**`The White Bicycle`: possible contributions of psychoanalysis to general psychiatry**

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*a conceptualization is not the reality itself,*

*but who could claim that reality is not embedded in it?*

We are once more living in an era of rapid psycho-social, cultural and technological changes. A noticeable one is in the means of human interaction; first time in the history we could relate to each other and interact at a *third space*, fully independent from the space and time of the communicating persons, i.e., at *a virtual space*. As stated among the themes of International Psychoanalytical Association 49th Congress (Changing World: the shape and use of psychoanalytic tools today) (IPA, 2015), such developments in communication and computer technologies, increasing diversities and cultural shifts invite us to review many of our theoretical and technical concepts, tools and basic paradigms.

Being and practicing as a general adult psychiatrist, trained more than 30 years ago at a psychoanalytic oriented residency programme and trained as an assistant therapist of psychodrama-sociodrama and worked in different in- and out-patient psychiatric settings, teaching psychopathology and supervising psychiatry residents and clinical psychology master programme students, I would like to revisit the possible contributions of psychoanalysis to general psychiatry, on the basis of my experience and relevant literature. In fact, all through this paper questions as, “How could a general psychiatrist benefit from psychoanalytic theories and practice? What could a general psychiatrist expect from psychoanalytic theories and practice?” are kept at the back of my mind and are intended to be discussed.

**The clinical encounter in general psychiatry**

Whatever the theoretical orientation of the psychiatrist is, the clinical encounter, where the clinician and the person seeking help meets, has some commonalities. First, the relation between the clinician and the person is a human interpersonal interaction build by the demand of the patient with a specific reason, i.e., to diminish the suffering of the person. It is mainly a verbal and nonverbal communication relying on the impact of exchange of words and signs or behaviour. Clinician-patient communication during the clinical encounter is a multifaceted process. The psychiatrist and the patient although interacting as two real persons, from a psychoanalytic point of view, they are also both acting and reacting to Each Other via the *imagined* and *internalized* Other. This creates *a virtual reality* right in the consulting room. On both sides, there is not only *one self*, but also *a perceived* and *an expressed self*. The interview room hosts a small group of real and virtual people, in this sense (Kuey L, 2013).

Second, in all clinical encounters, the person is consulting due to some emotional pain and suffering which he/she is experiencing. This experience and the expression of it by the person lead to a perception and experience in the clinician. The expression of the person and the impression and interpretation formed in the psyche of the clinician, together, built up the dynamics of this joint, ongoing interpersonal human interaction. Through this relation, i.e., a therapeutic process of restoration and reconstruction in the psyche of the person, it is expected that the person overcomes or decreases his/her suffering by the help of the clinician. Using marathon as an analogy, and as the marathon runner novelist Murakami (Murakami, 2008) had indicated, “Pain is inevitable. Suffering is optional. Say you`re running and you start to think, *Man this hurts, I can`t take it anymore*. The *hurt* part is an unavoidable reality, but whether or not you can stand any more is up to the runner himself.” The therapeutic process aims the acknowledgement and acceptance of the pain caused by the various unavoidable human conditions in our life marathon (e.g., aging gradually every year, loosing beloved ones, or reality of mortality) and comfort and restore the integrity of the person working through and transforming suffering or at least living tolerably (Bolognini, 2006) with it (e.g., tolerating life stages, mourning the loss a significant other).

Another common feature in all clinical encounters is the question in the mind of the clinician: How can I collaborate with this person to reduce his/her suffering and to reconstruct his/her integrity? At this point, we could emphasis that the theoretical orientation of the clinician will shape and accompany this process and set the context and the therapeutic techniques used.

**Current practice of general psychiatry**

A brief critical review of the current paradigms and practice of general clinical psychiatry and residency training programmes shows that it is profoundly shaped by the descriptive biological paradigms in many parts of the world. This means the medical approach is the prevailing practice and little, if any, space for psychotherapies. The conventional medical approach works in three steps: diagnosis, explanation and treatment.

