both maintaining and blurring the boundaries between the meaning-making and medical paradigms. The way practitioners in one group talk about other kinds of

\[3 \text{ See for instance Ross and Mirowski (1989) and Van Gundy (2002), who show that low autonomy increases stress levels.} \]
practitioners – MDs about PhDs and vice versa – and particularly when they point out what the other group does (both well and poorly) that they do not marks what they think they do well. They often define their own work and sense of professional self in terms of what they do not offer to their patients.

For instance, the psychodynamic group describe being glad that they do not prescribe medicines; some talk about winding up in psychology precisely to avoid the medical track because they do not want to be like a psychiatrist or do the work of a medical doctor. In my interviewees’ narratives, it is clear that people have a need to identify themselves not only by what they do, but by what they refuse to do or choose not to do (Mullaney 2006). Particularly in the case of psychodynamic psychologists, pointing out that they do not prescribe medications makes them feel like more competent talk therapists, and combats the super-psychiatrist mentality of the biodynamic group. In this sense the boundaries between meaning-making and medicalization are defined by the identity differences between types of practitioners and the separateness that comes from recognizing the different kinds of work they do (and do not do).

Identity is also important in the sense that the medical model produces a particular doctorly identity (identifying as a psychiatrist and medical doctor) which is a difficult one to soften and can cause problems for doctors when it is threatened. This is part of the reason the routines discussed in Chapter Five are so crucial to the practice of the biodynamic group. Medical schools, psychiatric training and the hospitals that provide the institutional structure for this schooling are powerful agents of socialization.
When psychiatrists come out of their training, the expectation is that their identity as practitioners is bound up in the medical model. We can see this in the descriptions of how difficult it is for psychiatrists to train in psychoanalysis — thus, to what extent is the dominance of the psychiatric schema or lens at least partially attributable to the fact that psychiatrists report as their primary professional identity their sense of themselves as “doctors first?”

DiMaggio (1997: 279) suggests (as do other sociologists of culture) that emotion-laden, “hot” schemas are likely to produce different consequences than those that are “cold” or value-neutral. We can see this in the link between identity and routines for psychiatrists. Medical schools inculcate doctors into the notion that their undivided identity commitment should be to the biological model. When this is challenged, then, the biodynamic group must use routines to avoid experiencing any possible tension between their primary and secondary professional socialization. The specific challenges to identity and particularly to highly valued roles and the relationship between identity and the likelihood of invoking certain schemas is an issue that needs greater attention.

**Concluding remarks**

Perhaps what this project has made me question more than ever before is whether, in the face of all the obstacles to its survival, any form of meaning-making practice (psychoanalytic or otherwise) can survive in a financial, cultural and professional climate that favors evidence-based practices and short-term, particularly medicinal, treatment. Mojtabi and Olfson claim that “a key challenge facing future psychiatrists will largely
involve maintaining their professional role as integrators of the biological and psychosocial perspectives” (Kaplan 2008:7), but if my interviewees are any indication, the assumption that this is a challenge seems overly optimistic. I would argue instead that the field has become so biologicized that this integration simply is not the goal of psychiatry, despite the party-line that the field is bio-psycho-social; even the biodynamic practitioner, who should be the most willing of any psychiatrist in the country today to integrate the biological and psychological perspectives, leans toward the biological model both as a defense against the tensions that might otherwise arise, should the practitioner too greatly favor meaning-making practices in a medical world, and because she genuinely feels as though she can offer patients more relief (at least in the short terms) with medications than through talk therapy.

