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Special Feature Article

Psychoanalytical Psychiatry in the Field of Liaison Psychiatry

Hiroyuki KIMURA

Department of Psychiatry, Nagoya University Graduate School of Medicine

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Abstract

The roots of consultation-liaison psychiatry (or liaison psychiatry) can be traced to 1902, when Albany General Hospital in New York was struggling to deal with psychiatric symptoms in patients treated for physical conditions, and therefore added a psychiatry unit. Psychoanalysis emerged around the same time. In 1981, shortly after liaison psychiatry's introduction to Japan in 1977, the Japanese Psychoanalytic Association held a symposium titled "Psychoanalysis and Liaison Psychiatry" to discuss the influence of the patient's unconscious on medical personnel and group dynamics in team medicine. However, with the loss of the psychoanalytic perspective in the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition (DSM-III)* released around the same time, opportunities to study psychoanalysis as part of medical school education diminished. As a result, the connection between liaison psychiatry and psychoanalysis largely disappeared.

However, psychoanalysis has often contributed to the consultation-liaison field in actual clinical situations. This has occurred in various ways, such as sharing a dynamic understanding of the clinical situation of patients with physical illnesses based on group dynamics with a medical team, or by providing individual psychotherapy to patients suffering from such illnesses. Physical medicine has also placed less emphasis on psychiatric liaison activities since the 1990s, when a direct relationship was clearly shown between psychiatric symptoms of patients with multiple physical diseases and the

prognosis of their physical disease. Furthermore, in Japan, team medicine has been widely promoted since 2000. In recent years, evidence has been disseminated regarding the therapeutic effects of liaison psychiatry in team medicine. In daily clinical practice, there are strong expectations that psychiatrists will be part of the medical team. It is necessary for psychiatrists to acquire additional special skills to become able to effectively work in such a team.

This paper provides a historical overview of Psychoanalytical Psychiatry in the field of liaison psychiatry, and discusses their contemporary significance.

Keywords: psychoanalytical psychiatry, consultation-liaison, liaison psychiatry, team medicine

Introduction

Liaison psychiatry began in 1902 when a general hospital in New York, struggling with the mental symptoms of patients with physical illnesses, established a psychiatric department. Around the same time, Psychoanalysis was also founded by Freud, S., and became the basis for psychotherapy in the years that followed. In the 1940s, these two fields overlapped through psychosomatic medicine, but in the 1980s, the link between liaison and psychoanalytical psychiatry disciplines was lost with the absence of the perspective of psychoanalytical psychiatry (dynamic psychiatry) in DSM-III. Since the 1990s, it has been established that psychiatric symptoms in patients with certain physical illnesses are directly related to their physical illness-related prognosis, and

consultation-liaison has also been established as a field of psychiatry. In recent years, in clinical settings where team medicine has become widespread, the application of psychoanalytical psychiatry has contributed to the practice of medicine in several ways, such as by sharing the group dynamics of patients with physical illnesses with the medical team, restoring the functioning of the medical team through psychoanalytical interventions if it becomes dysfunctional, or providing psychotherapy that is a modified form of standard psychoanalytical psychotherapy for patients suffering from physical illnesses. To be more specific, let us consider the dysfunction of a team. When a group is hit by a major shock that was not anticipated, such as complaints from patients/their families or medical problems, even a

cooperative and productive medical team will experience a decrease in communication, negative feelings, and in some cases, suspicion. As a result, the medical team may become uncooperative, unproductive, and dysfunctional. In applied practice based on psychoanalytical psychiatry, psychiatrists on the medical team can objectively perceive the dynamics of the situation without being involved in the group that has fallen into this state, and they can work with the entire team in team conferences, or if a specific individual is having a significant impact on the group, they can discuss the situation and help restore that individual's emotional state, and work toward restoring the entire team. Psychiatrists who provide psychotherapy for patients with physical illnesses may visit the patients' bedside to conduct interviews if they are unable to come to the office because of the effects of their physical illnesses. During interviews, they may modify psychoanalytic psychiatry techniques, such as flexibly adjusting the length and frequency of interviews if a patient finds it difficult to accept too much loss or despair both mentally and physically, or strengthening or supporting the patient's defenses without interpretation.

In this paper, I provide a historical overview of the two fields of liaison

psychiatry and psychoanalytical psychiatry, and discuss the significance and role of two issues (shown in the figure) in modern times: individual psychotherapy for patients with physical illnesses, and the application of psychoanalytical understanding in medical teams.