The descriptive diagnostic step is based on the widely used so-called atheoretical, pragmatic categorical classification systems. Although these systems helped to raise the reliability of clinical diagnosis to a certain extent, they ignore the intra-category heterogeneity, and the uniqueness of the person seeking help is offered as a sacrifice to the spirits of diagnostic categories. The assessment of the aetiology is done in the context of *explanation* not *understanding* and focuses on the biological variables and to some recent life events, at the best. The richness of the theories of developmental psychopathology and psychiatry is ignored and reduced to cross-sectional assessments. Intervention and treatment is usually undertaken according to the evidence based practice guidelines and prescribing medications. The time strain that the clinicians face in many outpatient departments across the world reinforces this cross-sectional, reductionist medical exercise in the general practice of psychiatry.

We were warned by Weich and Aray (2004) a decade ago, "We may now be at the limits of what this approach of categorical systems of phenotypic classification is capable of achieving”. Furthermore, Cloninger (1999) stated that "there is no empirical evidence" for"natural boundaries between major syndromes," that "no one hasever found a set of symptoms, signs, or tests that separatemental disorders fully into non-overlapping categories," andthat "the categorical approach ... is fundamentally flawed. "

In fact, diagnosis and treatment in psychiatry, as a formulation and as a joint reconstruction process between the clinician and the patient, is an essential step in clinical care. Accordingly, a two-fold task is faced. On one hand, the clinician is in need of making a comprehensive diagnostic assessment to construct a valid and working formulation of the patient’s situation and a treatment plan, and on the other hand, a solid ground for a therapeutic alliance should be established. Whatever the treatment is, psychotherapy or pharmacotherapy or a combination of both, the establishment of the therapeutic alliance at first contact or interview is an essential priority as a starter.

As far as the current treatments are concerned in general practice of psychiatry a meta-analysis of randomized trials in which the effects of treatment with antidepressant medication were compared to the effects of combined pharmacotherapy and psychotherapy in adults with a diagnosed depressive or anxiety disorder will be mentioned here. This study has shown sufficient evidence that combined treatment is superior for major depression, panic disorder, and obsessive-compulsive disorder. The results also suggested that the effects of pharmacotherapy and those of psychotherapy are largely independent from each other, with both contributing about equally to the effects of combined treatment. It is concluded that combined treatment appears to be more effective than treatment with antidepressant medication alone. Additionally, these effects remained strong and significant up to two years after treatment. Briefly, this study highlighted that monotherapy with psychotropic medication may not constitute the optimal evidence based treatment for common mental disorders (Cuijpers, 2014).

Despite such strong evidences, an investigation of recent trends in the use of outpatient psychotherapy in general population have revealed that, during the decade from 1998 to 2007 psychotherapy assumed a less prominent role in outpatient mental health care as a large and increasing proportion of mental health outpatients received psychotropic medication without psychotherapy (Olfson and Marcus 2010).

The practice of general psychiatry needs the contributions of psychoanalytic / psychodynamic theory and practice in improving it towards a more human based good clinical practice. We could mention some of the major contributions in this regard: on integrating psychodynamic psychiatry in the mainstream of general clinical practice in psychiatry (Schwartz, 1995), on integrating psychoanalytic conceptual and practical tools into clinical interview, into the work of the mental health team, and psychiatric inpatient treatment (Quartier 2004, Quartier and Bartolomei 2013); on the psychological aspects of pharmacologic treatments from a psychoanalytic perspective (Busch and Sandberg, 2007); on integrating new neuroscientific evidences with psychodynamic understanding so that clinicians can reach a real formulation of a biopsychosocial approach in clinical practice (Gabbard, 2014) are current challenges. Also work on the potentials of what could psychodynamic psychotherapy offer clinicians in creating new ways of practicing in order to improve the quality of lives of their patients via a more comprehensive listening, reflecting, and intervening (Cabaniss, 2011) and on how essential therapeutic principles could be incorporated into clinically relevant patient management (Bienenfeld, 2005) are some other studies of relevant importance. Furthermore, the current marginalization of psychodynamic work within the mental health field could be tackled with conducting empirical research. As emphasized by Levy and Ablon (2009), sound empirical research has the potential to affirm the important role that psychodynamic theory and treatment have in current psychiatry and psychology.

