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Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Psychoanalysis in Modern Psychiatry

Learning Objectives
After reading these articles, you should be able to:
1. Describe the key elements of a psychoanalytic session.
2. Explain the process of psychoanalysis from both clinician and patient perspectives.
3. Identify some of the useful psychoanalytic concepts that can be applied to general psychiatric practice.

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

Rebecca Twersky-Kengmana, MD
Psychiatrist in private practice, New York, NY

Dr. Twersky-Kengmana has disclosed that she has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

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

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

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In Summary

- Psychoanalysis differs from psychodynamic therapy in that the clinician and patient meet more frequently and over a longer time span, and there is more emphasis on understanding the transference.
- Recent research has shown that psychoanalysis is effective for a broad range of psychiatric symptoms.
- Psychoanalytic training includes didactics, supervision of cases, and a personal psychoanalysis.

Q&A With the Expert

How Psychoanalysis Works
Eric M. Plakun, MD

Associate medical director, director of admissions at the Austen Riggs Center in Stockbridge, MA

Dr. Plakun has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

TCPR: Dr. Plakun, what would you say is the essence of psychoanalysis?
Dr. Plakun: It's both a form of treatment and a theory of mind and development. The treatment involves the exploration of the unconscious meaning of symptoms and behaviors. The idea is that many of our patients'—and our own—personality traits and behaviors are governed by unconscious forces. The goal is to "break the code" of the choreographed symptoms and behaviors, bringing their meaning into awareness where they can be reflected on, put into perspective, and brought under conscious control. The theory encourages us to always be curious about the meaning of symptoms, and this curiosity can come in handy whether you are doing therapy or psychopharmacology.
TCPR: How is this helpful for a psychopharmacologist?
Dr. Plakun: In many ways, but I'll give you an example of a person I worked with

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type of therapy.

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

A brief description

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

Psychodynamic therapy and psychoanalysis are similar. Both ascribe to the above theory of the mind, but a psychodynamic therapist will typically meet with a patient 1–2 times per week, sit face to face, and converse with the patient. A psychoanalyst will meet with the patient more frequently (3–5 times a week) and for a longer time period (4–5 years). The patient lies on a couch and "free associates," saying whatever comes to mind, including fantasies, dreams, and thoughts about the analyst, while the analyst sits out of view behind the couch, primarily listening, but occasionally interpreting the patient's comments.

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

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

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

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

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

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

The most recent meta-analysis of psychoanalytic research looked at 14 studies, which enrolled a total of 603 patients, with the number of patients in each study varying from 17 to 92. Psychoanalysis was defined as at least 2 sessions per week, with the patient lying on the couch. In these studies, the duration of analysis ranged from 2.5 to 6.5 years. Only one of these studies was an RCT that included a control group. The other 13 were pre/post cohort studies, meaning that all patients were assigned to the same treatment (psychoanalysis) and researchers compared their symptoms before treatment with symptoms after treatment.

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

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

Analytic training

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

As a PGY-3, I had two supervisors who were analysts, and I was fascinated by how they thought about patients with

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respect to developmental trauma, unconscious motivations, and conflicts. It was vastly more complex than the DSM assessments I had become accustomed to. After attending the annual meeting of the APSaA and hearing actual analytic cases presented, I knew I would eventually become an analyst.

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

I enrolled in the New York Psychoanalytic Institute, which follows the tripartite training model of didactics, clinical work, and a personal analysis. I attended 6 hours of classes per week, including theory, technique, and continuing case conferences, for 4 years. Over the 7 years until I graduated, I treated a total of 4 analytic "control" cases, each 4 times per week, with 1 hour of supervision per week, per patient.

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

Pearls from supervision

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

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

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

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

Getting analyzed

My personal analysis was the most grueling of the 3 components of training. Psychoanalysis produces a regressed state in the patient. There's something about lying on the couch, not facing the analyst, day after day, that brings up primitive thoughts and sensitivities, and turns mature, responsible adults into fragile children, like a return to the cradle. This is good for the analysis, because it facilitates access to the unconscious, but after each session, you need to put yourself back together and act like a grownup, even though you're not feeling like one. In the face of this vulnerable experience, analytic trainees tend to bond with each other for support, which helps to develop our identities as analysts. I found that being in analysis helped me empathize with my patients' feelings about being patients, and it also gave me firsthand knowledge of how an experienced analyst thinks and works.

