

## **Psychodynamic Psychiatry and Psychodynamic Therapy Versus Traditional Approaches**

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Psychodynamic psychiatry is the term that was used first more than 100 years ago Ellenberger [1]. Psychodynamic psychiatry is an approach to the diagnosis and treatment characterized by a way of thinking about both patient and clinician that includes unconscious conflict, deficits and distortions of intrapsychic structures, and internal object relations" [2]. The term "psychodynamic psychotherapy" is not synonymous with psychodynamic psychiatry. Psychodynamic psychiatry provides a conceptual framework within which all treatments are proscribed and all treatments are psychodynamic informed.

In contrast to the traditional approach, that categorizes patients according to common behavioral and phenomenological checklist, psychodynamic analysts try to determine what is unique about each patient, how a particular patient differs from other patients as a result of a life story like no other. Symptoms and behaviors are viewed only as the final pathways of highly personalized experiences.

In psychodynamic psychiatry and psychodynamic therapy we are identifying a tendency within a growing part of contemporary psychologists, psychiatrists and psychoanalytically oriented psychotherapists for the include in their system of clinical thinking the role of psychological, social, cultural and religious factors which are beyond the narrow exclusively biomedical model. The use of term "psychodynamic" has become salient across the wide spectrum of contemporary psychoanalysts with predominant orientation on the object relations and self-analysis approaches.

Psychodynamic theory instead of seeing relationships as the result of the drive discharge, sees self-expression in the relationships as the foundation of all psychic functioning. Not the combination of instincts defines both healthy mental development and the appearance of psychopathology but the history of the attachments. An individual in her or his natural state is essentially alone and then drawn into social interaction because he or she psychobiological are social beings, and they, as a matter of fact, are embodied in an interactive matrix with others.

The rejection and separation from an object (from the person) causes casually the frustration that is experienced as a primary source of anxiety. This anxiety presents in itself the conscious awareness of unconscious sense of traumatic separation from the existentially needed object.

Frances Tustin [3] points out that some patients suffering from the environmental deficiency experience so severe frustration as if they were feeling themselves into a bottomless void.

From point of view of the psychodynamic approach, contrary to the traditional one, libido is object seeking. It seeks not only pleasurable objects and the satisfaction of biological instincts is not the primary task of the psychodynamic development.

Fairbairn [4] stated that the ego was dedicated to the relationships with painful objects. These painful “part-objects” relations are split off and repressed, but nevertheless they continue to press for the return to consciousness. Fairbairn explained that already children blame persistently themselves for bad experiences with their caregivers so that they can maintain the objects as good and maximize the chance of being loved. If the objects are seen contrary as bad, then nothing the child can do. This condition Fairbairn termed “unconditional badness”. But “if the child sees herself or himself as bad and the object as good, there is a chance for being loved if only the child can right himself. Fairbairn called this condition by the term “conditional badness”.

In psychodynamic psychotherapy particular role play nonverbal signs of communication (expressions of empathy) which include eyes contact, activation of muscles of facial expression, posture, tone of voice, hearing of the whole person (empathic listening). The word “empathy” is derived from the Greek word “empathia” (“em”-in, “pathos”-feeling) and German word “Einfühlung” (feeling into). It was used firstly to describe the emotional experience that was evoked by viewing a works of art and feeling one’s way into an emotional experience. The phenomenon that an artist whom the viewer may never meet can project emotions that inspired the painting, or music, or play, was the first attempt to describe how we can feel our way into the emotions of others.

William James [5] (a contemporary of Freud) wrote of the value of what we now would call “sustained empathic inquiry” for psychological integrity: “One must have musical ears to know the value of a symphony; one must have been in love one’s self to understand a lover’s state of mind. Lacking the heart or the ear, we cannot interpret the musician or the lover justly, and we are even likely to consider him weak-minded or absurd” (p.300).

According to Summers and Barber [6], essential features of the psychodynamic psychotherapy are: (1) emphasis on uncovering painful affects, understanding past painful experiences, (2) use of exploratory, interpretative and supportive interventions as appropriate, (3) goal is to facilitate emotional experience and increase understanding, (4) focus on the therapeutic relationship, including attention to transference and countertransference.

