THE PSYCHIATRY LETTER

Table of Contents

CONTINUING MEDICAL EDUCATION (CME) CREDITS AVAILABLE

Receive 1 CME or CEU credit per issue, Available for physicians, nurses, and psychologists

Questions, comments, cases? Write us at
info@psychiatryletter.org

The Final Issue

We have reached the final issue of PL. With ambivalent feelings, this will be the last introduction to a newsletter issue.

The final special article is devoted to a central question of clinical practice: psychopharmacology versus psychotherapy, and whether one is better than the other, whether they should be combined, and if so by whom. This topic is discussed at length, with the rest of the issue condensed to a final Psychotherapy section on cognitive-behavioral therapy, using an analogy from baseball, and a final note of farewell.

We would like to remind readers that this December 2018 issue is the final subscription issue of PL. The PL website will remain open for questions and curbside consults, and will include commentary on new journal articles. E-books also will be made available there. In the meantime, PL readers also can buy a new psychopharmacology textbook authored by me, to be published by Oxford University Press in January 2019, now available for pre-order, as described in the sidebar.

Thank you for your past support. Without you, we couldn't have achieved our mission.

Nassir Ghaemi MD, Editor

New truths begin as heresies and end as superstitions - T. H. Huxley

Special Article: Psychotherapy versus Psychopharmacology

How to understand the two main approaches to treatment

A general topic of both clinical and conceptual interest is whether clinical practice in psychiatry should involve using drugs or giving psychotherapy. Should one approach be more common than the other? Should they combined? Is one better or worse?

This final special article of PL will discuss this central topic, with a focus on the viewpoint that psychoanalytically-oriented approaches should be preferred and provided commonly, along with medications, to many patients, and further that MD-psychiatrists should be seen as best positioned to provide this kind of combined psychopharmacology/psychotherapy treatment.

Psychoanalytic ("psychodynamic") psychotherapy

At first, it may be useful to define terms. Freud's ideas have evolved and the term "psychoanalytic" has been replaced by "psychodynamic." The latter term implies something very exciting or profound, which it might be, but PL thinks the older term is less misleading. There is an "analysis" that happens in this approach: interpretation of the meaning of psychological experiences. So PL will continue to use the phrase psychoanalytic therapy.

"The nature of psychoanalytic therapies involves a common set of methods, despite many differences in content and emphasis..."

The nature of psychoanalytic therapies involves a common set of methods, despite many differences in content and emphasis. As Leston Havens described well, the core of all aspects of psychoanalytic approaches involves the method of free association. Patients are encouraged to think about ideas or feelings that they might not think important, or which they might suppress consciously or repress unconsciously. The concept of unconscious emotions is central to this approach to psychotherapy, and despite many years of controversy about this concept, especially during Freud's lifetime, one can say that experimental research has shown that there certainly are unconscious emotional states. Whether those states involve a predominance of sexual and/or aggressive feelings, as Freud held, can be argued still, but it is not unreasonable to make that assertion based on a certain amount of clinical and empirical evidence regarding human psychology.

"Integration" versus "split" treatment

There has been a major change in psychiatric training and practice in the past few decades. Until the 1990s, it was routine for psychiatrists to be trained in psychoanalytic psychotherapy extensively, and to practice it. As drugs became central to practice, many clinicians trained in that era and earlier have taken to the practice of treating with drugs and psychoanalytic psychotherapy at the same time. Younger psychiatrists trained in the last two decades also tend to receive extensive psychoanalytic teaching, and often practice both approaches at the same time as well. They may not necessarily conduct formal psychoanalytic psychotherapy, with once weekly one hour

sessions (or they might), but they will tend to interpret clinical experiences via psychoanalytic inferences, along with or alongside biological judgments.

The perspective for "integrated" treatment where psychotherapy is combined with psychopharmacology has been presented well in a classic paper by the prominent psychiatrist/psychoanalyst Glen Gabbard, called "Whatever happened to the biopsychosocial psychiatrist?"

In that paper, Gabbard made the point that the biopsychoscial model (BPS) should be seen as the basic conceptual structure of psychiatry, and that it inherently supported the provision of care by a MD-psychiatrist as being preferable to all other mental health professionals. The reasons he gave for this view are summarized below.

"Psychiatrists have a special privileged position, in Gabbard's view..."