Life as an analyst

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

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

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

While psychoanalysis is a small part of my practice, the skills I learned enrich all my work with patients. My ability to listen and discern meaning has made me more astute at recognizing symptoms, and thereby a better psychopharmacologist as well as therapist. I also have the intellectual stimulation and community of my analytic institute, where I teach, attend lectures, and am active on various committees. So far, I don't feel burned out, as many doctors do. Frankly, I think my job is fun.

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Expert Interview
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some years ago who showed a lot of resistance around my prescribing suggestions. She would refuse meds, she would sometimes take mini-overdoses; it was quite a struggle. When I learned her story of early experiences being sexually abused in ways that involved oral rape by a relative, it began to make sense that she didn't want me to be in charge of what went into her mouth. We then paid more attention to the meaning aspect of the relationship, focusing on issues like the inevitable mistrust and worry about repetition of any kind of oral penetration, and as we worked this through, the struggles around prescribing lessened.

TCPR: That's looking at the meaning of a behavior—what about meanings of symptoms? How does psychoanalysis view these?

Dr. Plakun: While we often tend to view symptoms as problems, in the psychoanalytic view symptoms may look like problems, but they are also actually solutions. They aren't very good solutions, and hopefully we can help patients discover better ones. A term that's often used in analytic jargon is "compromise formation." A patient's symptoms are a compromise effort to solve a problem. If our patients' problems were just problems, they would be easy to solve. For example, consider a borderline patient who cuts himself repeatedly—if the cutting were just a problem, the patient would stop it, solving the problem. But it is also a solution. Cutting might represent the punishment that he feels he deserves, or perhaps he is struggling with not knowing who he is and feeling emotionally numb, and finds that when he cuts at least he feels something, even though it's pain. And it isn't for us to tell them the meaning. It is for us to be in a listening stance that allows us to learn the meaning—which our patient may know—or we may need to discover it together. So paying attention to what problem is being solved by a symptom is useful. In addition, paying attention to what they might lose if they were to lose the symptoms can also be important.

TCPR: Why would a patient not want to lose a symptom?

Dr. Plakun: Years ago, a woman came to Riggs with intractable psychotic depression, and no amount of medication would touch it: She kept hearing the voices. Now, if you talked to her you got the story—which was that the voices were of her dead child, her only child. And if she were to lose those voices, she would lose that dead child forever. When she could use her psychodynamic therapy to help her grieve the loss of her child, she was better able to respond to medications.

"While we often tend to view symptoms as problems, in the psychoanalytic view symptoms may look like problems, but they are also actually solutions."

Eric M. Plakun, MD

TCPR: Any other examples of how symptoms may have hidden meanings?

Dr. Plakun: Another common example is anxiety. Anxiety is two things: both a symptom and a signal. As a symptom, we might try to reduce or eliminate it. As a signal, though, anxiety is like a "check engine" warning light. We can try to ignore or cover up the light and drive on, or we can try to understand what is causing it—because it may signal important trouble that is out of our awareness.

TCPR: Can you give us an example?

Dr. Plakun: I once saw a woman who developed a bridge phobia after the death of her father. During our sessions, I learned that in childhood her relationship with her mother was distant, but she was closer to dad—who was more loving but could also be quite belittling and demeaning. In speaking about her phobia, she said that she had a terror of being swept over the side of a bridge while crossing it, and she felt a knot in her stomach when crossing bridges. When I asked if she'd ever felt that kind of knot in her stomach before, she recalled a childhood episode when she had climbed a steep and exposed fire tower with her father one windy day. It had been scary going up, but the prospect of descending was utterly terrifying. She asked father to hold her hand, but he refused, went down alone, and told her she would have to find her own way down. She had felt the same terrifying knot in her stomach as she descended very slowly. Father made fun of her timidity from the bottom. She had felt humiliated, enraged at "her father," and abandoned by him.

TCPR: And what was the connection between her father's death many years later and the onset of the bridge phobia?

Dr. Plakun: Her bridge phobia replicated the fire tower experience. She had felt abandoned by her father when she was descending the fire tower, and later her father's death felt on some level like another abandonment, reawakening the old fears of vulnerability and of being swept away and falling.

TCPR: It is an interesting orientation to treating patients. In a more psychopharm-oriented practice, when a symptom is not responding, we tend to look for just the right combination of meds. But you're saying we shouldn't forget the value of digging a bit deeper into the meaning of symptoms.