Even if meaning-making remains a goal, there are other professionals who are equally if not more capable of practicing talk therapy (social workers, psychologists, priests and other religious counselors and even paraprofessionals such as life coaches and chat room counselors) and do so for far lower fees. This means there is competition over who the legitimate talk therapists are. Can talk therapy persist within psychiatry when there are such great challenges? The issues of professional competition and methodological preferences I have described throughout this project are intermingled with structural constraints on practice -- namely the financial concerns for patients and practitioners that stem from the unwillingness of insurance companies to reimburse for psychoanalytic. Even the much-anticipated Mental Health Parity Act will likely do nothing to bolster psychoanalytic treatment, as the basis for the new law is that mental
health conditions must be treated as any physical health problem would be. However, the kind of treatment for mental illness that insurance companies will cover will be biologically based and if any talking treatments are covered they will be, as they are now, short-term, and cognitively and/or behaviorally oriented. Both culturally and structurally, the chance that psychodynamic treatment will regain any sort of prominence in the field of psychiatry is unlikely at best.

And so I end with the words of Nancy McWilliams (2005), whose description of the complex professional situation for psychoanalysts begins the first chapter of this dissertation. Here she conveys optimism that practitioners will be able to keep the unique attributes of psychoanalytic thinking and treatment alive while working within a profession and a health care system that makes it quite difficult to do so.

On the simple ground that they help people, I expect that the traditional psychotherapies, and the values they honor, will survive. But they may do so only outside the health care mainstream. In response to insurance-driven limits on treatment, some professionals have already redefined what they do as “coaching,” an activity that can be marketed to those who can pay out of pocket. Other therapists simply reduce their fees for less wealthy patients who need more comprehensive, personalized treatment than their health plan offers (though there is a limit to how generous clinicians can be without becoming self-defeating). We all find ways to adapt, to keep doing what we value, whatever the social context. Whether therapeutic values can enter public discourse and influence how mental health questions are viewed nationally, however, remains to be seen. (P.148)

If the practitioners in my sample are any indication of where the field of psychiatry and mental health treatment more broadly are headed, then it is true that the biological dominance of psychiatry is likely to further the marginalization of talk therapy, especially psychodynamically oriented talk therapy. Even the practitioners who are the
most psychodynamically informed and should be the most likely to think dynamically – both because of their own allegiances to the biological model and because of their identity as medical doctors, and due to external constraints such as insurance reimbursement and patient demand -- are much more likely to practice as a medically trained, biological practitioner than they are as a psychoanalytically trained therapist.

I cannot conclude without noting that the biological dominance I have described throughout this project has serious consequences for patients’ experiences of their own illness and treatment, something I do not address here but that is of importance for future studies. Perhaps more consequential is that for practitioners, as Light (1980) reminds us, the hyper focus on biology comes at the expense of learning how to engage in meaning-making practices. In fact, this is one of the regrets many of my interviewees (even a few of the biological practitioners) express; their students are emerging from psychiatry residencies barely able to engage with their patients. Although residents are more capable than ever before of finding medical solutions to their patients’ problems because of their advanced training in psychopharmacology, practitioners run the risk of missing their patients’ experiences or truly understanding their suffering (Smith 2010). This is the case in any medical specialty today. Though it is flawed and not nearly a perfect science, the biomedical model has given rise to symptom alleviation in ways psychiatrists worried might never be possible. In spite of the advances, the eclipsing of the meaning-making practices that characterized the psychodynamic model is not to be taken lightly.
APPENDICES

Appendix 1: Questionnaire

1) Why did you decide to become a psychiatrist [or psychologist]?
   a. At what point in your schooling did you decide and why?
2) [For analysts] Why did you decide to become an analyst?
3) In your opinion, what do you see as the currently dominant paradigm of therapy in psychiatry (or psychology)?
4) [For analysts] If you had to choose one or two major guiding principles of the psychoanalytic approach, what would it be?
5) What is the experience like being a part of both the psychoanalytic community and the psychiatric community?
   [Substitute for psychologists] What is the experience like being a part of both the psychoanalytic community and the psychological community?
6) [For psychologists] Do you see yourself differently than analysts who are psychiatrists?
7) [For psychologists] Can you describe any tensions between Psychologists and Psychiatrists in the analytic community?

