

# ***Shrinks: The Untold Story of Psychiatry,*** **by Jeffrey A. Lieberman, M.D., with Ogi Ogas:** **A Critical Discussion**

## **Editorial**

*Shrinks: The Untold Story of Psychiatry*, By Jeffrey A. Lieberman, M.D., with Ogi Ogas. Little, Brown, 352 pp., illustrated, \$28

## **INTRODUCTION**

Although book reviews customarily appear in the “Book Review” section of this journal, *Shrinks: The Untold Story of Psychiatry* warrants an editorial because of Jeffrey Lieberman’s role in American psychiatry and the controversial nature of the book.

A central theme of the “untold story” is the assertion that psychoanalysis exerted a negative influence on the diagnosis, understanding and treatment of mental illness in the United States for three or four decades following World War II. Lieberman characterizes psychoanalysts who practiced and published articles during this period as “charlatans” (pp. 85, 109), similar to alchemists, venal hucksters who coddled the affluent worried well while assuring themselves and the general public that they were physicians of the mind. He contrasts this tale with the uplifting story of biological psychiatry. Because of advances in the biological sector, the mentally ill can at long last receive appropriate treatment, and Lieberman divides psychiatrists into two groups: heroes and “shrinks.”

*Shrinks* is a troubling discussion of a troubled profession. Lieberman states that he wrote the book “with” Ogi Ogas, but Ogas’ role in preparation of the manuscript is unclear. Lieberman acknowledges Ogas as follows: “...a skilled writer and neuroscientist, Ogi and I bonded and

became virtual Siamese twins for eighteen months while developing the story and creating the manuscript" (p. 318).

The Deputy Editors of *Psychodynamic Psychiatry*—psychoanalysts Drs. Jennifer Downey and César Alfonso—often contribute to these editorials. Both work in the Department of Psychiatry at Columbia University of which Jeffrey Lieberman is the Chair. I felt that it was important not to place our Deputy Editors in an awkward position professionally, so accordingly they were given no role in contributing to this Editorial.

### SERIOUS MENTAL DISORDERS ARE COMMON

According to studies representative of the general population, about 20% of Americans suffer from a major psychiatric disorder at any given time, and about 50% during a lifetime (Kessler, Chiu, Demler, & Walter, 2005). Millions of dollars are spent on treatment and many millions more on time lost from the workforce because of impaired function for behavioral reasons (Lazar, 2010). Lieberman's historical approach to psychiatry and aspects of his discussion are therefore relevant to the general public. He is at his best when discussing the discovery of psychotropic medications, the treatment of the mentally ill prior to the twentieth century, and the contributions to psychiatry by seminal figures such as Kraepelin and more recently Robert Spitzer and Eric Kandel.

### PSYCHIATRIC DIAGNOSIS

As Lieberman points out, accurate diagnosis of mental disorders has bedeviled psychiatrists over the years. In the United States, the most commonly accepted diagnostic criteria are listed in the *Diagnostic and Statistical Manual of Mental Disorders* published (and updated regularly) by the American Psychiatric Association. Lieberman's description of the crucial change in conceptual framework from *DSM-II* (1968) (psychoanalytic) to *DSM-III* (1980) (descriptive and atheoretical) is informative. The methods used in the most recent, fifth edition of the *DSM* have been criticized by Dr. Thomas Insel, the Director of the National Institute of Mental Health, who has suggested a different, more biologically-based conceptual model for mental disorders. A prominent group of psychoanalytically oriented researchers and scholars has independently published a text discussing yet a different diagnostic approach (PDM

Task Force, 2006). The most important criticisms of the *DSM* are that it is organized around lists of psychiatric symptoms but should be based on psychobiology and that it ignores narrative experience and therefore does not illuminate the subjective context within which psychological symptoms occur. There is other criticism as well, especially that lists of symptoms have a way of being placed in ever-changing groups, leading to the apparent “discovery” of “new” disorders. This, in turn, can lead to new markets for (biological) treatments and the increasing pathologization of everyday psychological experience (Frances, 2013).