Kernberg [7] regards psychodynamic therapy as the “judicious of traditional psychoanalytic techniques. He observed that psychoanalysis and psychodynamic therapy are convergent with respect to their interest in unconscious meanings and the impact of early relationships.

Luborsky [8] stated that psychodynamic psychotherapy is in its essence supportive-expressive one. In the context of mental disorders Core Conflictual Relationship Themes (CCRT) were revealed. Core psychodynamic problems include fear of abandonment, low self-esteem, depression, panic anxiety, and psychological trauma.

McWilliams [9] characterizes the essence of psychodynamic psychotherapy differently. She emphasizes the sensibility of the therapist, her or his attitudes of curiosity and awe, the respect for empathy, complexity, appreciation of attachment, and a capacity for faith. McWilliams is more interested not in technique but in the process, the therapist attempts to activate in the patient.

Author’s many years of clinical experience and fruitful discussions with psychodynamic oriented psychiatrists, psychologists, and sociologists have all shaped the conviction that psychodynamic theory and practice broadly conceptualized had more to offer clinicians and their clients than numerous other theories and approaches to psychotherapy of various mental problems that exist today.

From the psychodynamic perspective, it was especially interesting to observe and to analyze the psychological states that were localized at the borderline zone between the mental health and mental pathology. Addictions have their own place in this zone. New findings in neuroscientific studies have redefined addiction from a condition of flawed character to a model of biology and disease. It appears that brain reward centers in an area called the nucleus accumbens are so powerfully actuated when exposed to opioids, alcohol, or other addictive substances or activities (in case of process addictions) that the prefrontal cortex is outmuscled by the reward centers of the brain, overpowering reason, resolutions, willpower, and promises. This explains Gerard Evan’s (organizational psychologist) observation that

“an addict is willing to give up everything for one thing so they can have everything” (1990). We know about the long list of drug-addicted famous artists (Goya, Bosch, Baudelaire, Rimbaud...) and many of alcoholic writers, painters, and musicians. However, the relationship between the creativity and the disruption of the senses remains rather obscure. There are, of course, creative people with no interest in drugs and alcohol, and addicts with no talent or creativity. Moreover, while there were painters, musicians, writers, for example, whose productivity depended on drugs, there were others, who were destroyed by drugs or alcohol. Whether addictive substances use increases or destroys creativity remains a moot question. Nevertheless, there does seem to be a high incidence of drug use among artists. May be that what addicts and creative people (not just artists) have in common is a penchant for risk-taking, a desire for “living on the edge” of possibility. In this sense, addiction and creativity may share a common characterological denominator rather than a casual relationship.

This idea is present in Bateson’s [10] theory of alcoholism, and in the works of existential analysts (for example, Fromm, 1992) [11]. They all have a sustained interest in the risk-taking, in the outsidersness (maverick), and even in a drive to self-destruction.

The psychodynamic approaches to alcoholism are present in AA practice, although the AA organization promotes the disease model, its methods addresses psychological needs and facilitates lasting structural personality change [12]. These approaches to drug addicts support the existence of the association of personality disorder and depression with the development of drug addiction [13].

Treece [14] concluded that the key factor differentiating the chronic drug addict from the controlled or casual abuser is the presence in the former of severe personality disorder. Compared with alcoholics, drug abusers are much more likely to have significant coexisting psychiatric disorders.

Treatment reveals often that the addict without realized addiction is psychologically flat and passionless person. Psychodynamic therapy of addicts requires recognizing that their return to “normality” may seem more boring existentially than they can bear. So, the psychodynamic therapy of addicts requires that their need for passion and risk-experience be taken into account, not as the sign of “neurosis”, but as a legitimate element of motivation.

In this sense, Binswanger [15] wrote that addiction is “not only a somatically conditioned need but at the same time the need for filling up the existential emptiness or craving”.

Psychodynamic approach creates a deliberate focus on the innovative clinical thinking. This kind of thinking is encouraged by exploration of the sometimes-surprising contributions to the traditional psychiatry of ideas and findings from other fields, for instance, from biology, religion, philosophy, anthropology, culture in general.