Now I’m going to ask you a bit about your practice and experience with patients:
8) What usually leads patients into treatment?
9) What is the first question you ask a patient when meeting them for the first time?
10) When with a patient, what kind of treatment do you consider and why? What might some indicators be?
11) What do you take into account in making a diagnosis?
12) Is it important to know what symptoms mean for patients early on in a treatment? Why or why not? If not, is that something comes over time?
13) What role does pain play in treatment?
   a. Do you see yourself as treating pain?
14) Is that different that suffering?
15) Do you see pain and suffering as pathological?
   a. Are they ever useful?
16) What role does DSM play in your practice?
17) Do you find the categorizations in the manual useful?
18) Some people refer to DSM as the “bible of psychiatry.” What do you think about this statement?
19) When you think about problems with DSM, what’s the first thing that comes to mind? How about usefulness?
20) [For analysts] When you think of problems or disagreements with the Psychoanalytic perspective, what is the first thing that comes to mind?
21) [For psychologists] Do you refer patients for medication?
   a. What are the reasons for which you would do so?
   b. Is there any particular type of therapist you prefer to refer patients to for medicine?
22) What is the role of medication in treatment?
23) What do you think about the increasing centrality of psychopharmacology in psychiatry?
24) Has advertising directly to consumers changed the interaction you have with patients? If yes, in what ways?
25) Patients have a wide range of access to information about treatment and medication.
   What do you see as the main costs/benefits associated with increased access to information about treatment and medication?

   **Now I’m going to turn to some theoretical issues:**
26) How do you think about the etiology of mental illness?
   a. What do you think the major influences are in the development of mental illness?
   b. What kinds of influences do you consider?
27) When with a patient, in what ways is it useful to think about similar conditions you see in other patients? If so, in what way?
28) There is a lot of talk about the rise of new disorders in the media – debates about what will be in DSM V. Most of them are connected to compulsions of some sort – shopping, gambling, video gaming.
   a. What do you think about adding these categories to DSM?
   b. Have you seen an increase in patients coming to you with these problems in the last few years?
29) Is there anything you think isn’t included in DSM IV that should be in V?
30) What contribution do you think psychiatry [psychology for psychologists + psychoanalysis for analysts] makes to society?

**Demographic Questions:**
1) What year were you born?
2) Where were you born and where did you grow up?
3) Where did you attend college?
4) For MDs:
   a. Where did you attend medical school?
   b. At what hospital did you do your residency?
   c. If you had to pick the main therapeutic orientation of your training, what would it be?
   d. At what age did you start med school?

   For PhDs, substitute:
   a. Where did you attend graduate school? What age did you start? Finish?
   b. Where did you do your internship?
   c. If you had to pick one therapeutic orientation of your training, what would it be?
5) [If relevant] Where did you train in psychoanalysis?
6) At what age did you start your training?
7) How many years did it take?
8) What is your current hospital affiliation?
9) How many patients do you have?
   a. [if relevant] Of them, how many are in analysis?
b. [if relevant] How many (or what approximate percentage) of them do you see for medication only?
c. How many patients would you say are not on any meds?
d. Do you treat any particular population?
e. Do you specialize in treating any particular disorders?
Appendix 2: Descriptive Tables

Table 1. Demographics

<table>
<thead>
<tr>
<th>Demographics</th>
<th>Biodynamic (n=20)</th>
<th>Psychodynamic (n=10)</th>
<th>Biological (n=10)</th>
</tr>
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<tbody>
<tr>
<td>Age: Median Range</td>
<td>55</td>
<td>54</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>38-80</td>
<td>39-65</td>
<td>37-58</td>
</tr>
<tr>
<td># Women</td>
<td>11</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>Where grew up:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Metro NYC:</td>
<td>11</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>East Coast:</td>
<td>4</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Other US:</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Outside US:</td>
<td>2</td>
<td>3</td>
<td>1</td>
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Table 2. Treatment Characteristics