Despite these problems, I agree with Lieberman that *DSM-III* marked an important step forward in the history of psychiatry. For the first time, psychiatric disorders could be diagnosed *reliably*. Independent clinicians interviewing the same patient would reach the same diagnosis most of the time. Prior to 1980, when the *DSM-II* was first used and the conceptual framework was psychoanalytic, reliability of diagnosis was not achieved.

Lieberman appropriately credits Robert Spitzer, a research psychiatrist and professor at Columbia University Department of Psychiatry, with leading the effort to improve diagnosis of psychiatric disorders by chairing the *DSM* Committee of the American Psychiatric Association. Spitzer’s leadership has been lauded in many settings, but still cannot be overemphasized. The etiology of most mental disorders was (and remains) unknown. A crystal clear way of describing symptoms was necessary to guide clinicians. The contributions of the Washington University group under the leadership of Feighner are clearly described (Feighner, Robins, Guze Woodruff, Winokur, & Munoz, 1972). The ideas of Feighner and colleagues at Washington University were then developed by Spitzer and colleagues and ultimately shaped the organization of *DSM-III*.

## DRUG TREATMENT

Avoidance of inconvenient information is common in the worlds of advertising and politics but is unacceptable in academia. The pronounced lack of balance in Lieberman’s book speaks, in my opinion, to persuading rather than informing. The story of the search for diagnoses, causes and treatments of mental illness should be told with the dispassionate fairness of an historian or an investigative reporter. Unfortunately, Lieberman fails to meet this standard. His critique of psychoanalysis, although it contains elements of truth, deteriorates into an ill-informed, mean-spirited rant against a method of treatment

which in its updated forms continues to provide needed and valued assistance to many people (Auchincloss, 2015, Hoffman, 2015).

### SIDE EFFECTS

Psychopharmacology, Lieberman's specialty, is treated with kid gloves with virtually no discussion of the side effects of psychotropic agents. Side effects of psychiatric medications are a known entity for all medical providers. The first generation of antipsychotics sometimes caused tardive dyskinesia after long-term use. The newer antipsychotics can increase the likelihood of diabetes mellitus, alter lipid profiles for the worse and contribute to obesity. The three major mood stabilizers used to treat bipolar disorder all cause weight gain as well as numerous other problematic side effects (Schatzberg & Nemeroff, 2009; Taylor, Paton, & Kapur, 2015).

Modern practitioners are grateful for the discovery of the SSRI (Selective Serotonin Reuptake Inhibitor) drugs. These medications are effective antidepressants and are also helpful in the treatment of anxiety disorders, obsessive compulsive disorders and sexual deviations. Unfortunately, these widely prescribed medications also have serious side effects. They may increase suicidality in depressed patients, especially younger patients. They may cause weight gain and a dulling or flattening of affect.

Most commonly however, SSRIs depress sexual desire and interfere with sexual performance or both. These medications are often prescribed long term and their influence on romantic/sexual relationships can be very problematic. Despite the fact that countermeasures may be taken to overcome these adverse effects, ameliorative drugs are often ineffective, or cannot be prescribed for one reason or another. Psychiatric practitioners today routinely prescribe SSRIs and just as routinely struggle to help their patients maintain an acceptable sexual quality of life (Schatzberg & Nemeroff, 2009; Taylor et al., 2015).

### PSYCHIATRY AND THE DRUG INDUSTRY

The history of the troubling relationship between organized psychiatry and the drug industry is entirely omitted by Lieberman. Is it reasonable to infer that he hopes that this remains part of the *untold* story of psychiatry? Some psychopharmacologists have profited from their close relationships with drug companies, which in and of itself is not wrong, but may allow for influence on research findings. Some drug companies have withheld important data about the efficacy of their

drugs and inflated claims of successful outcomes. The influence of the pharmaceutical industry on American psychiatry has been discussed in depth elsewhere by recent scholars (Frances, 2013; Kirsch, 2010; Whitaker, 2010; Whitaker & Cosgrove, 2015).