I. Historical Transition

1. The early years: The beginnings of psychoanalytical psychiatry and liaison psychiatry

From around 1860, there was a gradual increase in the momentum to add psychiatry to physical medicine education. In 1902, Mosher, J.M., who was the editor of the *American Journal of Insanity*, established a psychiatric department at Albany Hospital in New York.⁴⁹⁾ Eleven years later, a psychiatric department was also established at Johns Hopkins Hospital, and at the opening ceremony, Osler, W. and Meyer, A. emphasized the importance of psychiatry in general hospitals.⁴⁶⁾ In 1923, the third psychiatric department was established at Henry Ford Hospital in Detroit. At that time, approximately 30% of patients with physical illnesses were found to have mental illnesses, and many psychiatric consultations were carried out.²¹⁾ In 1934, a psychiatric department (Psychiatric Liaison Department) was established at the University of Colorado Hospital in

Denver with support from the Rockefeller Foundation. In 1939, Billings, E.G.⁶⁾ reported on his four years of clinical activities and introduced the term "liaison psychiatry" for the first time. In the same year, 1939, the journal "Psychosomatic Medicine," which was concerned with the mind-body connection, was launched, and two psychoanalysts, Dunbar, H.F.⁵⁷⁾ from New York and Alexander, F.⁴⁾, who had moved from Berlin to Chicago, were closely involved in its establishment. After that, Alexander disseminated many findings based on psychoanalytical understanding of the mind and body, including alexithymia. After the 1940s, when attention was focused on the mind and body, there were contributions from psychoanalytical psychotherapy in the treatment of patients with physical illnesses. Eissler, K.R. in New York conducted individual psychotherapy, applying psychoanalytical psychotherapy to patients in the terminal stages of their illness, and published the results in 1955 in: "The Psychiatrist and the Dying Patient."⁹⁾ Around the same time, Eissler presented the idea that the psychotherapeutic process could be accelerated by the therapist temporarily deviating from the principles of psychoanalytical psychoanalytical therapy techniques,⁸⁾ and it is

considered that this was influenced by his experience of psychotherapy with terminal patients. Subsequently, liaison psychiatry gradually became established as a field of psychiatry, and after being conceptualized by Lipowski, Z.J., one of the leading figures in the field,⁴³⁾⁻⁴⁵⁾ it was consolidated into four main models by the 1960s⁴⁶⁾:

- (i) Comprehensive assessment that includes not only the patient's diagnosis but also their personality and response to physical illness⁵⁾⁴³⁾
- (ii) Therapeutic intervention in crisis situations⁵⁹⁾⁷²⁾
- (iii) Personal consultation for specific patients⁴⁶⁾
- (iv) Requests regarding the group dynamics of patients and the clinical team¹⁷⁾⁴⁷⁾

After that, the areas of liaison activities became differentiated by organ and disease, and further differentiated into areas such as oncology (psycho-oncology), nephrology (psycho-nephrology), cardiology, transplantation, etc. In 2020, the Guidelines and Evidence-Based Medicine Subcommittee of the Academy of Consultation-Liaison Psychiatry listed: addiction, emergency, gastrointestinal, HIV, neurology, nephrology, psycho-oncology, somatoform disorders, suicide, transplantation, and women as liaison fields based on the latest research

evaluating the quality of clinical practice and research.⁶³⁾

In the same way that liaison psychiatry began, in the 1900s, as an application of psychoanalytic therapy inpatient psychoanalytic psychiatric treatment of patients with mental disorders by a team of psychoanalysts and other staff began. According to Iwasaki,²⁵⁾ the application of psychoanalytic therapy began and developed as follows. In 1926, Simmel, E. opened the Tagel Sanatorium in Berlin, and around 30 inpatients were treated by four psychoanalytical psychiatrists. In this inpatient treatment, the staff working as a team were structured to function not as specialists acting independently, but as part of the psychoanalytical psychiatry doctor's function. Regarding the application of psychoanalytic therapy, Freud predicted that in the future it would be necessary to modify the techniques to suit various conditions. Although Freud also visited the Tagel Sanatorium every year for two to three months to recuperate, he did not seem to be very interested in the application of psychoanalytic therapy. Unfortunately, the Tagel Sanatorium, which was carrying out these experimental trials, was closed down five years later in 1931 due to persecution by Nazi Germany and financial reasons. In 1925, the

Menninger Sanatorium with 13 beds was opened by the Menninger family in Kansas, USA, and after that, while also interacting with Simmel, inpatient treatment based on psychoanalytical psychiatry began to be carried out.