<table>
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<th>Treatment Characteristics</th>
<th>Psychodynamic</th>
<th>Biodynamic</th>
<th>Biological</th>
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<tr>
<td><strong>Total # of patients</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>15,20</td>
<td>30</td>
<td>100</td>
</tr>
<tr>
<td>Mode(s)</td>
<td>20</td>
<td>20, 100</td>
<td>100</td>
</tr>
<tr>
<td>Range</td>
<td>8-30</td>
<td>8-300</td>
<td>20-500</td>
</tr>
<tr>
<td><strong>% Patients seen for medicines only:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median(s)</td>
<td>NA</td>
<td>50</td>
<td>35,50</td>
</tr>
<tr>
<td>Mode</td>
<td></td>
<td>50</td>
<td>25</td>
</tr>
<tr>
<td>Range</td>
<td></td>
<td>48-93</td>
<td>0-99</td>
</tr>
<tr>
<td><strong>% Patients who do not take any Medicines:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median(s)</td>
<td>43,60</td>
<td>40, 50</td>
<td>5,10</td>
</tr>
<tr>
<td>Mode</td>
<td>40, 70</td>
<td>50</td>
<td>10</td>
</tr>
<tr>
<td>Range</td>
<td>25-90</td>
<td>70-52</td>
<td>0-50</td>
</tr>
<tr>
<td><strong>% Patients in analysis:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median</td>
<td>0.4</td>
<td>10</td>
<td>NA</td>
</tr>
<tr>
<td>Mode</td>
<td>0</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Range</td>
<td>0-6</td>
<td>0-20</td>
<td></td>
</tr>
<tr>
<td><strong>% Patients on medicines:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median(s)</td>
<td>35,57</td>
<td>50</td>
<td>90,95</td>
</tr>
<tr>
<td>Modes(s)</td>
<td>60,70</td>
<td>50,52</td>
<td>97</td>
</tr>
<tr>
<td>Range</td>
<td>0-40</td>
<td>5-50</td>
<td>50-100</td>
</tr>
<tr>
<td><strong>% Patients in talk therapy:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Median(s)</td>
<td>100</td>
<td>40, 50</td>
<td>50</td>
</tr>
<tr>
<td>Modes(s)</td>
<td>100</td>
<td>50</td>
<td>1</td>
</tr>
<tr>
<td>Range</td>
<td>100</td>
<td>5-92</td>
<td>1-100</td>
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</table>
### Table 3. Practitioner Characteristics