Interestingly, part of what makes people with substance use disorder often so unsympathetic is that they themselves can lose sight of empathy. They can become so consumed by their addiction that they no longer take into account the thoughts and feelings of other people, including even the ones they love. The truth is that they do still care but the empathic centers of their brain have been hijacked by addictive process.

Psychodynamic psychotherapy is essential to the care not only addictions but of many diagnostic groups of psychiatric patients. It can be crucial for depressed patients, especially for those who are resistant or simply cannot take antidepressant medication [16].

In the use of psychodynamic psychotherapeutic approaches with clients suffering from problems connected with existential problems, in part with persons located in the zone of borderline personality organization and borderline personality disorder. We use the phenomenon of the “background presence of primary identification”. It is phantasies and mythical counterpart of E. Erickson’s concept of epigenesis. The persons feel a sense of comfort that someone stands behind them in their effort to face the world. The Background Presence of Primary Identification (BPPI) is a background of safety. It regulates the relationships between “I” and its interpersonal objects, much as placenta did in utero.

BPPI evolves from being a co-participant in the mysterious oneness of primary identification to a spiritually protected person. This psychodynamic takes place probably already as infant accepts separation and find the confidence to use his or her epistemophilic capacities, designated as K by Bion [17] in conjuncture with libidinal organization as Bion's L and their inherent undifferentiated defense organization, sometimes known as the aggressive drive or the death instinct, H. The BPPI helps the patients to concentrate the K, L, and H.

The clients may experience of BPPI as designating a greater sense of I-ness, one that is preternatural and thus beyond their rational reach. BPPI opens the way for the free associations descending from a greater Truth than it is possible to access.

The "I" of clients with activated BPPI moves in a benevolent shadow of something that is all-hovering although ineffable.

BPPI in our clients was activated by the wide utilization of the specific narratives. In the structure of the psychodynamic psychotherapeutic sessions, the periods of listening attitude (appropriate so long as the client has not unconsciously indicated the need for verbal intervention) should be combined with an activation of client's narratives. Listening is a "holding" intervention that encourages unconscious communication that can be expressed in narratives. Narrative is the basic form of language more ancient than non-narrative speech. Stone Age humans told stories around the camp-fire as a form of recreation and social regulation. In telling stories, our ancestors sent unconscious signals to one another about everyday events and social interactions. Narration includes the expression of episodic memory and can also be creative. Client as a writer of fiction may invent narratives. Narration is an extremely important capacity. The stories that clients tell during session are often highly meaningful responses to their analysts' management of the ground rules of analysis. Violations of the ground rules (rules of psychoanalytic frame) normally evoke negatively-toned narratives [18]. By examining the client's narrative, the therapist "heard" the unconscious communication, and senses what needs to be done in order to make correct interpretation.

All of the narrative material presented by the client in therapeutic session relates to the immediate encounter as an unconscious commentary on the therapist's actions. Therapist can decode this unconscious commentary on their work and access the client's accurate observation of the interpersonal reality of the interaction [19].

Realizing psychodynamic approaches, we [20-22] observed and revealed the mild form of personality disturbance that, contrary to forms of personality disorders that are present in DSM 5 or ICD 10, is "anti-addictive" one. This form was called "temporal lobe personality". The clients with this disturbance expressed no tendency for the use of any addictive substances, so more for the development of narcotic addiction. It was linked with their power of imagination, with the ability for their ability to fantasize, daydreaming, for an easy escape from the disturbing inner and outer reality into the comfortable world of wishful thinking and feelings orientating exclusively on their own mental resources. The persons with the traits typical for temporal lobe personality experience serious troubles with the adjustment to the challenges of modern and especially postmodern society. Nevertheless, traditional psychiatry with its predominantly biologically oriented therapeutic approaches is not the best tool for helping these categories of clients which do not suffer from organic brain damages that degrade one's psychological capacities at the biological level and call for psychopharmacological intervention. So more, the response on the use of psychopharmacological drugs in the persons with temporal lobe characteristics is usually unpredictable. These clients need the utilization of psychodynamic psychotherapy oriented on the establishment of empathic atonement, mutual trust and understanding that includes the deciphering of encoded messages from the deep unconscious wisdom system [23,24].