At the Menninger Sanatorium, unlike the Tagel Sanatorium, the staff were not seen as part of the function of the psychoanalytical psychiatry doctors, but functioned independently as specialists. Also, for treatment groups that had fallen into dysfunction due to patients, the function of the group and patients was restored through psychoanalytical psychiatry-based understanding and intervention. This kind of attempt can be said to be the beginning of team medicine, where specialists from a variety of professions come together. Following these two pioneering hospitals, in the United States, Sheppard and Enock Pratt Hospital, which was established by Sullivan, H.S., and the Austen Riggs Center, which was established by Knight, R.P. and Gill, M.M., who were on the staff at the Chestnut Lodge Sanatorium and Menninger Sanatorium, respectively, were established. In the UK, the movement developed around Cassel Hospital, which was led by Main, T., who had been in contact with Bion, W.R. and Bowlby, J. since the 1940s.

Thus, there were two trends in the application of psychoanalytical psychiatry in hospitals: One was the implementation of individual psychotherapy in a limited setting, such as during the treatment of physical illness, as Eissler did in the consultation-liaison field; the other was the trend of inpatient treatment of patients with mental illness in a psychoanalytical psychiatry-based setting.

2. The Encounter between Psychoanalytical Psychiatry and Liaison Psychiatry in Japan

The application of psychoanalytical psychotherapy in Japanese hospitals was accelerated by Iwasaki's 1977 introduction of "Psychoanalytic Hospital Psychiatry."²⁵⁾ The following year, Iwasaki presented a paper, entitled: "Education in Liaison Psychiatry and the Clinical Practice of Psychosomatic Medicine in General Hospitals," at a symposium of the International Society of Psychosomatic Medicine in Kyoto, and expanded the scope of his work from patients with mental disorders to those with physical diseases. In 1981, the Japan Psychoanalytical Association organized a symposium, entitled: "Liaison psychiatry and Psychoanalysis," and psychoanalytical psychotherapy and consultation-liaison met for the first

time in Japan. Iwasaki,²⁷⁾ one of the symposium speakers, stated that "the essence of liaison psychiatry is not so much that psychiatrists are directly involved in the examination and treatment of patients from other departments, but that it is concerned with the various therapeutic relationships surrounding those patients (such as the relationship between the patient and attending physician from each department, the relationship between the patient and nursing staff, the relationship between the patient and family, etc.)." Okonogi⁵⁴⁾ listed: (i) psychodynamic, therapeutic, and situational understandings, (ii) personality-based understandings, and (iii) work on object loss, anxiety, emotional crises, and grief as "psychoanalytical psychoanalytical understanding, and methods in liaison psychiatry." Ogura⁵³⁾ introduced the practice of multi-disciplinary consultation, not only in terms of cooperation within hospitals, such as among departments of pediatrics, internal medicine, ophthalmology, and otolaryngology, but also in terms of cooperation outside hospitals, such as with public health centers and schools. Kashiwagi and Tsuji gave a joint presentation on terminal cancer patients. Kashiwagi³²⁾ introduced the psychological characteristics of patients and presented specific case studies,

while Tsuji⁷⁰⁾ discussed the team approach to patients. In the general discussion,²⁴⁾ Nishizono said that how other departments and the psychiatric department cooperate is a matter of technique, and that it is important to help patients regain their independence. Doi explained the situation in which case workers are connecting the various departments, and stated that it is important for the top people in the organization to recognize the need for this. Kandabashi stated: "The most functional organization is the military, and the whole field of medicine has created an organization similar to the military. In this context, the liaison psychiatry that has emerged should be a team that works hard to create something together." In this symposium, Iwasaki and Ogura referred to the medical team surrounding the patient, while Okonogi referred to the individual patient's problems and medical team surrounding the patient. Kashiwagi and Tsuji referred to the individual patient's problems and medical team, respectively, while giving a joint presentation. In the general discussion, Nishizono referred to the individual patient, while Doi and Kandabashi referred to the medical team.