In his discussion of medications and pharmacological treatments, Lieberman omits a number of areas, which I consider important. Lieberman does not discuss the placebo response—which is particularly important for clinicians to be informed about in order to fully understand drug studies of therapeutic efficacy (Papakostas, Otergaard, & Lovieno, 2015). Lieberman also does not discuss the fact that drugs, undoubtedly useful, are rarely curative, or that there are presently no known biological markers for major psychiatric disorders. He omits a discussion of chronic and recurrent psychiatric disorders, the role of poverty or social support in mental illness, the therapist-patient relationship or treatment non-adherence (e.g., patients who won't take medication, or begin a course of drug therapy and unilaterally discontinue it). Unconsciously motivated self-destructiveness may be an important influence in treatment non-adherence and psychoanalytic insights about the negative therapeutic reaction may shed light on patients' motivations to undermine the therapeutic endeavor.

## DISCUSSION OF PTSD

Lieberman's discussion of Post Traumatic Stress Disorder (PTSD) is misleading and weakened by avoidance of clinical issues. He points out that the processes involved in PTSD "involve three brain structures, the amygdala, the prefrontal cortex and the hippocampus" (p. 265). He then implies that since we now understand the neurobiology of PTSD we have effective therapies to treat people who suffer from it. Sadly, this is not the case! There are no medications or psychotherapeutic techniques that are reliably effective in treating this very debilitating and common disorder (Moore & Penk, 2011). Here the distance between neurobiological research and clinical efficacy is substantial.

Antipsychotic medications are unfortunately likely to be over-used to treat PTSD despite the fact that they have serious side effects and no proven efficacy. This was most recently demonstrated in a study of 186,460 veterans of the Iraq and Afghanistan wars who had PTSD, were not bipolar or schizophrenic, yet 35,000 were prescribed antipsychotic medication (Cohen, Shi, Neylan, Maguen, & Seal, 2015). They tended to have comorbid diagnoses such as personality disorders or substance abuse but not specific indicators supporting the use of antipsychotic drugs.

As someone who once directed a military hospital for psychiatric casualties during the Vietnam War, I have followed the PTSD story with great interest. To this date treatment depends on accurate assessment, not only of the trauma itself but of the patient's history and mental status. My own view, based on clinical experience and the vast literature on the subject, is that PTSD must be understood from a developmental bio-psycho-social perspective. A developmental psychodynamic approach, while unable to provide a total map of etiological bio-psychological relationships in PTSD, often provides a model of the mind that helpfully informs a treatment strategy.

### DEPTH PSYCHOLOGY

Lieberman does not discuss how complex a task it is to understand people. His clinical vignettes are uplifting, but often avoid discussing really difficult clinical problems. These difficult clinical issues often stem from severe *ambivalence*, a psychiatric and psychoanalytic concept. Many patients behave in ways that are inconsistent, and seem to seek opposite goals simultaneously. Often they express opposite feelings at the same time, or in rapid succession. There is no single "modern method" for assisting someone who simultaneously loves and also hates her child, or his sexual companion. There are, however, a number of therapeutic techniques, most of which have been based on the clinical insights of pioneering psychoanalyst-psychiatrists. There is no pill, no descriptive solution to the conundrum of helping this type of patient, especially since she or he may be prone to "loving but also hating" the physician as well. The patient may in fact need a diagnostician who understands irrational motivation—an area Lieberman also avoids.

This apparent lack of awareness of the historical lines of psychoanalytic thought, upon which much modern psychotherapy is based, raises questions, for me, about the breadth of his clinical sophistication.