Nevertheless, the crucial question deserves to be elaborated further: How could psychoanalytic / psychodynamic theories and practice contribute to the practice of general psychiatry?

**Possible contributions of psychoanalytic / psychodynamic theories and practice in general psychiatry**

*“Just because people ask you for something doesn’t mean that   
that’s what they really want you to give them”  
Lacan*

In general clinical practice, from an epistemological point of view, the clinicians should be aware of that they can never be *objective observers*, since they are not free of their own observations. Hence, *the reality of the patient* is not independent from the conceptual and emotional constructs of the clinician (*Jaspers, 1913,[1997]).* The *subjectivity of the clinician* is a part of the clinical work to be taken into consideration and managed by the clinician.

Besides evaluating the transference issues of the person, the clinician should also implement an insight oriented perspective to see his/her own feelings, reflections, and countertransference issues. It is stated that the concept of countertransference has evolved and gained a central importance in current psychoanalytic theory and practice (Michels, 2002).

The *subjectivities of the person and the clinician* are to be taken as *the objective evidences emerged at the clinical setting*. In understanding and managing this complex process the clinician could use the theoretical and practical tools of psychoanalysis. Let us review some possibilities on such contributions at different levels of the clinical work step by step.

*Interview and establishment of the rapport*

Clinical encounter is a specific human encounter built by the demand and for the benefit of the person seeking help and this interaction is based on the communication between the two. The principles and dynamics of verbal and non-verbal communication (Kuey, 2013) sets the context and framework of the interview. Psychiatric interview is shaped on principles of psychoanalytic psychotherapy, with special emphasis on empathy that requires a balance between fusion and separateness (Bolognini, 2004), and on not only what is expressed but also not expressed or latently or distortedly expressed and on non-verbal cues. A systematic way for listening, reflecting on what is heard and observed, and making choices about how and what to say during the interview are essential contributions of the psychodynamic theory (Cabannis, 2011).

Respect to the *suffering* and *subjectivity* of the person is a priority in establishing the rapport. A non-judgemental, containing, humane attitude is a must: not *objectifying* the person as a mere victim of psychopathology but *subjectifying* the person as an active co-agent of the development of psychopathology; besides, not *passivization* of the person as a mere *receiver* of treatment but *activation* of the person as an effective co-agent of the therapeutic relation and intervention.

*Description of the problems, patterns and diagnosis*

A detailed description of the current problems that lead the person to seek help for at that time of his/her life, and of the behavioural and emotional patterns is the first step in working with the complexity of diagnostic process in general psychiatry. This description also includes not only what is *said* but also what is *expressed* during the interview; behaviours (especially the non-verbal cues) and attitudes of the person at the clinical setting and towards the clinician are attentively recorded. The repetitive patterns of behaviour either expressed in the therapy office, or during daily life, or over a life time are searched as important gateways to develop further insight.

Clinical practice in psychiatry takes place in the context of language. Language is a means of expression and verbalization at one hand and reciprocally, a means for reconstructing the clinical practice, i.e., psyche of the patient. Language shapes the clinical practice and is shaped by it. In other words, the discourse of the patient not only reflects his/her intra-psychic reality but also reconstructs it. Paying attention to this interactional character of the discourse of the person opens the doors to further understanding. Diagnosis is not a mere categorization, made by the clinician, of putting symptoms into various clusters but is a joint, ongoing reconstruction process.

Diagnostic categories are not the reality itself but human made conceptual constructs to be used in helping the clinician to understand the internal reality of the person. Consequently, respect to the uniqueness of the person becomes a priority in describing the current problems and symptoms.

*Reviewing the developmental history and rewriting the unique life story of the patient*

One of the major contributions of psychoanalysis is the emphasis on using the theories to find out causative links between the current problems and the past. It is not listing a chronology of life events but searching the developmental story for the *conflicts, knots* and *traumas*, covering the prenatal development, first years of life, early relationships, childhood, adolescence and adulthood periods. This approach gives the clinician the opportunity of evaluating the situation not only in a cross-sectional manner, but also in its historical and longitudinal context. Besides, it sets the basis for forming working hypotheses about what is happening now, and what might happen in the future. Understanding which patterns are resisting, which are remaining, which are fading, and which are emerging is possible via a historical psychodynamic perspective. The meanings of the patterns and symptoms in the person`s concrete life story and emotional attributions and transferences could be questioned and revealed where possible.