<table>
<thead>
<tr>
<th>BIODYNAMIC Pseudonym</th>
<th>Important Practice/Practitioner Characteristics</th>
<th>Interview Date</th>
<th>Age at interview</th>
<th>Total # of patients (Age at interview)</th>
<th>Patients seen for meds only (Total)</th>
<th>Patients who do not take any meds (Total)</th>
<th>Patients in Analysis (Total)</th>
<th>All patients on meds (Total)</th>
<th>All patients in talk therapy (Total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Dr. Warren</td>
<td>Mostly children.</td>
<td>4/4/2007</td>
<td>40</td>
<td>100</td>
<td>50 50%</td>
<td>25 25%</td>
<td>0 0%</td>
<td>75 75%</td>
<td>50 50%</td>
</tr>
<tr>
<td>2 Dr. Mill</td>
<td>Many children.</td>
<td>4/11/2007</td>
<td>45</td>
<td>50</td>
<td>35 67%</td>
<td>16 32%</td>
<td>3 6%</td>
<td>34 68%</td>
<td>25 33%</td>
</tr>
<tr>
<td>3 Dr. Lewis</td>
<td>Specializes in borderline personality disorder.</td>
<td>4/18/2007</td>
<td>51</td>
<td>100</td>
<td>93 93%</td>
<td>7 6%</td>
<td>93 93%</td>
<td>7 7%</td>
<td></td>
</tr>
<tr>
<td>4 Dr. Park</td>
<td>Teaches theory at the analytic institute.</td>
<td>6/7/2007</td>
<td>60</td>
<td>100</td>
<td>50 50%</td>
<td>50 50%</td>
<td>5 10%</td>
<td>35 70%</td>
<td>15 30%</td>
</tr>
<tr>
<td>5 Dr. Nelson</td>
<td>Adults.</td>
<td>6/17/2007</td>
<td>48</td>
<td>50</td>
<td>35 70%</td>
<td>15 30%</td>
<td>5 10%</td>
<td>35 70%</td>
<td>15 30%</td>
</tr>
<tr>
<td>6 Dr. Madison</td>
<td>Adults.</td>
<td>6/21/2007</td>
<td>55</td>
<td>300</td>
<td>210 71%</td>
<td>75 25%</td>
<td>2 .5%</td>
<td>225 75%</td>
<td>90 29%</td>
</tr>
<tr>
<td>7 Dr. King</td>
<td>Adults.</td>
<td>7/9/2007</td>
<td>44</td>
<td>30</td>
<td>12 40%</td>
<td>15 50%</td>
<td>5 17%</td>
<td>15 50%</td>
<td>18 60%</td>
</tr>
<tr>
<td>8 Dr. Sullivan</td>
<td>Children and adults.</td>
<td>7/10/2007</td>
<td>59</td>
<td>25</td>
<td>12 48%</td>
<td>13 52%</td>
<td>7 28%</td>
<td>12 52%</td>
<td>13 52%</td>
</tr>
<tr>
<td>9 Dr. Plymouth</td>
<td>Adults.</td>
<td>7/13/2007</td>
<td>51</td>
<td>20</td>
<td>10 50%</td>
<td>10 50%</td>
<td>10 50%</td>
<td>10 50%</td>
<td>10 50%</td>
</tr>
<tr>
<td>10 Dr. Ferris</td>
<td>Adults.</td>
<td>7/17/2007</td>
<td>52</td>
<td>50</td>
<td>30 65%</td>
<td>12 24%</td>
<td>0 0%</td>
<td>38 76%</td>
<td>20 35%</td>
</tr>
<tr>
<td>11 Dr. Halsey</td>
<td>Many children. Also works with some patients in a clinical setting.</td>
<td>7/26/2007</td>
<td>38</td>
<td>60</td>
<td>5 8%</td>
<td>30 50%</td>
<td>1 2%</td>
<td>30 50%</td>
<td>55 92%</td>
</tr>
<tr>
<td>12 Dr. Taylor</td>
<td>Adults.</td>
<td>8/2/2007</td>
<td>38</td>
<td>30</td>
<td>25 83%</td>
<td>5 17%</td>
<td>3 10%</td>
<td>25 83%</td>
<td>5 17%</td>
</tr>
<tr>
<td>13 Dr. Gold</td>
<td>Mostly children.</td>
<td>8/3/2007</td>
<td>71</td>
<td>20</td>
<td>10 50%</td>
<td>10 50%</td>
<td>10 50%</td>
<td>10 50%</td>
<td>10 50%</td>
</tr>
<tr>
<td>14 Dr. Brown</td>
<td>Some training in CBT. Adults.</td>
<td>2/27/2008</td>
<td>60</td>
<td>20</td>
<td>13 67%</td>
<td>7 23%</td>
<td>4 20%</td>
<td>13 67%</td>
<td>7 23%</td>
</tr>
<tr>
<td>15 Dr. Sterling</td>
<td>Adults.</td>