For example, he states, "The great benefit of psychoanalysis, Freud insisted, was the fact that hypnosis worked on only about one-third of patients while psychoanalysis worked on everyone" (p. 53). The implication here is that Freud thought that psychoanalysis was an effective and universally applicable therapeutic method. He did not. Freud fully realized that the therapeutic value of psychoanalysis was often limited, might not be helpful in specific cases and was not an effective treatment of serious and chronic psychotic disorders. He was actually more enthusiastic about the use of psychoanalysis as an investigative method than a therapeutic technique. Freud recognized that the neurosciences were primitive in his day and he hoped that much would be

gleaned from scientific studies of the brain in the future (Freud, 1905, 1937). The results of his own psychoanalytic efforts were mixed. Some of the patients he treated did well, others did not (Breger, 2001). The term “psychoanalysis” had a different meaning at various phases of Freud’s life than it does to clinicians today. For example, Freud’s “psychoanalysis” of the composer Gustav Mahler consisted of an intense talk for a few hours during a walk in the park. Mahler, who consulted Freud because of depression, found this brief intervention quite helpful even so (Feder, 2010).

### LIEBERMAN ON PSYCHOANALYSIS: A CLOSER LOOK

Lieberman writes, “[W]e shake our heads now at his conviction that young boys want to marry their mothers and kill their fathers, while a girl’s natural sexual development drives her to want a penis of her own...many of Freud’s less credible conjectures would have been scrubbed away ...if they had been treated as testable hypotheses...” (p. 56). In thinking about this point it is important to emphasize that the term “psychoanalysis” has many meanings. It refers to depth psychology and its application to clarify symptom formation as well as non-pathological psychic phenomena such as slips of the tongue (Freud, 1901). “Psychoanalysis” also refers to a professional/political movement and to a method of psychological treatment which has changed over the years. Today it tends to refer to intense, lengthy psychological treatment that is based on a few central concepts including the influence of unconscious conflict on motivation, transference, resistance, free association and the importance of the therapeutic relationship (Auchincloss, 2015).

In criticizing Freud for being antiscientific and intolerant of dissent Lieberman almost takes credit for discovering the wheel. A long line of critics have indicted psychoanalysis for being antiscientific (Breger, 2001; Crews, 1996; Fisher, 1973; Fisher & Greenberg, 1977; Grunbaum, 1985; Sulloway, 1979). Freud’s dogmatism and imperious narcissism was expressed quite early in the history of psychoanalysis. As Louis Breger has pointed out, this was a major reason that Breuer, Freud’s original collaborator in creating psychoanalysis, broke with him (Breger, 2009). Later Eugen Bleuler, the Director of the Bergholzi Hospital in Switzerland who had studied with Freud, also withdrew from the burgeoning psychoanalytic movement because of Freud’s intolerance of dissenting views (Freud, 1914). A small army of dissenters followed. Karen Horney deserves special mention here since one of Freud’s important limitations concerned his misunderstanding of the basis for sex

differences in behavior. Freud attributed this to penis envy which he viewed as an aspect of biology. Horney challenged this, emphasizing the importance of socio-cultural influences, and presented her views openly and in Freud's presence (Horney, 1924). (Interested readers will find a discussion of Freud's erroneous theories about penis envy and castration anxiety in a book by my colleague Jennifer Downey and me [Friedman & Downey, 2002].)

The social/political structure of the psychoanalytic movement was modeled on Freud's dogmatic insistence of the validity of his core assumptions which he considered discoveries. Many scholars, including myself, believe that psychoanalysis was wounded because of this. Lieberman points out that during the years when psychoanalysis was most influential in American psychiatry it did not function like a scientific organization, but resembled a religious order. He does not mention the scholars who attempted to bridge the gap between science and psychoanalysis, however (Engel, 1962; Masserman, 1958; Reiser, 1984; Stoller, 1968).

I find that Lieberman's contemptuous tone in considering Freud's ideas is unwarranted. Biological psychiatry did not offer acceptable theories of mental functioning during Freud's lifetime. Many of Freud's formulations proved incorrect, but mocking them makes little sense since future historians will undoubtedly criticize our current medical theories and practices as well.