Dr. Plakun: Yes. For example, let's take the issue of treatment resistant depression. We all have such patients, and the question is "why is this patient treatment resistant?" There are certainly those who don't take the medication, and then there are those who do not respond to medication they are taking. It turns out that among these non-responders, a large number have a history of early adversity and a lot of comorbidity. In the one large study, Skodol and colleagues found that comorbid personality disorders, especially borderline personality disorder, "robustly predicts the persistence" of major depressive disorder (Skodol AE et al, *American Journal of Psychiatry* 2011;168(3):257–264). So the practical tip is that if you have a patient with treatment resistant depression, don't think only about the next medication to try, think about the impact of early adversity, and think about the contributions of

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Anger, Anxiety, and Pain: A Description of an Analytic Session

Rebecca Twersky-Kengmana, MD

[Editor's note: Due to confidentiality concerns, patient details are fictionalized, but are representative of common clinical issues.]

The patient is a 31-year-old, single female attorney, who was referred by her primary care physician for somatic complaints that have been worked up thoroughly, with normal results. In the past, she has been worried about and has pursued various diagnoses, including endometriosis, neurofibromatosis, and ovarian cancer, and has doctor-shopped when told her problems might be psychological in origin. Her primary care physician referred her to me for evaluation of possible somatization disorder.

This session occurred three years into a 4-session-per-week analysis. During my initial evaluation sessions, I learned that the patient has a history of fainting spells as an adolescent. At the time, her pediatrician pursued a workup that was negative for organic causes, but the doctor was fired by the parents after referring the patient to a psychiatrist. Of note, when she was a preschooler her mother contracted a rare tropical disease, and for a year of convalescence a widowed great aunt lived with the family to take care of my patient.

My provisional diagnosis was somatization disorder. I did not prescribe any medication for the patient, in part because there were no clear target symptoms to medicate, and in part because I felt medication was likely to feed into her wish to take on the sick role. Over time, I hypothesized that the rage she experienced towards her mother for neglecting her as a small child had become a source of guilt, which resulted in a wish to punish herself. She chose illness as the form of punishment because it served multiple functions: it allowed her to identify with her mother, to compete with her, and to feel worthy of the kind of sympathy and attention she had craved as a child. Since beginning analysis, the patient has been more willing to consider the possibility that she somaticizes, but in times of stress, she rapidly reverts to the belief that she has a fatal illness.

This session took place on a Thursday afternoon, her fourth session that week. She entered the office, hung up her coat, put down her bag, and lay on the couch without first making eye contact.

Pt: My boss is being such a bitch.
Me: What happened?
Pt: Just the usual. She doesn't take me seriously. Sometimes I think she rolls her eyes when I come to her with questions.
(She is silent)
Pt: I know what you're going to say about this, but I've been coughing and having hip pain again. You'll say I'm somaticizing—sometimes I believe that, but sometimes I just don't know. How can I ever really tell whether these symptoms are real?

I wonder about the transition between comments. Why does she go from complaining about her boss to talking about her somatic symptoms? My sense is that she associates her boss with her mother, and her anger at both of them is intertwined. But being angry at her mother makes her feel guilty and anxious, so to defend against these emotions she uses somatization, her accustomed mode of defense. And yet, she is beginning to be aware of this tendency, so she comments about it with some ability to self-observe.

I think that her key issue now is uncertainty. She has been developing insight into the fact that she fabricates her symptoms, but then, under stress, she doubts that insight. How does that doubt help her?

I know from prior sessions that she was angry at her mother. I wonder if her continued doubt about the reality of her symptoms is a way for her to tolerate her guilt about this anger: "I am angry, which means I am destructive and bad, so I deserve to be punished with a terrible illness; but perhaps there is justification for my anger towards my mother, in which case I don't deserve to be punished. Still, I have no right to think that my mother (in the guise of her boss) is the one who is bad, because she is so ill, so I need to remain unsure."

I have my own association to a memory of waiting two weeks for a lab result, to find out if I had a very serious illness (I didn't). I think about how painful it was not to know, but how in some ways that state of doubt and anxiety was preferable to getting the result and potentially learning that something was really wrong.

I decide to pursue her feelings about certainty.