<td>3/16/2008</td>
<td>46</td>
<td>25</td>
<td>15 60%</td>
<td>10 40%</td>
<td>3 12%</td>
<td>15 60%</td>
<td>10 40%</td>
</tr>
<tr>
<td>16 Dr. Carroll</td>
<td>Adults.</td>
<td>3/18/2008</td>
<td>80</td>
<td>8</td>
<td>4 50%</td>
<td>4 50%</td>
<td>4 50%</td>
<td>4 50%</td>
<td>4 50%</td>
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<tr>
<td>17 Dr. Remsen</td>
<td>Many young adults.</td>
<td>3/19/2008</td>
<td>67</td>
<td>40</td>
<td>16 40%</td>
<td>24 60%</td>
<td>3 8%</td>
<td>16 40%</td>
<td>24 60%</td>
</tr>
<tr>
<td>18 Dr. Linden</td>
<td>Adults.</td>
<td>3/26/2008</td>
<td>55</td>
<td>30</td>
<td>20 67%</td>
<td>10 33%</td>
<td>3 10%</td>
<td>20 77%</td>
<td>10 33%</td>
</tr>
<tr>
<td>19 Dr. Elliot</td>
<td>Many women. Many people in the field.</td>
<td>4/1/2008</td>
<td>67</td>
<td>14</td>
<td>7 50%</td>
<td>7 50%</td>
<td>3 21%</td>
<td>7 50%</td>
<td>7 5%</td>
</tr>
<tr>
<td>20 Dr. Dean</td>
<td>Adults.</td>
<td>5/5/2008</td>
<td>67</td>
<td>25</td>
<td>12 48%</td>
<td>13 52%</td>
<td>4 16%</td>
<td>12 48%</td>
<td>13 52%</td>
</tr>
<tr>
<td>PSYCHODYNAMIC</td>
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<td>Pseudonym</td>
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<tr>
<td>Important Practice/Practitioner Characteristics</td>
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</tr>
<tr>
<td>Interview Date</td>
<td>Age at Interview</td>
<td>Patient Total</td>
<td>Patients on meds</td>
<td>Patients who do not take any meds</td>
<td>Patients in Analysis</td>
<td>All patients on meds</td>
<td>All patients in therapy</td>
<td></td>
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<tr>
<td>1 Dr. Kane</td>
<td>11/1/2008</td>
<td>48 20</td>
<td>3 15%</td>
<td>17 85%</td>
<td>3 15%</td>
<td>3 15%</td>
<td>100%</td>
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</tr>
<tr>
<td>2 Dr. Brighton</td>
<td>1/12/2009</td>
<td>60 20</td>
<td>6 30%</td>
<td>14 60%</td>
<td>0 0%</td>
<td>6 30%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Dr. Kent</td>
<td>1/22/2009</td>
<td>42 12</td>
<td>9 75%</td>
<td>3 25%</td>
<td>3 25%</td>
<td>9 75%</td>
<td>100%</td>
<td></td>
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<tr>
<td>4 Dr. Butler</td>
<td>1/29/2009</td>
<td>65 25</td>
<td>15 60%</td>
<td>10 40%</td>
<td>1 4%</td>
<td>15 60%</td>
<td>100%</td>
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</tr>
<tr>
<td>5 Dr. Adams</td>
<td>2/6/2009</td>
<td>63 15</td>
<td>9 60%</td>
<td>6 40%</td>
<td>0 0%</td>
<td>9 60%</td>
<td>100%</td>
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<tr>
<td>6 Dr. Livingston</td>
<td>4/3/2009</td>
<td>39 8</td>
<td>6 75%</td>
<td>2 25%</td>
<td>0 0%</td>
<td>6 75%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 Dr. Coffrey</td>
<td>4/14/2009</td>
<td>51 10</td>
<td>1 10%</td>
<td>9 90%</td>
<td>4 40%</td>
<td>1 10%</td>
<td>100%</td>
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</tr>
<tr>
<td>8 Dr. Sutton</td>
<td>5/14/2009</td>
<td>59 30</td>
<td>4 13%</td>
<td>26 87%</td>
<td>6 20%</td>
<td>4 13%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 Dr. Haman</td>
