#  International Psychoanalytical Association (IPA) Boston, Pre Congress

# (Re)discovering Psychoanalysis

# First of all, I would like to thank the organisers for giving us the opportunity of sharing our experience. It is truly a pleasure and a great honour to participate in today’s debate.

# For many years I have been working with multidisciplinary groups in institutions, psychiatric centres for adults and psychiatric services in the prison sector. The participants are doctors, nurses, social workers, psychologists. In psychiatry many teams are worried about having to complete questionnaires while they need to work rapidly. Also, the push for results prevents the team from establishing a personal dialogue with each patient. This is one of the current major concerns in psychiatry. I would like to insist on how we can contribute to the protection of the clinical practice. The transmission of psychoanalysis, showing the richness of the clinical practice experience is at the heart of my present concerns.

# The method we have used has a long history. Already in the 1970’s we studied with analysts who worked with us in psychiatry. All of them were full members of the IPA. But let’s keep these historical details for later and focus in the elements characterising the method.

# The working-groups are set up on clear guidelines. Let me explain you the more important elements, three elements:

# 1. Firstly, our method is to encourage an open discussion. It is up to the group participants to decide who will introduce a difficult situation. It is often a doctor and a nurse who do it. They don’t give a classical medical presentation. I suggest them to give a current situation of the patient and explain why they need or want to discuss this specific case at this specific time. The patient’s history will probably come out during the discussion even if it is not necessary to investigate the past. It is surprising to observe how often the group participants starts the debat before the introduction of the case is completed. It does not matter: the questions come (pop) up and I take them. Everyone has the right to participate. Part of my role in the group is to point out the rich complexity of the points being made. Otherwise, such points may have been missed by the participants, who are perhaps too close to a relationship with a patient which they find too difficult or too repetitive.

# 2. Secondly, the work is always performed in the framework of ongoing training programmes set up by the institution. I do not want to run the risk of being an analyst parachuted into an institution without any knowledge of how it functions.

# 3. Thirdly, I always co-host the session with one of the institution’s senior doctors. He or she is in charge to frame the debate and remind the group about the general policy of the institution.

# The group discussion is focused exclusively on clinical work. Our method is a work done in group but not as a group dynamic. It stays in a clinical context. It is important to emphasize this aspect, because it is here that the work of the group, the work of the doctor and my own work converge : all of us, we have a common interest in defending clinical practice. In my view, this way of working is very suitable for integrating the analytical ideas into the institutional context.

# What happens during the open discussion? Little by little we can:

#  - bring out the richness of clinical practice.

# - give the participants the desire and the courage to enter into the relationship with the patient, and :

# - suggest useful links between practice and theory. This is an aspect I enjoy a lot. If the group so wish, I take time to develop any point in a more theoretical manner. I provide a lot of different references. Recently I proposed Anna Freud’s conferences, while another day I would rather suggest re-reading Freud’s Katharina, a text of Bion or Kernberg or Ferenczi or Paul Denis, and so on. I just want to help the participants to discover texts that provide a precise answer to their questions. In my opinion, the transmission of our so rich and living clinical heritage is a very important part of our work today.

# At this point of the work and the discussion, I always come back to the patient which case has been discussed by the group, so that everyone can leave the meeting with a renewed interest.

# On our side, what can we think about such a discussion with the participants? A aspect I want to share with you is that we very often feel that we need to rebuild the basics( foundations) of psychoanalysis. Today we work a lot with doctors, nurses and psychologists, who know nothing, or very little about analysis. They may know it exists but in their view it’s often an out-dated way of working. At the same time, these colleagues are faced with the so difficult problems imposed by the clinic: it is hard and sometimes very painful to meet a patient who is referred to as “borderline”. Doctors and nurses today have their interview techniques and they are very certainly useful techniques. But when I propose in parallel to (re)discover psychoanalysis, they are very interested. For example when I make clear:

# - the complexity of the links with the past, and :

# *-* the complexity of the continuity between normal and pathological.

# - the complexity of the link that the patient constructs with a nurse.

# In this case I don’t necessarily use the term ‘transference’. For example when the group is worried about a *young adult,* I prefer emphasise certain subtle elements – picked up during the discussion of the group about the patient - which are very similar to the elements that ‘normally’ appear in adolescence: aspects of narcissisim, megalomania and so on. By doing this I can develop a certain way of seeing, which includes different movements of mental functioning at different moments of development. A young “psychotic” adult has a pathological fonctionning and a “normal” fonctionning. We rarely go beyond adolescence with adult patients in psychiatry because it is often their adolescence that is more obvious than the rest of their childhood. Please excuse me for simplifying matter. You will have noticed that I do not interpret (the patient’s (case) from the material presented. Or, if I do ‘interpret’, it’s just in general terms, to give an idea of what is narcissism or Oedipal movements.

# My desire is for the participants to have some sort of proof through clinical facts. By this way, they are faced with these elements of adolescence which continue to contribute to the problems of the adult but which they could not see before our discussion. Naturally I tell them that adolescence is the result of what went before. The aim is to offer to the patient the possibility to obtain a psychotherapeutic effect during the psychiatric treatment.

# Before I conclude, let’s me just give you a look on the past. As I mention at the beginning, we learnt this way of working many years ago, at the start of our training in the 1970’s.

# At that time, psychiatry and psychoanalysis were connected in a way that seemed totally natural to us. For example, René Diatkine came to Geneva regularly, and we were able to observe him working as a psychoanalyst in psychiatry. René Diatkine was familiar with our institutions in Geneva (he was working there with his very close friend J. de Ajuriaguerra) and we saw him as a close and approachable colleague. His book entitled *Le psychanalyste sans divan* (*The Psychoanalyst Without a Couch*) was published in 1973. With René Diatkine the work was focused on the interview with the patient and on the discussion with the whole team. With him we "touched" the transference, we "felt" the unconscious and we understood the relevance of the psychoanalytical approach.

# Twice a month he used to spend a whole day with us, working with the whole team and giving everyone a chance to express his/her ideas. We started our training in psychoanalysis in parallel. I’m not sure whether we really appreciated the opportunity we were given at that time to construct a professional identity in such a privileged setting.

# When René Diatkine stopped coming to Switzerland, the work between psychoanalysis and psychiatry has been maintained, and this link is still alive. There are some multi- disciplinary groups working in several institutions in Switzerland and France, we have found examples in Greece and, several years ago, also in Turkey. Référence : *Quartier Fl. Bartolomei J, avec participation P. Denis, Psychiatrie: mode d’emploi, Doin 2013.*

# In conclusion

# It seems to me that we can create or recreate the links between psychiatry and psychoanalysis. The time is right because we can develop our practice all around. And I tell you once more that the aim is to offer to the patient the possibility to obtain a psychotherapeutic effect during the psychiatric treatment. It is important because psychiatric patients are still often neglected. Today, everyone working in the field of mental health and wishing to maintain a living clinical practice can combine psychiatry and psychoanalysis. It is an interesting and important challenge, as much for psychiatry as for psychoanalysis.

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