Reconstructing and rewriting the unique life and illness story of the patient, compared to taking a mere cross sectional snap shot, helps the clinician to integrate the disease perspective with a life story perspective. Such an approach constructs the ground for not only assessing the present and the past but also for developing hypotheses about the possibilities of the future.

*Formulation*

An often neglected exercise in general practice of psychiatry is making a comprehensive and integrative formulation (Sperry, 1992). Such a formulation assists the clinician to find the best ways in helping the person and includes the biological, socio-cultural and cognitive-behavioural perspectives, where psychodynamic perspective should be an essential part. The formulation includes the hypotheses of the clinician which cannot be proven directly. These working hypotheses based on the clinical facts, are generated to help the clinician through the clinical work and are tested, disregarded, confirmed or replaced with alternative ones.

A psychodynamic formulation embraces the early cognitive and emotional difficulties, ego and ego functions, the drives, unconscious and subconscious elements of conflicts and defense mechanisms, object relations along with interpersonal dynamics, issues of self and existence and attachment styles. Besides, problems with self-esteem, relationships with others, characteristic ways of adapting (Cabannis, 2013) are covered in a psychodynamic formulation. Another essential part of a comprehensive formulation includes the strengths of the person, e.g., more adaptive ego functions and more mature defense mechanisms, conscious coping styles and psychosocial support systems.

A differential feature of a psychodynamic formulation is the focus on how the person thinks, feels, and behaves considering the impact and development of unconscious thoughts and feelings. Constructing a psychodynamic formulation is not only necessary for short or long term psychotherapy but also for psychopharmacologic treatment alone (Cabannis, 2013). Evaluating the attitudes of the patient towards medication is a first step in such a formulation. When undertaking psychopharmacologic treatment, information about some pre-existing opinions, feelings, and attributions of the patient about medication should be revealed (Cabannis, 2013). In line with this information, the styles of management and adaptation of the patient to stress are invaluable for psychopharmacological treatment. Medication may have specific meanings for patients which need to be included in such a formulation. These meanings attributed to medication may include a variety of relevant clinical material. The patient may attribute the prescription of medication to a biological causation of his/her problems; to a deficiency in his/her self-esteem or failure of resilience that needs to be supported by an external agent (i.e., medication); similarly, to an external control over his/her body and free will (Busch, 1995), or to problems with basic trust and dependency. The psychodynamic formulation in the service of a pharmacologic treatment enables the clinician to predict and manage the reactions of the patient to this treatment in the context of his/her patterns of object relations, i.e., relating to self and others.

Formulation is not a *fait accompli* or *done-and-all-done* type of exercise; it is an ongoing process. Re-formulation wherever *new-old* material arises, or re-formulation wherever *new-new* material arises or re-formulation regarding the treatment responses become a necessity to keep up with the dynamic nature of the clinical work.

Besides, self-formulation of the patient should be an integrative part of a comprehensive formulation. The person`s answers to questions as, What are his/her own explanations and interpretations of the situation? What are his/her emotional and cognitive attributions to the problems and patterns? What are his/her preferences and hypotheses in terms of intervention/treatment? must be incorporated in the formulation.

*The interventions and treatment*

The clinician, after describing the current patterns and understanding the developmental and historical links, aims to set specific treatment goals, choose therapeutic strategies, construct meaningful interventions and conduct the process. Psychoanalytic / psychodynamic therapy provides a solid ground to the essentials for beginning the treatment, including fostering the therapeutic alliance, setting the frame, and setting goals. Furthermore, whatever the treatment chosen and agreed by the clinician and the patient is, either psychotherapy or pharmacotherapy alone, or a combination of both, the assets of a broader range of insight oriented psychotherapeutic interventions have many new routes to offer the clinicians.

The intervention and treatment plans should not be built merely on the treatment algorithms developed for diagnostic categories but on the unique life story of that specific individual.