In this symposium, as in the global trend described by Lipowski,⁴⁶⁾ the discussion focused on the application of psychoanalytical psychiatry in

consultation-liaison, and included discussion of individual patients with physical illnesses and the medical teams affected by them.

3. Development in Japan

Since the 1980s, the application of psychoanalytical psychiatry in Japan has mainly involved the inpatient treatment of patients with mental disorders. It was thought that if the pathological mental dynamics of the patient affected the interpersonal relationships around them, that is, the relationships between the attending physician and staff involved with the patient, and if this influence was not made open but remained latent, it would lead to a worsening of the patient's psychiatric symptoms. Therefore, the attending physician and staff can restore function by holding staff meetings and sharing information about the impact on relationships between staff members, and as a result, the patient's own mental symptoms can be resolved. Regarding the clinical practice of inpatient treatment, Iwasaki²⁶⁾ carefully explains the roles and significance of the ward doctor, psychotherapist, and nursing staff, while also taking into account the historical background of inpatient treatment. According to Bion,⁷⁾ groups have both "work groups" that work toward the achievement of goals and

"basic assumption groups" that hinder the achievement of goals, with the latter including "dependent groups" in which the group becomes dependent on the leader, "fight-flight groups" in which the group has a belief that there are enemies to attack and enemies to avoid, and "pairing groups" in which the group has a savior-like desire for two members. When a group becomes dysfunctional, "basic assumption groups" predominate, and it is considered that the group's function as a medical team is restored by focusing on meetings by the attending physician and staff. Tachi⁶⁶⁾ and Gon¹⁶⁾ both emphasized the importance of the attending physician having a consultant function, showing leadership, and organizing staff meetings in the clinical practice of inpatient treatment in psychoanalytical psychiatry. Aida emphasized the psychological organization of the ward, not only in terms of the clinical practice of staff surrounding inpatients,³⁾ but also in terms of the various groups that exist in the hospital.²⁾ Horikawa also practiced dynamic team medicine in psychiatric hospitals for many years, and stated: "We did not regard 'psychotherapy' in hospitals as a therapist-patient relationship only in the examination room, but rather, not only the staff but also the patients, their families, neighbors, and local community ... have continued to devise

the entire hospitalization process based on the idea of 'psychotherapy'.²³⁾²³⁾ Kano²⁸⁾ practiced dynamic inpatient treatment on a psychiatric ward of a university hospital, and examined the relationships among psychiatrists in an educational position, young psychiatrists, nurses, and patients from a dynamic perspective in 98 cases of dynamic inpatient treatment.³¹⁾

Conversely, regarding the application of psychoanalytical psychiatry in the consultation-liaison field, the same therapeutic practices as those employed in inpatient psychiatric treatment were used, as Iwasaki stated that: "the psychiatrist is involved in the various therapeutic relationships surrounding the patient, rather than directly examining and treating the patient in another department." Narita⁵¹⁾⁵²⁾⁵⁶⁾ described the role of psychiatrists and psychotherapeutic approaches in the consultation-liaison field, focusing on liaison activities for kidney transplant recipients in general hospitals. Kano and Hashimoto also presented on the role of psychiatry in university hospitals¹⁹⁾²⁹⁾³⁰⁾ and reported on the treatment of patients with mental disorders who have physical complaints.²⁰⁾ Kikuchi et al.³³⁾ also reported on clinical activities in a general hospital, focusing on relationships. Kimura et al. have practiced long-term psychiatric liaison

activities (structured regular multidisciplinary meetings) in a university hospital, and reported clinical findings obtained from the fields of transplantation³⁷⁾³⁸⁾⁵⁵⁾⁶¹⁾⁶²⁾ and head and neck cancer.¹⁾⁵⁰⁾⁶⁰⁾ Takano presented on the dynamic management of patients who have attempted suicide⁶⁸⁾⁶⁹⁾ and psychoanalytical psychotherapy for such patients⁶⁷⁾ in the field of emergency and critical care medicine at a general hospital. In the same field, Kimura³⁴⁾³⁵⁾ reported on a case of psychotherapy that focused on collaboration with emergency physicians regarding the acting-out of patients with borderline personality disorder. Furthermore, Harada, K. et al.¹⁸⁾ and Eto¹⁰⁾ are also working on prevention activities for patients who have attempted suicide in collaboration with the emergency and critical care center at university hospitals. In particular, Eto proposed a psychological approach to suicide prevention based on psychoanalytical psychiatry.¹¹⁾