<td>7/10/2009</td>
<td>47 14</td>
<td>8 57%</td>
<td>6 43%</td>
<td>0 0%</td>
<td>8 57%</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Dr. Porter</td>
<td>7/16/2009</td>
<td>65 20</td>
<td>7 35%</td>
<td>13 65%</td>
<td>0 0%</td>
<td>7 35%</td>
<td>100%</td>
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</tr>
<tr>
<td>BIOLOGICAL Pseudonym</td>
<td>Important Practice /Practitioner Characteristics</td>
<td>Interview Date</td>
<td>Age at Interview</td>
<td>Patient total</td>
<td>Patients seen for Meds only</td>
<td>Patients who do not take any meds</td>
<td>All patients on meds</td>
<td>All patients in talk therapy</td>
<td></td>
</tr>
<tr>
<td>----------------------</td>
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<td>-------------------------------</td>
<td>---------------------</td>
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</tr>
<tr>
<td>1 Dr. Brooks</td>
<td>Mostly research since residency.</td>
<td>2/8/2008</td>
<td>50</td>
<td>10</td>
<td>10 50%</td>
<td>10 50%</td>
<td>10 50%</td>
<td>10 50%</td>
<td></td>
</tr>
<tr>
<td>2 Dr. Lawrence</td>
<td>Kids, teens and adults. Non-med patients are in some form of talk therapy. Has some training in dynamic.</td>
<td>3/11/2008</td>
<td>37</td>
<td>80</td>
<td>44 55%</td>
<td>12 15%</td>
<td>68 85%</td>
<td>36 45%</td>
<td></td>
</tr>
<tr>
<td>3 Dr. Reeve</td>
<td>All 100 patients are families. The children are the ones on medication.</td>
<td>4/15/2008</td>
<td>42</td>
<td>100</td>
<td>95 95%</td>
<td>5 5%</td>
<td>95 95%</td>
<td>5 5%</td>
<td></td>
</tr>
<tr>
<td>4 Dr. Hart</td>
<td>Adults. Specializes in depression and anxiety.</td>
<td>5/19/2009</td>
<td>52</td>
<td>100</td>
<td>0 0%</td>
<td>10 10%</td>
<td>90 90%</td>
<td>100 100%</td>
<td></td>
</tr>
<tr>
<td>5 Dr. Poplar</td>
<td>Adults, specializes in bipolar.</td>
<td>5/19/2009</td>
<td>44</td>
<td>75</td>
<td>10 13%</td>
<td>0 0%</td>
<td>75 100%</td>
<td>65 87%</td>
<td></td>
</tr>
<tr>
<td>6 Dr. Morris</td>
<td>Specializes in sexual abuse, borderline cases.</td>
<td>7/22/2010</td>
<td>53</td>
<td>100</td>
<td>35 35%</td>
<td>35 35%</td>
<td>65 65%</td>
<td>65 65%</td>
<td></td>
</tr>
<tr>
<td>7 Dr. Elm</td>
<td>Adults. Specializes in PTSD and Dissociative Disorder.</td>
<td>8/31/2010</td>
<td>57</td>
<td>200</td>
<td>50 25%</td>
<td>20 10%</td>
<td>80 90%</td>
<td>150 75%</td>
<td></td>
</tr>
<tr>
<td>8 Dr. Sutter</td>
<td>Specializes in couples and families.</td>
<td>4/21/2011</td>
<td>54</td>
<td>75</td>
<td>19 25%</td>
<td>2 3%</td>
<td>73 97%</td>
<td>56 75%</td>
<td></td>
</tr>
<tr>
<td>9 Dr. Evans</td>
<td>Only children. Specializes in ADHD.</td>
<td>5/18/2011</td>
<td>50</td>
<td>500</td>
<td>495 99%</td>
<td>2 4%</td>
<td>497 97%</td>
<td>5 1%</td>
<td></td>
</tr>
<tr>
<td>10 Dr. Doughty</td>
<td>Specializes in depression and anxiety.</td>
<td>5/21/2011</td>
<td>58</td>
<td>210</td>
<td>208 99%</td>
<td>2 1%</td>
<td>208 99%</td>
<td>2 1%</td>
<td></td>
</tr>
</tbody>
</table>


Press.


National Institute of Mental Health (NIMH) 2009. Anxiety Disorders. Retrieved August