The current practice of general psychiatry is traumatised with a reductionist approach where *the patient complaints, the clinician diagnoses and treats, and the patient drops out*! Indeed, reductionist practice in general psychiatry decreases the compliance rates. As an example, in the course of treatment with antidepressants, between 30% and 60% of patients do not take their medications as prescribed, hence non-adherence to antidepressant medication is a significant clinical issue in the management of many patients with depressive disorders (*Demyttenaere, 1997; Demyttenaere, 2000)*. Among the reasons for patient non-compliance, along with the side effects and stigma and attitudes toward drugs, another important factor is the patient-doctor communication failure (Johnson, 1981); i.e., a relation focused on *explaining* rather than *understanding*. This problem shows the need of transforming the clinical work, covering diagnostic assessment, formulation and treatment, to a collaborative, joint, ongoing, reconstruction process, by incorporating the contributions of psychoanalytic / psychodynamic theories and psychotherapeutic tools into general practice of psychiatry.

As a conclusion, the theory and practice of psychoanalysis, besides being one of the essential paradigms in psychiatry, offer remarkable contributions to the clinician in managing the clinical work. Understanding the meaning of the human pain and suffering through empathy in a judgment free milieu is essential in the establishment of rapport, and for a better compliance and clinical outcome. Basic concepts of psychoanalysis, with particular attention to intrapsychic and interpersonal conflicts, and to the potential of enabling the clinician and the patient “to distinguish more clearly internal reality from external reality, and the past from the present, thereby minimizing the confusion and the transfer- interferences in our contact with the world” (Bolognini, 2013), and the related psychodynamic oriented psychotherapeutic skills could be useful for mental health professionals in various clinical settings, especially in an era dominated by dehumanizing algorithmic diagnostic and treatment approaches.

At this point, a brief vignette from my clinical practice, *`the white bicycle`*, will be presented to broaden the scope of discussion.

**The white bicycle**

*Time, place, context*

It was early autumn of `96; after the summer holidays and just before the fall term of the school starts. A clear day, in İzmir (Symrna), on the Aegean coast of Anatolia; time for late summer sun and early chilly evenings of Mediterranean climate. Izmir does not only have a soft climate but also a relaxing psycho-social life and milieu and considered as the most *Westernized* city of Turkey, welcoming vast immigration for the last two centuries (Kuey, 2014).

*The person seeking help*

A lady of 38 dropped herself into the chair of a psychiatric consultation room of an outpatient department of a general hospital, certainly not offering an intimate milieu. Consultation rooms of different medical branches, including psychiatry, located side by side along a long corridor. People seeking help would come to a general registration desk, ask for a place in a line and wait in the hall and then called to enter the psychiatrist`s office.

She came as the first afternoon patient and was complaining of “total sleeplessness” and asking for “a strong medication”. The clinician’s first impression confirmed the complaint; she really looked as if she had not slept at all; with full red eyes circled with dark shades, along with a deep, sad expression, as if frozen at her face since time immemorial.

She is an elementary school teacher, and has been married to a man of the same profession for 14 years. They had migrated to İzmir, from a far Eastern Anatolian city of Kars, two months ago. Kars is one of the most migration cities of the country, described by Pamuk (2000) as: `It wasn`t the poverty or the helplessness that disturbed him (in Kars); it was the thing he would see again and again during the days to come in”, “These sights spoke of a strange and powerful loneliness. It was as if he were in a place that the whole world had forgotten, as if it were snowing at the end of the world.”

At early July, a month after the spring term was finished, they happily moved to İzmir, with their 12 year old daughter. In fact, they had been hoping for this move for the last couple years. Just the day after they had moved to İzmir, the daughter and the father went to buy a bicycle for her. The parents had promised this as a gift for her graduation from the elementary school, 5th grade. Actually, she was graduated two months ago, while they were still living in Kars, but she had to wait for a white bicycle until they had moved to İzmir. The parents had thought that it would not be socially acceptable for the young daughter of the teachers running around on a bicycle in that small conservative community. Most of the families of the girls of that age were arranging marriages for their daughters in the region. So, she was very much looking forward to moving to İzmir and her freedom of riding a mostly desired white bicycle; this time, not only in her dreams but also in her daily life!