The argument for MD psychiatrist-integrated treatment

Gabbard takes a psychoanalytic approach to psychotherapy. When he says psychotherapy, he means the kind that originated in Freud's psychoanalysis and has been further developed from that basic structure. Some basic psychoanalytic concepts that are relevant to the strengths of single-clinician MD-psychiatrist treatment have to do with concepts like splitting, where patients will treat different clinicians differently, often idealizing one and demeaning another. This cannot happen if a single clinician treats them.

Further he supports the view that patients with psychiatric conditions like depressive or bipolar or anxiety states often have important aspects of care that may grow out of biological problems, but are not themselves biological. The sense of self, of who they are as persons, can be affected. The distinction between the illness and the person who has the illness is central, and can be addressed only in psychotherapy.

Psychiatrists have a special privileged position, in Gabbard's view, because they can understand biological and psychological aspects of the interplay between a mental illness, and the person who has it, in a way that is beyond the training of non-medical mental health professionals.

A key component to the benefit of integrated treatment too, according to Gabbard, is the relevance of more frequent and lengthier visits. The combined psychotherapy/psychopharmacology given by a MD-psychiatrist can occur in weekly one hour sessions, or perhaps biweekly one hour sessions. This set-up is much more preferable than the 15-20 minute "med check" which is so frequent in psychopharmacology practice. In pure psychopharmacology, with brief med checks, the psychiatrist does not get to know the patient as a person. This lack of connection can lead to multiple problems: there can be misdiagnosis of the mental illness itself, as the psychiatrist can misinterpret the patient's experiences. There can be incorrect medication treatment decisions, as the psychiatrist targets symptoms incorrectly. There also can be classic psychoanalytic experiences that arise in the treatment and impede correct diagnosis and/or treatment and/or adherence to treatment. These include, of course, transference and countertransference between

doctor and patient, but also between the patient and the medication, as well as unconscious beliefs or feelings about a diagnosis or a set of symptoms or certain behaviors.

The harm of the med check

The perspective described above has much to commend it, and PL differs little with it in some clinical aspects. It is a major problem in clinical practice that many clinicians provide medications for psychiatric purposes without getting to know their patients well. This problem mostly is related to insufficient time in clinical appointments. The 15 minute medication check is the problem, in many cases. Sometimes these brief visits are driven for structural reasons: a clinician may work for an organization (hospital, department, clinic, group practice) where salaries are dependent on the number of patients seen. The shorter the visit, the more patients seen, the more one meets one's salary requirements. This may be good for the clinic or practice, but it is bad for patients. Sometimes, clinicians in private practice see more patients in less time because in that setting, time literally is money. More patients means more income. Again, this is good for the clinician, but bad for the patient.

"This problem mostly is related to insufficient time in clinical appointments..."

We should be careful then not to lay blame at the feet of clinicians alone; much of this problem in practice is driven by the health care system in the United States, which is organized poorly, and the subject of intense political interference.

Within this poor health care structure, PL would agree with our colleagues that better care is provided by clinicians who see patients for longer periods of time. 15-20 minutes is too short; 30 minutes is better; longer would be ideal, especially for complex cases or during symptomatic crises. Initial evaluations also should be longer: 45 minutes is too short; one hour is better; longer is ideal, especially for complex cases or consultations.

So there is no disagreement on the question of getting to know patients better. Nor is there disagreement on the good examples of transference to medications, or transference to the clinician, or splitting of treatment. All these scenarios are managed well by invoking psychoanalytic concepts and experience. Further, PL agrees with a need to give more general attention to identity, or the "self" of the patient, what Havens used to call "the person in the patient."

All this is correct, but the PL view is that only sometimes is a "psychodynamic" approach required or helpful; sometimes it is irrelevant, weak, or even harmful.

Is it "psychodynamic" or existential?

For instance, where is the literature on the "self" in psychoanalysis? Freud wrote nothing about it. His "ego" was part of a tripartite structure of self-conception, not really a "self." In fact, in the psychoanalytic literature, the concept of the self emerges half a century or more after Freud, in writings of people like Heinz Kohut and Erik Erikson and others in the 1960s and later. Psychoanalytically-oriented colleagues often discuss the concept of empathy in relation to Kohut. This is fine, but Kohut is just one of hundreds of prominent thinkers/therapists who have written about empathy, and most of them

are not "psychodynamic" in training or thinking. The concept of "empathy" was invented and used for the first time in psychiatry by the founder of the existential approach to psychotherapy, Karl Jaspers. The perspective of empathy was central to the existential approach to psychotherapy for half a century before Kohut ever wrote a word about it. The concept of self has been described in detail for the past century in the existential tradition, including with Jaspers during Freud's own life, and even before Freud with William James.