## PSYCHOANALYSIS AND JUDAISM

This section of *Shrinks* was, to me, particularly distressing and poorly thought out. In commenting on the fact that in the recent past most academic psychiatrists were *Jewish* psychoanalysts, Lieberman likens psychoanalysis to the spread of an infectious disease (p. 64). He cites Freud's comments to Jung while en route to the United States to deliver the Clark lectures: "They (e.g., the Americans) don't realize we are bringing them the plague." Lieberman then goes on to elaborate, "Freud's comment would eventually seem more prescient than he realized" (p. 64).

Lieberman also discusses the psychoanalytic movement as an organized conspiracy designed to invade and control American psychiatry.

Knowing that the path to influence ran through medical schools and teaching hospitals, psychoanalysts began to *target universities*....[E]ach new conquest [e.g., Department Chair of Psychiatry by a psychoanalyst] was celebrated as a triumph within the psychoanalytic movement. (p. 74, my italics)

Having *conquered* academic psychiatry and created an industry of private practice for this specialty, American psychoanalysts reevaluated the potency of their therapeutic *métier* and now concluded it was even stronger medicine than originally believed. (p. 78, my italics)

How is one to understand this type of writing? I found myself reluctantly and painfully recognizing that it is similar to the style of invective routinely used in anti-semitic propaganda, including that used in Germany in the 1930s and '40s. By this I mean labeling psychoanalysts as a group of "outsiders" led by a Jewish mastermind—"Sigmund Schlomo Freud" (p. 39) who infect native institutions and simultaneously attempt to conquer and control them.

This depiction of psychoanalysis is both prejudiced and superficial. Modern physics was ushered in by Albert Einstein, a Jew who published his revolutionary theories contemporaneously with Freud and, like Freud, became a refugee. Leo Szilard, Edward Teller and J. Robert Oppenheimer were all Jews, yet physics is not usually thought of as the product of a persecuted minority group. Emile Durkheim, the founder of modern sociology, was Jewish but sociology is not considered a Jewish discipline. The Jews that survived the holocaust, including many psychoanalysts, were resilient, generative, sturdy, and energetic and made seminal contributions to many fields.

When Lieberman refers to the 1960s, he makes the observation that the vast majority of academic psychiatrists were psychoanalysts, and this is correct. At that time, biological psychiatry was in its infancy and offered no integrative conceptual model of motivation or psychological development or treatment. Most controlled studies of psychotropic drug efficacy had not yet been carried out. Psychoanalytic models seemed based heavily on the clinical experience of psychoanalysts and not entirely on dogma. Even so, the criticism that psychoanalytic paradigms were the only conceptual framework taught to psychiatric residents was often accurate.

To understand how this came about requires much more data and careful scholarly work than Lieberman provides and is, also, outside the scope of this editorial. I feel that his discussion of this topic is largely superficial, even casual, given the seriousness of his assertion.

For example, he states, "By 1910 psychoanalysis had become the treatment du jour in continental Europe...especially among affluent Jews" (p. 59). Read in 2015, this statement is misleading.

Lieberman neglects to point out that psychoanalysis as we know it today did not exist at that time. The term was used to refer to techniques that were just being discovered and new approaches that were being tried out. Patients who needed help understandably turned to a

new discipline that seemed promising at the time. Lieberman seems disappointed that in 1910 Freud did not design research based on comparing outcomes between groups that received “treatment”—psychoanalysis—and groups that received no treatment. Exactly how Freud, in 1910, could have carried this out is a bit of a mystery.

### THE WORRIED WELL

Lieberman’s opinion that psychoanalysts primarily treated (and continue to treat) the “worried well” is contradicted by evidence. He states: “Instead of wearing white coats and shouldering through a daily grind of raving and catatonic inmates, psychiatrists could chat with well-heeled businessmen about their childhood memories and gently guide well-coiffed matrons through their free-associations” (p. 72). Sometimes this did happen of course, just as some psychiatrists prescribed pills for profit regardless of the welfare of patients.