*The clinician*

At this nice weather, during the lunch break, the clinician, aged 36, went out for a light lunch, with his close friend, a neurosurgeon. While, they were enjoying their after lunch coffees and playing backgammon, they were also chatting about their summer holidays and beloved daughters and sharing the challenges of fatherhood.

The daughter of the neurosurgeon, aged 7, had nocturnal enuresis, and the clinician was helping her to overcome this problem; now, the fathers were discussing what could be the proper parental attitudes and behaviour in this situation. The neurosurgeon also revealed his own problems of enuresis of his childhood, and his parents’ threats of planting him in the toilet all night long. Issues of trans-generational transmission went far beyond the end of the backgammon game.

On the other hand, the clinician’s daughter, aged 3, had also some health problems lately. She had an infection of upper respiratory track couple weeks ago, with high fever. She developed a febrile convulsion, while, her father was trying to cool her down under the shower, in the middle of the night. It was really hard and traumatizing times for both of them.

After the convulsion was over, father took her to the hospital and with his fellow neurosurgeon; they both did their best to help her compassionately. When taken back home that evening, she was feeling better and slept peacefully at first. But, her body temperature was fluctuating and the parents followed up and continued cooling her in case of need, in rotations, all through the night.

During that long day and night, at one break, the father had a chance at last, to hide himself in a room for a while, where he welcomed his tears and cried. His sorrow and tears made him to recollect an old childhood memory.

He was around 6, by then, and just after a febrile sickness of about a week, his father had gifted him with a red football. He was allowed to go out to play with friends on the streets, happily again. He had missed to kick a ball for so long! One hard kick made the ball to fly over the backyard wall of a house nearby and the kids started screaming for the ball to be thrown back. The wall was too high for the kids to see the inside of the garden. They shouted till the bottom of their voices: “We want our ball back, please throw it back!”

After a while, as if a year for the kids, someone started shouting from the back of the wall.

It was the angry voice of the neighbour: “Didn’t I tell you not to play in front of my house, you are making so much noise, I am tired of you. Here is your ball, get your ball and your ass out of here. Go to hell!” Yes, the ball was thrown back, but with a big knife cut on it.

The kid, later to become the clinician, gave a hug to the torn ball and ran to his hell. Entering home and without saying a word to anyone, he found a room for himself under the sofa to cry and welcome his tears. Yes, the later clinician remembered this memory of his red ball while struggling to help her daughter in fever.

Well, in a week, the daughter recovered and the clinician also. But, of course, with the painful prints of this experience in their own emotional library archives, written on the clay tablets where experiences of loss and threats of loss were imprinted.

*Back to the clinical setting and encounter:*

The lady put her documents on the clinician’s desk and with an angry voice, exclaimed:

“I cannot sleep at all, I want sleeping pills”.

First words of the clinician, rather spontaneously, came out to be as,

“What happened, did you lose your sleep?”.

Her answer was striking:

“NO, NO, I did not LOSE anything, I want to sleep, give me MY pills”.

After a short hesitation, the clinician asked, “YOUR pills?”

A tough confused rejection came from her again:

“NO, NO… but yes. I want pills! I meant a strong medication to make me sleep forever!”

“Well, OK, I will certainly help you to restore your sleep. But, please tell me, what is this ‘MY pills’ issue?” insisted the clinician.

The lady went into an outbreak and crying out, shouted:

“I want MY daughter back!”

During the interview, in due course, it is revealed that, three weeks ago, her daughter while riding her bicycle near their home, was hit and killed by a car, the driver of which was an unlicensed young boy!

The clinician hardly managed to remain focused and carried on the interview. She was in tears while giving the details of their long waited dream of moving to Izmir, and her daughter`s desire for a white bicycle. At the same time, she was experiencing and expressing her absolute disbelief on what had happened. “What was my sin to deserve this punishment!” she frequently proclaimed without asking for a reply. Eventually, they could reach a compromise that she will come to see the clinician again next day. The clinician, quite contrary to his usual practice in bereavement situations, also advised her to take 10mg. of Amitriptiline, at nights.