As to what is really important in psychotherapy, our colleagues note the important work of Jerome Frank, whose *Persuasion and Healing*, is a classic. Frank tried to show, as many had argued during Freud's era and before, that psychotherapy really is about persuasion, about agreement between therapist and client/patient. Some have interpreted this view in a postmodernist bent, about creating a joint "narrative." The test is utilitarian: Does it help the patient? Does the patient like it? There's no truth to the matter otherwise. Freud would have disagreed: he went to extensive lengths to argue that his psychoanalytic thinking was discovering some truths of reality, not just persuasion to a shared narrative. It is not Freudian, or psychoanalytic, or "psychodynamic", to argue for non-specificity of therapeutic influence. However, if it is true, it argues for a general impact of the "therapeutic alliance" as key to psychotherapy benefit. There are some systematic reviews of empirical studies that support this view. If this is true, then it would agree with the central position of the existential approach to psychotherapy, which was about empathy between therapist and client, which was all about the relationship and nothing else, not interpretations or transferences or defense mechanisms or transference. In short, the literature on the therapeutic alliance from Frank onwards contradicts the psychoanalytic/psychodynamic approach to therapy, and completely confirms the central thesis of the existential approach to psychotherapy.

In short, much of what is argued above in favor of a psychoanalytically-inspired psychotherapy instead is found more clearly in existential psychotherapy. The PL view here is not that psychotherapeutic influences are irrelevant, but that the wrong ones are being promoted.

"...the PL view is that only sometimes is a "psychodynamic" approach required or helpful; sometimes it is irrelevant, weak, or even harmful."

Psychotherapy by the MD-psychiatrist versus other mental health clinicians

We now come to the practical question about whether the MD psychiatrist is privileged to provide psychotherapy along with psychopharmacology in integrated treatment in a way that other mental health clinicians cannot provide, and whether this integrated treatment is the best approach for patients.

As described above, PL would agree that this perspective could be valid for many patients for whom psychoanalytic concepts would be relevant. Sometimes these factors are quite common, like transference and countertransference, or unconscious feelings about medications.

However, also as described above, many of the reasons claimed to support "psychodynamic" approaches instead do not find strong support in Freudian-inspired psychotherapeutic ideas, but rather are supported and advanced more clearly

and more strongly in the existential psychotherapy approach. If readers agree with this view, then one can ask the question whether MD psychiatrists are trained adequately in the existential psychotherapy approach. The answer is obvious. Most psychiatrists know very little about existential psychotherapy, and it likely is true that at least in the United States, the majority could not tell a questioner one useful fact about its key founders, like Karl Jaspers or Ludwig Binswanger. More would know who Heinz Kohut was.

This reality has to do with the fact that the psychiatric profession in the United States was overwhelmed by Freudian psychoanalytic hegemony for most of the 20th century. Outside of biological approaches, almost nothing else was taught but Freudian orthodoxy and its derivatives (object relations, self psychology, etc). Jaspers and the existential school was ignored almost totally. Social psychiatry approaches (such as Harry Stack Sullivan) had limited impact. Cognitive behavioral approaches were much more prominent in PhD psychology schools rather than in psychiatry residences.

"... what is argued above in favor of a psychoanalytically-inspired psychotherapy instead is found more clearly in existential psychotherapy....."

Against eclecticism

The basic problem, as described by the PL editor in book format previously, is that American psychiatry has moved from psychoanalytic dogmatism throughout most of the 20th century to biopsychosocial eclecticism for most of the past few decades. After drugs became more prominent in the 1970s and 1980s, the prior psychoanalytic orthodoxy was preserved by the grafting of drugs on top it. This hybrid was termed the biopsychosocial (BPS) model. This article cannot do justice to the pros and cons of this philosophy, which the PL editor has described at length in book format. Readers are referred there for a fair discussion of the topic and the rationale for what can be provided here only as conclusions, without sufficient premises or explanation. Suffice it to assert, with that important caveat, that the BPS model was developed by the psychoanalyst/gastroenterologist George Engel as a means of preserving a place for psychoanalytic concepts in medicine (and psychiatry). As noted, the PL approach is not that there is no place for psychoanalytic views in psychiatry; there is a place for such views. The PL approach is that there also are many places in psychiatric practice where psychoanalytic views are irrelevant or even harmful.

The contrast here is between an eclectic approach, as with the BPS model, where everyone is recommended to get biological and psychosocial components to the clinical formulation and treatment. This approach naturally tends to end in the recommendation of medications and psychotherapy, with the latter aspect being psychoanalytically-influenced in the US because of the past century of Freudian hegemony. This eclectic perspective is convenient and self-referential; it is not based on empirical studies but rather on a conceptual assumption that more is better.