II. Team medicine

In the past, each department in a hospital would work together and support patients in their own way. Fukazawa,²⁴⁾ a social worker at St. Luke's International Hospital who was one of the designated discussants at the symposium on "Liaison psychiatry and psychoanalytical psychiatry" mentioned

above, stated that when she was asked to talk about liaison psychiatry from a social worker's perspective, she was advised that the word "liaison" was popular at the time, but that St. Luke's had been using it for a long time, so she should just talk about her experience. As Fukazawa points out, cooperation and team-building between departments and divisions has been practiced at each medical institution. Conversely, at the time, the medical system was based on a top-down medical system led by doctors, rather than such horizontal cooperation. However, with the occurrence of a series of major medical accidents around 2000, medical safety began to attract attention, and the top-down medical system centered on doctors was seen as a problem. Subsequently, team medicine was promoted as a national policy. In 2010, the Ministry of Health, Labour and Welfare defined team medicine as: "a system in which a wide variety of medical staff engaged in medical care share information and objectives, and while dividing up tasks, cooperate and complement each other based on their respective high levels of expertise, provide medical care that accurately responds to the patient's situation" (Report of the Study Group on the Promotion of Team Medicine).³⁹⁾ In 2012, a new psychiatric liaison team allowance was established as a medical

fee, and in 2014, the Act on the Coordination, etc., of Relevant Acts for the Promotion of Comprehensive Securing of Medical Care and Long-Term Care in the Community came into effect, and team medicine has been rapidly spreading in medical settings.

Now, as team medicine has spread in this way, the role of psychiatrists in general hospitals has changed. At first, psychiatrists working in consultation-liaison were expected to provide support for patients with mental disorders or physical illnesses presenting with psychiatric symptoms, and were positioned as support staff to reduce psychiatric symptoms that affected physical treatment. At the time, Okonogi⁵⁴⁾ also commented on his involvement in consultation liaison, saying: "I think there was a sense of insecurity and hesitation about leaving my main job to go and help out with someone else's work." However, in 1993, it was clearly shown¹³⁾ that mental disorders directly affect the mortality rate associated with physical illness, and from this point on, evidence began to be published showing that mental symptoms and disorders affect physical illness. Prince, M. et al.⁵⁸⁾ published a paper in the *Lancet*, entitled: "No health without mental health," which comprehensively discussed the risk factors for developing physical illness, impact of mental illness on adherence to

treatment for physical illness, and impact of physical illness on the prognosis and outcome. It is no longer a case of: "helping out with other people's work." As team medicine evolved, the focus shifted from group dynamics of the medical team surrounding the patient to the effectiveness of team medicine itself. In the primary care setting, a comparison of specialized consultation-liaison (intervention by a multi-professional team) with other care for 2,605 patients with comorbid psychiatric disorders showed that the consultation-liaison treatment model improved satisfaction and adherence at 12 months compared with standard care.¹⁵⁾ In addition, multi-professional team intervention for mild depression in the elderly was more effective than standard care.⁴¹⁾ Furthermore, a 2017 systematic review found that multi-professional team interventions for depression in cancer patients reduced depression and maintained this reduction one year later.⁴²⁾ This evidence to support team medicine assumes a functioning medical team, but in clinical practice, it does not always function effectively. If a medical team becomes dysfunctional, applied practice based on the understanding of psychoanalytical psychiatry can be useful as a basic skill to restore group functioning.

Here, I give an example of a specific clinical situation. A psychiatrist was working as a liaison in a medical team treating a patient with a certain physical illness. One day, the patient made an unexpected and serious suicide attempt, which caused great confusion. The normally cooperative and productive medical team began to blame the psychiatrist in their hearts, and stopped talking about the suicide attempt. After that, the medical team began to excessively avoid patients with psychiatric disorders as candidates for physical treatment. As a result, the psychiatrist on the medical team felt excluded. Therefore, the psychiatrist first consulted the head of the physical medicine team to gain their understanding, and then explained the effectiveness and limitations of psychiatric assessment at a team conference to clarify points for future improvement. The atmosphere of the medical team did not change immediately, but it gradually recovered to the point where the psychiatrist could function within it.