While, he was writing down the prescription and explaining the effects/side effects of the medication, she interrupted with a shy low tone of voice:

“What color are these pills?”

“White”

“Good, I will take them…”

After the patient had left, the clinician locked the door, took a deep breath and hold his head in his hands and let his tears to pour down; crying out all his emotional pain; re-reading and reconstructing his clay tablets of suffering once more, where experiences and traces of loss and threats of loss had been imprinted.

This case vignette, summarizing a consultation in a crisis situation very briefly, also emphasizes the complexities of emotional interactions of the clinician with their patients. Moreover, the importance of paying attention to the emotional experiences of not only the patient`s but both, and how to become more attuned to one's own experience of a patient (Maroda, 2000) is elaborated.

The person expressed her need in an indirect and concealed way: talking about `a loss`; not the loss of her daughter but her sleep. The clinician`s mind, on the other hand, was full of the issues of parenthood and the health problems of his and his friend`s daughter. Triggered by these fearful phantasies of loss in his internal reality and his observation of her sad looking funereal gaze, he made an exclamation as, “did you lose your sleep?” instead of asking, “what kind of sleep problems do you have?”, as he would usually do. He had partially passed over the conventional discourse of a medical interview, revealing some of his own subconscious. This made the internal realities of both to get in contact. The clinical encounter became a setting where both met not only the Other but also Each Other. This link between the internal realities of both, even very fragile at the beginning, set the basis for a therapeutic alliance. A genuine channel for a humane touch of two psyches became possible.

Promising some medication (but not sleeping pills) was kind of a reward presented to the person. The *meaning* of reward for her was to be revealed in due course of the treatment, lasted about two years with sessions of once in two/three weeks. A process of bereavement and mourning was complicated with a deep depression and her personal history. She had struggled all through her life, aiming an independent personal, economic, and social well-being; becoming a teacher; marrying a well behaved colleague; educating children of low economic classes (similar to her family origins) were her major life tasks and accomplishments. Her hearty desire of migrating to Izmir meant to be the concrete reward for her life struggle comforting sufferings of the past. The meaning attributed to migration turned into a deep tragedy instead of a rewarding. Her profound self-guilt leading to a clinical depression soon after the first stroke has passed, was accessible in this context.

Another important point deserving to be emphasized in this vignette is the strong rejection of the patient when she was questioned of any loss. Only knowing the basics of psychoanalytic concepts and defense mechanisms (e.g., reaction formation) could help the clinician to see the *yes* in a *no*; i.e., which `no` means in fact a `yes`.

Although there are various psychoanalytic oriented psychodynamic schools and therapies, some core common issues that may be relevant to any daily clinical practice of psychiatry and mental health and also general medicine needs further elaboration.

**Conclusions**

*In search of a remedy for my malady  
I realized, the malady itself was the real remedy for me.  
In search of an evidence for myself  
I realized, my ownself was an evidence for me.  
Mısri (1618-1694)*

Not only the praxis of general psychiatry but also that of the general medicine and the training of psychiatry residents and medical students need to be enriched by the contributions of psychoanalytic / psychodynamic theories. Why?

First, multi-morbidity of physical and mental disorders seems a rule rather than an exception (Goodell, 2011). A significant portion of the adult population has co-occurring physical and mental disorders. In the 2003 National Comorbidity Survey Replication (NCS-R), more than 68% of adults with a mental disorder had at least one medical condition, and 29% of those with a medical disorder had a comorbid mental health condition (Allegria, 2003). Mental health workers should keep in mind that the reasons of multi-morbidity are complex and bidirectional. Medical disorders may lead to mental disorders, mental conditions may increase the vulnerability for specific medical disorders, and mental and medical disorders may share common predisposing and triggering factors (Goodell, 2011). This high multi-morbidity demands an integrative understanding and management of all illnesses, including their psychoanalytic / psychodynamic aspects.

Second, all illnesses and their treatment processes, including the ones classified as *pure* medical disorders, have psychological/emotional aspects which needs careful attention of the health workers. These emotional aspects, contributing to the development of the medical disease or have an impact on the treatment process or both, need the clinician to have competency in understanding and managing them; e.g., at least, the emotional meanings attributed to the symptoms or formulation of the primary and secondary gains.