Indeed in the 1970s Valium was the most commonly sold drug in the United States (Sullivan, 2005). One could easily depict pharmacologists of the ‘70s in precisely the same way as Lieberman depicts psychoanalysts. Is it not credible to suggest that some (many?) chatted with wealthy businessmen and gently guided well-groomed matrons through their anxious worries? I intentionally frame the issues in provocative terms to make a point about Lieberman’s style, not because I mean to disparage pharmacologists. I certainly do not. Abuses of therapeutic modalities are regretful but they occur across disciplines. Norman Doidge studied psychoanalytic patients and reported that they tended to have serious psychopathology and clearly were not the “worried well” (Doidge, 1997; Doidge, Simon, Lancee, First, Brunshaw, Brauer et al., 2002). A study I directed at The American Academy of Psychoanalysis and Dynamic Psychiatry independently found the same result (Friedman, Garrison, Bucci, & Gorman, 2005). Our group wished to collect information about the precise characteristics of patients treated about 15 years ago in private practice by medical psychoanalysts. We were specifically interested in whether they were the worried well. Each of the 51 experienced psychiatrist/psychoanalysts was queried about the clinical characteristics of *every* private psychotherapy patient presently in treatment. To avoid selection bias psychoanalysts were not allowed to select patients for investigation. Psychology graduate students systematically interviewed the analysts using the *DSM-IV* as a research instrument. We found that 88% of patients had an Axis I Disorder, 59% had Axis I and Axis II Disorders concurrently, and 11% had only an Axis II disorder. Most of the patients appeared to be seriously

psychiatrically disturbed although not hospitalized. Forty-four percent of the patient sample was treated with *both psychotherapy and psychopharmacology*. Of the 551 patients, 80 had experienced childhood sexual abuse, 95 had a family history of severe mental illness, 30 had both family history of severe psychiatric illness and childhood history of sexual abuse, 15 were presently being treated for a psychotic disorder and 130 for a major mood disorder. The most severely ill patients were treated for the longest time; often years. A subsequent investigation by Sandell, Blomberg, Lazar, Carlsson, Broberg, and Schubert (2000) found that frequency of sessions and duration of treatment are separate and potentially additive contributors to psychotherapeutic treatment efficacy.

This is not to say that the psychoanalytic profession bears no responsibility for taking a wrong turn in the two decades immediately following World War II. The emphasis on treating high functioning neurotic outpatients who could attend the private offices of psychoanalytic practitioners three to five times per week was a reality then and is part of the history of psychiatry. Much of this occurred prior to the time when efficacious psychotropic medications were available, however.

The development of other types of talk therapy, such as Cognitive Behavioral Therapy (CBT), did not replace the need for and widespread practice of psychodynamic psychotherapy. The diversity of psychopathology in the general population is very great, and there is a corresponding need for therapeutic flexibility and the use of multiple types of therapy in order to adequately treat the different types of patients who need assistance.

Many psychiatric patients have multiple disorders (such as co-morbid alcoholism, bipolar disorder and obsessive compulsive disorder). They have past histories of severe trauma and often live in chaotic social environments, without financial resources. There is no simple "biological" treatment for these patients. There are many interventions which are useful in treating single *episodes* of illness. Treatment of the whole person, however, is by no means simply a matter of dressing in a white coat and proclaiming the virtues of "modern psychiatry."