Me: There's something important about keeping yourself in doubt about whether you are actually ill.
Pt: Why would I do that? It's such an uncomfortable state to be in! It just makes me more anxious!

Her affect has intensified, which makes me think I chose the best course to pursue.

Me: With what thoughts?
(She pauses)
Pt: There was this game my aunt would play with me. I had this toy doctor kit, you know, with a plastic stethoscope. They got it for me when my mom got sick. I think they thought it would help me understand what was happening. So I would lie down on the sofa and pretend to be sick, and my aunt would do silly stuff with the toys, like listen to my foot with the stethoscope, and tap the hammer on my nose. And then suddenly, she would say, "All better!" and tickle me. And I would giggle and run away.
(She is silent)

I think there might be an association between her memory of lying on a "sofa" as a child and her lying on a couch during our sessions.

Pt: I don't know why I thought of that. I guess it has something to do with being sick. Maybe with the idea that being sick is fun.
Me: And that your being sick is something silly that doesn't need to be taken seriously.
Pt: Nah. My mom was the one who was really sick. And everyone needed to be quiet so we didn't disturb her.
Me: But you were still in pain—you missed having your mom care for you.

Here I am probing to see if she is

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Five Psychoanalytic Concepts for Your Practice

Rebecca Twersky-Kengmana, MD

Psychoanalytic training may not be right for you, but here are some analytic concepts that can be useful to anyone practicing psychiatry.

~ The unconscious: Patients are often unaware of patterns of behavior and their underlying conflicts. Unacceptable feelings like aggression and sadness may be banned from conscious thought, and therefore inaccessible to direct confrontation. I find clues to these feelings in slips of the tongue, chronic lateness to sessions, dreams, and fantasies. If a patient brings in some artwork, I treat it like a dream, asking about its various elements and encouraging her to free associate in response to them, as well as exploring the reasons she brought it to our session.

~ Compromise formations: This term refers to maladaptive behaviors that may be a patient's best attempt to solve an unconscious conflict with limited tools. If a patient is not taking medication as prescribed, I try not to dismiss this as "bad" behavior or noncompliance, but to explore its meaning. For example, the patient may wish to get well while simultaneously remaining attached to the sick role (see case on page 5).

~ Meaning and symbolism: The patient may think of medication as a gift, or poison, or a piece of the psychiatrist that he can carry around. I always assume it means something more than just pills. And if a patient talks about a movie, or public transportation, or even the weather, I listen for clues to what he's trying to tell me about himself. One patient complained about the subway, and how he never knew whether to choose the express or local, and that he always picks the wrong one. I responded with an interpretation about his belief that he is "unworthy," and it is his fate that only bad things can happen to him.

~ Multiple determination: Contrary feelings towards a single object (ie person), like love and hate, frequently coexist. It's helpful to remind patients of this, because it encourages them to accept themselves and those with whom they are close. For example, when a patient protests that she enjoys her mother's company and is therefore not resentful of her mother's demands, I often say something like, "Why not both?"

~ Transference: Patients have strong feelings about their psychiatrists, even if those feelings are really about someone else. I've noticed that my vacations can evoke a painful sense of abandonment, and my occasional mistakes can evoke fury. It's uncomfortable to have these emotions directed at me, but it helps the patient if we try to understand them together.

Expert Interview
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comorbidity, especially comorbid personality disorders.

TCPR: How do we sensitively assess for early adversity?

Dr. Plakun: You don't do it with a DSM checklist of symptoms. You do it by listening to the patient's life narrative in a way that follows the affect. Typically, I start by asking about the events leading up to the problem that brought the patient in, what is usually called the history of present illness. But then I go back to their early childhood. "How were things? What was your mother like? What was your father like? What were your siblings like? How were you treated? Did anything go wrong? Were you bullied? Were you harmed in any way?" But I don't pepper them with questions; I try to hear the story and follow the affect. So if you hear that their mother died when they were young, you say, "That must have been awful," and you hear more about it. This kind of engagement is also part of building the therapeutic alliance—it shows you are with the patient in their experience. And it is crucial in finding therapeutic stories, which can be very helpful.

TCPR: What do you mean by a therapeutic story?