As described above, it is necessary to comprehend the movements of the group while also understanding the mental processes of the therapist in order to practice liaison psychiatry based on psychoanalytical psychiatry. In the author's personal opinion, in order to be able to objectively

understand the subjective mental processes of the therapist, it is desirable to undergo at least one year of training in dynamic psychotherapy supervision (individual or group). In the Japanese Society of Psychiatry and Neurology's specialist training program, it is stated that residents must have experience in psychodynamic psychotherapy under the guidance of a supervisor in their third year of training.

In recent years, the application and practice of psychoanalytical psychotherapy has been the subject of many symposiums and panel discussions at related academic conferences (see table), and it has also been the subject of discussion from the perspective of consultation-liaison.

III. Psychoanalytical psychotherapy for patients with physical illnesses

Findings on psychotherapeutic treatment for patients with physical illnesses continued to be reported even after Eissler published: "The Psychiatrist and the Dying Patient," in 1955. For example, Minerbo, V.⁴⁸⁾ reported on psychoanalytical psychotherapy for a patient with terminal cancer. The patient, who was receiving psychoanalytical psychotherapy three times a week, was diagnosed with cancer in the fifth year. After that, despite physical treatment, her physical condition deteriorated, and

in the last six months, her treatment was transferred to psychoanalytical psychotherapy by telephone (start with the therapist's intuitive suggestion). This continued until the day before his death. Minerbo raised the question of whether the psychoanalytic therapy was productive and the truth was being told, and then stated that it was meaningful for the patient, even during the painful process of death with mental pain. The Oxford Textbook of Psychotherapy⁷³⁾ describes the characteristics of psychoanalytical psychiatry psychotherapy for patients with physical illnesses as follows: (i) the concept of psychoanalytical psychiatry reconfigures the clinical issues of physical illnesses; (ii) the patient's childhood experiences are reactivated due to the physical illness; (iii) patients suffer from dependent situations and trivialize their conflicts with authority; and (iv) the main conflicts of patients are "believing" and "feeling separated/abandoned."

In recent years, evidence for psychoanalytical psychotherapy, including not only short- but also long-term psychoanalytical psychotherapy, is being established, mainly for depression.¹²⁾⁴⁰⁾ A recent meta-analysis⁶⁴⁾ found that psychoanalytical psychotherapy was as effective as drug and cognitive behavioral therapy. Furthermore, the latest network meta-

analysis¹⁴⁾ found that providing treatment from the acute phase using a combination of drug therapy and psychotherapy was more effective in maintaining the effects, and that, in terms of the type of psychotherapy provided, psychoanalytical psychotherapy was as effective as interpersonal psychotherapy, following cognitive behavioral and behavioral activation therapy. Conversely, a meta-analysis⁷¹⁾ of depression in patients with physical illness found that cognitive behavioral therapy, interpersonal psychotherapy, and supportive psychotherapy were effective. As for psychoanalytical psychiatry-based psychotherapy, there are only expert consensus reports and case reports/series, but evidence is still being accumulated. Recently, Heled, E.²²⁾ conducted a literature review of psychoanalytical psychotherapy for patients with chronic illnesses, and examined chronic illness and disability patients affected by a sense of loss, dividing them into those with congenital and acquired diseases, and concluded that psychoanalytical psychiatry-based psychotherapy can contribute to their recovery. In Japan, too, there have been reports of psychoanalytical psychiatry-based psychotherapy for patients with acquired chronic physical illnesses.³⁶⁾ Straker, N.⁶⁵⁾ also conducted a literature review of psychoanalytical

psychotherapy for patients with terminal cancer, and while looking back on the historical transition, he discussed dealing with denial, accepting an uncertain prognosis, improving self-esteem, and exploring death-related anxiety. In the future, it is hoped that findings with a higher level of evidence will be disseminated.

Conclusion

In this paper, I have provided a historical overview of the relationship between the two fields of liaison psychiatry and psychoanalytical psychiatry, and discussed their contemporary significance and role. This paper, which discusses consultation-liaison based on psychoanalytical psychiatry, is based on the clinical practice and findings of many of our predecessors. I apologize for not being able to cover everything, but hope that you will understand. In the future of psychiatric care, I hope that the clinical practice of applying psychoanalytical theory and skills will spread not only to the consultation-liaison field, but also to many other fields.