This is perhaps most dramatically illustrated in considering the treatment of patients with chronic schizophrenia—an area in which Lieberman has specialized. To date there is no drug which cures these patients even with long-term administration and compliance. It is generally accepted that the term "schizophrenia," like the term "cancer," refers to many disorders. Some of these may seem similar in the way that they present but differ with respect to etiological factors and particularly neuro-biological intermediate mechanisms. Many patients who are "schizophrenic" are best understood using a bio-psycho-social paradigm and are best helped by pharmacological, psychological and social

interventions. On one hand, a psychodynamic approach may be a helpful part of an integrated treatment plan (Robbins, 2012). On the other hand, some schizophrenic patients might not respond to psychosocial interventions even with the addition of psychopharmacological agents.

## HOMOSEXUALITY AND PSYCHOANALYSIS

The response by contemporary *psychoanalysts* to the radical change in *psychiatric* ideas about homosexuality was initially guarded, but soon became accepting. Today members of the LGBT community can and do receive appropriate psychotherapeutic treatment when needed. This treatment is based on accepting their sexual orientation as a core part of their identity. In the not so distant past, however, this was impossible and conversion from homosexual to heterosexual was assumed to be an indicator of successful psychotherapy. How did this change come about? Lieberman vividly recounts the way in which organized psychiatry in the United States changed its view of homosexuality. He emphasizes the effective and farsighted role that Robert Spitzer played in accomplishing this. Spitzer was fearless and stood for the best values of science and medicine. Deleting homosexuality from the *DSM* was one of the most important accomplishments of psychiatry in the twentieth century.

However, Lieberman does not discuss what happened next—which for me is a crucial part of the “untold story” of the relationship between psychiatry and psychoanalysis. The response by organized psychoanalysis to psychiatry’s radical decision was initially cautious. The events that led up to the decision to delete homosexuality from the *DSM* were turbulent and even rowdy at times. Many psychoanalysts believed that the American Psychiatric Association had buckled under political intimidation by gay activists. There was a widespread conviction that homosexuals had not resolved their unconscious oedipal conflicts. At that time it was believed that to develop a normal conscience structure a boy had to identify with his father. Male homosexuality was regarded as proof that this had not occurred. An argument against the conservative psychoanalytic perspective was that all the psychoanalytic evidence about homosexuality had been based on case reports of men in psychoanalytic treatment. Psychoanalysts had generalized from studies of patients to make assumptions about homosexuality in the general population. At that time all psychoanalysts were assumed to be heterosexual, though undoubtedly many hid their homosexuality from everyone, including their own psychoanalysts.

In 1988, I decided to carry out a research study that would bring evidence to bear on the fundamental question of the pathological nature of male homosexuality by studying hormones and psychodynamics in well-adjusted male homosexual and heterosexual non-patients. I was influenced by a classical study that demonstrated that it was not possible to distinguish homosexual from heterosexual non-patients on Rorschach tests. This indicated that homosexual men did not have pathological psychodynamics (Hooker, 1967). I concluded that homosexuality was not pathological *from a psychoanalytic perspective*, not just a psychiatric perspective. My research led me to believe that psychoanalysts needed to change their theories of psychosexuality rather than attempt to change the sexual orientation of gay patients (Friedman, 1988).

My research was fully supported by Lawrence Kolb, chairman of the Department of Psychiatry at Columbia at the time and a psychoanalyst who had previously accepted traditional psychoanalytic ideas about homosexuality. A friend and colleague, psychoanalyst Richard Isay, reached the same conclusion about homosexuality based on his personal experience of being gay (Isay, 1989). Although Isay and I did meet defensive responses initially, American psychoanalysts rather quickly accepted being criticized from within. For the most part they were thoughtful and ready to recognize that they had been in error.

Revision of psychoanalytic ideas about sexual normalcy and pathology led to the acceptance of LGBT faculty in psychoanalytic institutes. Although relatively few people today are treated by “psychoanalysis”—3–5 sessions per week for a few years—many are treated with psychodynamically oriented psychotherapy. Throughout the world, psychodynamically oriented psychotherapy is administered by psychiatrists, psychologists, social workers, and nurses to thousands of patients per year. The change in the psychosexual developmental model by this vast number of psychotherapists has had widespread consequences within the general population, where the opening up of attitudes and values about homosexuality occurred as well.