Dr. Plakun: Therapeutic stories are episodes from a life history that illustrate a powerful, often recurrent theme in a patient's life They can be useful metaphors for a patient's struggles. For example, I saw a patient in her forties who had been stuck in a pattern of treatment resistant depression for 10 years. In learning about her life, she told a moving story of having fallen into a cesspool as a young child, and nearly drowning in a difficult struggle to get out. Later, after a series of important relationship and work losses as an adult, she became depressed in a way that was refractory to treatment. It was quite useful for us to conceptualize her current plight in a way linked to the therapeutic story of the cesspool. She had once again fallen into one, and there was no one around who seemed able to help her get out—me included. We did a lot of work about her wish to be rescued, her anger at my limitations, and, ultimately, her own ability to find and use her own resources to reclaim her life.

TCPR: Thank you, Dr. Plakun.

CME Post-Test

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For those seeking ABPN Self-Assessment (MOC) credit, a pre- and post-test must be taken online at http://thecarlatcmeinstitute.com/self-assessment/

Below are the questions for this month's CME/CE post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning Objectives are listed on page 1.

1. According to Dr. Plakun, a therapeutic story is which of the following? (LO #2)
   - [ ] a. A narrative about a particular psychoanalytic session
   - [ ] b. An episode from a patient's life history that illustrates a powerful theme in the patient's life
   - [ ] c. A journaling method helpful for patients in psychoanalysis
   - [ ] d. A fable-like story that helps patients gain insight into their own problems

2. According to Dr. Plakun, which of the following statements about psychoanalysis is true? (LO #2)
   - [ ] a. Psychoanalysis is most effective for treatment resistant depression
   - [ ] b. Psychoanalysis focuses on anxiety as a behavioral trait
   - [ ] c. Psychoanalysis has been shown to be less effective than other forms of therapy
   - [ ] d. Psychoanalysis considers how a symptom may be a solution to a problem

3. The most recent meta-analysis of psychoanalytic research synthesized data from what? (LO #1)
   - [ ] a. 12 randomized clinical trials comparing psychoanalysis with medication
   - [ ] b. 14 studies, but only one was a randomized controlled trial
   - [ ] c. Primarily studies comparing psychoanalysis with cognitive behavioral therapy
   - [ ] d. Case reports only

4. Animal experiments have shown that early adversity can cause demethylation of DNA, which renders some genes inactive. (LO #3)
   - [ ] a. True [ ] b. False

5. A patient cuts herself superficially and says that this helps her to feel better because she believes she is a bad person and should be punished. This is an example of which of the following? (LO #3)
   - [ ] a. Projection [ ] b. Multiple determinants
   - [ ] c. Compromise formation [ ] d. Suicidal ideation

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Early Trauma and Epigenetics: Can Psychotherapy Demethylate Our Genes?

Eric Plakun, MD

We know that childhood trauma can scar our patients psychologically—but new research suggests it might actually change their genes. The effect of the environment on genetics is referred to as epigenetics. In one study, monkeys who had been separated from their mothers were found to have widespread methylation of their DNA (Provencal N et al, *J Neurosci* 2012;32(44):15626–15642). The methylation occurred in virtually all cells, including in eggs and sperm, setting up the transmission of the impact of this kind of adversity to the next generation. When genes are methylated, they are rendered inactive, while other genes take their place—DNA kept in reserve, one might say—for traumatic situations. When speaking about these studies, Dr. Moshe Szyf of McGill University noted that demethylation of the methylated genes (which brings them back online) can occur later, during what he described as periods of "quiet reappraisal" when a monkey is alone and given a cue to remind it of the lost mother. Such periods of quiet reappraisal of loss seem analogous to what we do as therapists when we sit with patients in their grief, despair, and rage. In that sense, I believe that psychotherapists are clinical epigeneticists.

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This Month's Focus:
Psychoanalysis in Modern Psychiatry

Next month in *The Carlat Psychiatry Report:* Medications in Pregnancy and Breastfeeding

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Anger, Anxiety, and Pain: A Description of an Analytic Session

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ready to acknowledge her anger toward her mother.
Pt: Yeah. I think they did care about me. That just wasn't the kind of thing that got paid attention to. They meant well.
Me: And here you are, lying on another sofa, and wondering if I will take your concerns seriously.

She is beginning to gain insight into her tendency to somaticize, but is not yet ready to address the feelings driving it directly, especially anger. For this reason, I needed to pick up on the transference in her description of the game on the sofa, so those feelings could begin to play out with me. Assuming that this transference intensifies, I will be able to interpret these feelings and help her connect the dots between her anger and her physical symptoms.

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