Third, any medical treatment should be undertaken in collaboration with the person as a *subject*; hence, the clinician should be aware of the conscious and unconscious worlds of the person, for a better rapport, compliance and outcome. Psychoanalytic / psychodynamic concepts with its potential of deepening such an integrative understanding of human beings in health and ill health should be a part of medical training and practice of general medicine and psychiatry.

Fourth, at any clinical setting, the main focus of the person seeking help from health workers is on pain and suffering. Any illness either classified as physical and/or mental disorder causes emotional pain and suffering. The term *patient* itself is a derivative of the adjective *patientem* (in Latin) defined as “bearing, supporting, suffering, enduring, permitting”, and of the noun *pacient* (late 14c. from Old French) defined as "suffering or sick person under medical treatment" (Harper, 2011-2014). Life is obviously a very rich but difficult and demanding process, and psyche is constructed and reconstructed in the struggle to deal with it. The dynamic turbulence created in the currents of mental life by these struggles lead people to develop means of avoiding pain: various ways of seeing, thinking, feeling and behaving can all serve this purpose. Much of this activity takes place out of awareness (Johnstone and Dallos, 2006). Psychoanalytic / psychodynamic theory and practice provides the health and mental health workers the perspective that there is an *internal world* (subjectivity) constituted differently from *external reality* (objectivity). It emphasizes the fundamental influence of the unconscious elements of this internal world on people`s life styles in health and illness. Furthermore, it stresses the repetitive character of these unconscious attempts to avoid pain since the awareness is limited. Failing defenses or these repetitive patterns give form to maintain patterns of mental disorders (Johnstone and Dallos, 2006). Mental health workers, only via a psychoanalytic perspective, could formulate the role of the unconscious in the development of the *malady* and the process of *remedy.*

Fifth, suffering forces the person to confront the thoughts and feelings which were previously put in the archives of clay tablets and mostly kept hidden from the conscious mind because they seemed to be too much to deal with. Mental health workers, via psychoanalytic / psychodynamic formulation, could help the patients to *reformulate* or to *reconstruct* what they are experiencing in a more inclusive way, and to confront, accept and tolerate the pain and find ways to decrease the suffering.

Sixth, the ongoing joint *understanding and reconstructing processes* that the clinician and the person develop about these difficulties expand the person’s awareness. It is focused on broadening the scope of *insight* compared to more behaviour management oriented psychotherapies. So, through the therapy process it is expected to open up new options for recovery, resilience and conflict management. The person’s capacity to bear emotional pain and cope constructively with dissatisfaction and suffering is enhanced, and the ability to reflect on and be curious about their own experiences is developed. Furthermore, as stated by Busch (2013) the person with the development of a psychoanalytic mind, “can acquire the capacity to shift the inevitability of action to the possibility of reflection”. Busch illustrates that while the analyst's expertise is crucial to the process, the analyst's stance, rather than mainly being an expert in the content of the patient's mind, is primarily one of helping the patient to find his own mind.

Consequently, this understanding of psychoanalytic / psychodynamic perspectives may be helpful in our daily practice of general psychiatry, where we try to find answers to that fundamental question of “how can we collaborate with this unique person to diminish his/her suffering and to reconstruct his/her integrity?” At this clinical encounter, where *the personal archives of emotional tablets* of the two meet, a challenge for the clinician is to harmonize the current available scientific universal knowledge and the uniqueness of that person.

Today, in general psychiatry, there is no meta-theory to help us to understand and explain *the clinical truth*. In fact, we do not need such a meta-theory, but we need multi-level / multi-dimensional approaches. We should be modest, honest and respectful towards *the clinical truth*. The clinicians need different perspectives and paradigms at different levels. Psychoanalytic / psychodynamic schools and therapies are valuable for practitioners of general medicine, psychiatry and mental health in confronting these challenges.

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***This text does not contain any sensitive clinical confidential material; they have been either removed or comprehensively anonymised. March 24, 2015, Istanbul.***

***Levent Küey***