As Lieberman himself points out toward the end of *Shrinks*, an integrative approach is greatly needed in modern psychiatry in which biological and psychosocial influences and responses complement each other. It is hard to understand how his book can help that happen while dividing psychiatrists into two groups—“heroes” and “shrinks.”

## REFLECTIONS ON MODERN PSYCHODYNAMIC PSYCHIATRY

Modern psychodynamic psychiatry remains built on a foundation of psychoanalytic ideas that were formulated and usefully applied in

clinical work during the very years that Lieberman accuses the field of being dominated by magicians and astrologers. At the same time today's psychoanalysts are fully aware that modern medicines make it possible for patients to respond to psychotherapy now who would have been resistant to it in the past.

On a personal level, I read and reread many of Freud's articles to this very day. I am well aware of modern biological discoveries about depression, for example, but the discoveries do not reduce the value of "Mourning and Melancholia" (Freud, 1917). Modern psychodynamic psychiatrists regularly refer to numerous psychoanalytic publications of past years and integrate what we glean from these writings with current biological advances. Though many of these psychoanalytic articles written 50, 75 or even 100 years ago seem outdated, odd and sometimes ridiculous today, the same could be said of biological articles published at the same time.

Psychoanalysis began with Freud's and Breuer's clinical reports of patients with hysteria and conversion reactions (Freud & Breuer, 1895). To this very day there is no somatic treatment for conversion reactions. Biological psychiatry offers no paradigm for understanding these patients and they are still best understood in psychoanalytic terms (Kaplan, 2014). Classical psychoanalytic ideas formulated during the so called "dark ages" of psychoanalytic thought inform modern understanding of treatment resistance (Plakun, 2012), the negative therapeutic reaction and its relationship to internalized homophobia (Friedman & Downey, 2002), psychology of borderline patients (Stone, 2012), intimate partner violence (Levendosky, 2013) and many other areas. Modern long-term psychodynamic psychotherapy has been empirically studied and was found to be effective in treatment of patients with complex chronic psychiatric disorders (Leichsenring & Rabung, 2011; Leichsenring, Salzer, Beutel, Herpertz, Hiller, Hoyer et al., 2014; Levy, Ehrental, Yeomans, & Caligor, 2014).

## CONCLUSION

On the front and back cover of *Shrinks* is a vacant, red couch—Lieberman's symbol of...what? Incompetence? Sexual seductiveness? The cover seems to express his view that American psychiatry was falsely led by an empty couch, the equivalent of an empty suit. Possibly the vibrant red color suggests that Lieberman is criticizing psychoanalysis for a sybaritic quality. Or, perhaps, red was chosen simply as a marketing device, a tempting lure enticing potential customers to buy the book. And what of the word "shrinks"? Lieberman might have simply

been deconstructing the use of the term in mass culture, but I don't think so. Rather, I believe that he joins with those who use "shrink" as a term of devaluation. In doing so, he seems to take the role of Gulliver amidst the psychoanalytic Lilliputians.

*Shrinks* is written in a popular style for a lay audience. It has academic ambitions, but dispenses with academic conventions. There are no references documenting the assertions and conclusions and no footnotes; there is simply a list—surprisingly brief—of "sources and additional reading" at the end. In expressing opinion without evidence Lieberman responds precisely like the "psychoanalysts" about whom he speaks with contempt.

Finally, I must confess that I was taken aback by Lieberman's reference to Freud as a "rogue," "Psychiatry's greatest hero and its most calamitous rogue" (p. 39).

The dead are forever silent but I cannot help but wonder what Freud would have thought of Lieberman. I imagine he had to deal with many Liebermans in his time.

Richard C. Friedman, M.D.

Editor-in-Chief

*Psychodynamic Psychiatry*

*Clinical Professor of Psychiatry, Weill/Cornell Medical School*

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