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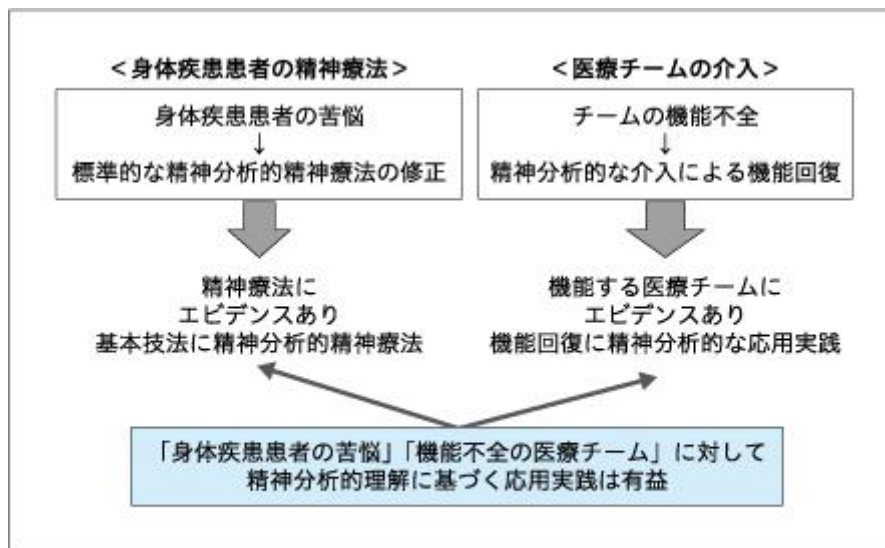


図 コンサルテーション・リエゾン領域における精神分析的な理解に
基づく応用実践

Figure: Applied practice based on psychoanalytical psychiatry in the field of
consultation liaison

表 精神分析的な応用実践について学会でとり上げられたテーマ

日本精神神経学会	シンポジウム「これからの精神医療における精神分析的な精神医学の役割」(2021)
日本精神分析的な精神 医学会	シンポジウム「精神分析は精神医学にどのように貢献できるか？」(2011) シンポジウム「精神分析の精神医学への適応を考える」(2013) 教育研修セミナー「医療に精神分析的な理解をどう活かすか Part II 医学教育, リエゾンの『場』から学ぶ」(2013) パネルディスカッション「この学会が目指す精神分析的な精神医学を実践する精神科医の姿とは? —— 力動的臨床の 広がり」と精神分析的な専門性の統合を目指して——」(2015) パネルディスカッション「死の臨床」(2019) シンポジウム「臨床的危機下で考え続ける——thinking under the fire——」(2022)
日本精神分析学会	医療問題委員会企画「臨床現場における精神分析的な視点について考える——力動精神医学の現在——」(2018) 医療問題委員会・臨床心理委員会合同企画「精神分析の学びと知恵を活かす——連携と協働について——」(2019) 医療問題委員会・臨床心理委員会合同企画「精神分析的な理解に基づく応用的な実践について考える」(2021)

Table: Themes discussed at academic conferences regarding applied practice from a
psychoanalytical psychiatry perspective

Japanese Society of Psychiatry and Neurology:

Symposium: “The role of psychoanalytical psychiatry in psychiatric medicine in the future” (2021)

Japan Academic Association of Psycho-analytical Psychiatry:

Symposium: “How can psychoanalytical psychiatry contribute to psychiatry?” (2011)

Symposium: “Considering the Application of Psychoanalytical Psychiatry to Psychiatry” (2013)

Educational Training Seminar: “How to Utilize Psychoanalytical Psychiatric Understanding in Medical Care Part II: Learning from the ‘Place’ of Medical Education and Liaison” (2013)

Panel Discussion: “What does the ideal psychiatrist practicing psychoanalytical psychiatry look like? - Aiming for the integration of the expansion of dynamic clinical practice and psychoanalytical psychiatry expertise” (2015)

Panel Discussion: “Clinical Research on Death” (2019)

Symposium: “Thinking under the Fire” (2022)

Japan Psychoanalytic Society:

Medical Issues Committee Planning: “Considering the psychoanalytical psychiatry perspective in clinical practice - the current state of dynamic psychiatry” (2018)

Medical Issues Committee and Clinical Psychology Committee Joint Planning: “Applying the learning and wisdom of psychoanalytical psychiatry - collaboration and cooperation” (2019)

Joint project of the Medical Issues Committee and the Clinical Psychology Committee: “Considering Applied Practice Based on an Understanding of Psychoanalytical Psychiatry” (2021)