### Bibliography

1. Ellenberger H F. "The Discovery of the Unconscious". The History and Evolution of Dynamic Psychiatry, New York, Basic Books (1970).
2. Gabbard GO. "Psychodynamic Psychiatry in Clinical Practice". Washington, DC, London. American Psychiatric Press (1990).
3. Tustin F. The Prefecture Shell. In Children and Adults. London. Karnac (1990).
4. Fairbairn WRD. "A revised psychopathology of the psychoses and psychoneuroses". In Psychoanalytic Studies of the Personality. London. Routledge. Kegan Paul, 1952 (1941): 28-58.

5. James W. "The Varieties of Religious Experience". New York. Collier 1961 (1902).
6. Summers RE and Barber JP. "Psychodynamic Therapy: A Guide to Evidence Based Practice". New York. London. Guilford Press (2010).
7. Kernberg OF. "Psychoanalysis, Psychoanalytic Therapy, and Supportive Psychotherapy". Contemporary Controversies". *International Journal of Psychoanalysis* 80 (1999): 1075-1091.
8. Luborsky L. "Principles of Psychodynamic Psychotherapy: A Manual for Supportive-Expressive Treatment. New York. Basic Books (1984).
9. McWilliams N. "Psychoanalytic Psychotherapy: A Practitioner's Guide". New York. London. Guilford Press (2004).
10. Bateson G. "Step to an Ecology of Mind". New York, Ballentine Books (1972).
11. Fromm E. "The Crisis of Psychoanalysis". New York. Holt, Reinhart, Winston (1992).
12. Mack J., et al. "In Dynamic Approaches to the Understanding and Treatment of Alcoholism". M Brown, N Zinberg (eds.). New York. Free Press (1981): 128-162.
13. Blatt S J., et al. "Psychodynamic Theories of Opiate Addiction: New Direction for Research". *Clinical Psychology Review* 4.2 (1984): 159-189.
14. Treece C. "Assessment of ego functioning in studies of narcotic addiction in the broad scope of ego function assessment". L. Bellak, L. Goldstein (eds.) New York. John Wiley (1984): 268-290.
15. Binswanger L. "The Case of Ellen West". In Experience RM May, G Angel H. Elenberger (eds) New York. Basic Books (1958).
16. Ursano RJ., et al. "Psychodynamic Psychotherapy". Third Edition. Washington, DC. London. American Psychiatric Publishing Inc (2004): 244.
17. Bion W. "Transformations". Heinemann Medical Books". Reprinted Karnac (1965).
18. Langs R. "A Clinical Workbook for Psychotherapists". London. Karnac (1992).
19. Smith D. "Hidden Conversations: An Introduction to Communicative Psychoanalysis". London. Routledge (1991): 285.
20. Korolenko Ts. "Postpsychiatry in the Regions of Russian North. Proceedings of the 14<sup>th</sup> International Congress on Circumpolar Health. S. Chartwood, T. Orr (eds.). Yellowknife (2009): 432-455.
21. Korolenko Ts and Korolenko T. "Temporal Lobe Personality in the Traditional Culture in Siberia". Annual Meeting Integrating Medicine and Psychiatry in Multi-Ethnic Settings. Abstract 2-4 (2011).
22. Korolenko Ts., et al. "Clinical Traits of Temporal Lobe Personality in the Inhabitants of North Siberia". *American International Journal of Contemporary Research* 2.9 (2012): 13-19.
23. Alon N and Omer H. "Demonic and tragic narratives in psychotherapy". In A. Lieblich, D McAdams, R. Jacobson (eds). "Healing Plots". The narrative basis of psychotherapy. Washington, DC. APA Books. Stanley Kubrick (2004): 29-48.
24. Egen G. "The Skilled Helper: A Systematic Approach to Effective Helping". 4<sup>th</sup> edition Pacific Grove, CA. Brooks-Cole Publishing (1990).

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