This is not to say that it is false. There are scenarios where empirical studies show that combining medications and certain psychotherapies (often CBT, sometimes psychodynamic) are more effective than either approach alone. But this is the case only in some

conditions, and some circumstances, not all or most conditions or circumstances. Yet the combination of medications and psychoanalytically-influenced psychotherapy is provided in practice far more frequently than any other approach.

A method-based scientific approach

The PL approach is method-based, which is synonymous with saying it is scientific. The PL view, which was originated by Jaspers, is that psychiatry has a few basic methods, and these methods need to be used when they should be used, and not used when they should not be used, and scientific research should be the main source of evidence to guide us as to when to use them. What are these methods? Again, space precludes a fair and sufficient discussion. Readers are referred to book-length treatments of the topic elsewhere. Again, providing conclusions without sufficient premises, the PL viewpoint is that one could describe these basic methods of psychiatry in different ways. One could start with Jaspers' dichotomy of *Erklaren* (causal explanation) and *Verstehen* (meaningful understanding). Many psychiatric conditions or situations involves biological diseases of the body and brain, which can be understood like any medical disease in a physical reductionistic manner (Erklaren). Other psychiatric situations involve humans dealing with life dilemmas, not diseases of the body, and an approach that is existential and humanistic is needed (the concept of empathy was introduced by Jaspers as part of his exploration of the method of Verstehen).

"The PL approach is method-based, which is synonymous with saying it is scientific..."

Or one could use the version of Jaspers modernized by Paul McHugh, and look at four perspectives of psychiatry: disease (as above, for schizophrenia and manic-depressive disease), dimension (continuous biological traits, as with personality), behavior (as with behavioristic theory, applied substance abuse or eating disorders), and life story (inspired by Frank, a shared narrative approach to meaning). Or one could use the version of Jaspers interpreted by Havens, and look at four schools of psychiatry: the objective/descriptive school (personified by Kraepelin and the medical model, best applied to schizophrenia and MDI), the psychoanalytic school, the interpersonal school (personified by Sullivan, best applied to managing paranoia and borderline personality), and the existential school (personified by Jaspers, applied to all humans). Or one even could just take Engel's simple tripartite division and split it up: there is a biological approach in psychiatry (which is legitimately reductionistic in some conditions), a psychological approach (which can be subdivided further into psychoanalytic, CBT, existential and other methods), and a social approach (which could be interpreted interpersonally, as with social work traditions, or societally, as in social epidemiology).

One can see with the richness of these various methods or schools that the "psychodynamic" approach is only one of a number of methods or schools, with a limited scope where it is helpful and valid, but with many situations or scenarios where it is not as relevant or valid as other approaches.

The argument for split treatment

The PL view is that non-MD psychiatrists often are better trained and able to apply these other methods or approaches that are need in many psychiatric conditions or cases. MD-psychiatrists tend to be trained well in the biological medical approach, of course (although even there PL has argued for an approach to medical/biological aspects to clinical practice that is different from mainstream psychiatry today), and often trained well in psychoanalytically-influenced approaches to psychotherapy.

However, clinical psychologists tend to be much better trained than MD-psychiatrists in cognitive-behavioral methods, and some clinical psychologists are among the few that are trained formally in existential psychotherapy. Social workers are much better trained that MD-psychiatrists or clinical psychologists in interpersonal aspects of clinical practice, and in societal aspects of psychiatric illness, such as poverty and stigma. Epidemiologists are better trained than any of the above clinical groups on the science of social factors as they affect illnesses. Also, it is worth noting that nurse practitioners often have a broader range of medical experience than many psychiatrists do (given the increasingly common limitation of internal medicine training in psychiatric residencies), which can impact beneficially the use of a medically-sound biological approach to practice.

In short, in all these scenarios, better care would be provided by a non-MD psychiatrist for aspects of treatment outside the medical/biological approach. This claim is not made for all scenarios, but for some, indeed many, clinical circumstances.

"The PL view is that non-MD psychiatrists often are better trained and able to apply these other methods or approaches..."

The PL Bottom Line

- There is not a strong conceptual or scientific rationale for combining psychopharmacology and psychotherapy in a general way for most people.
- There are benefits to psychoanalytically-oriented psychotherapy that are specific to a certain scope of problems or situations.
- Other psychotherapies, especially existential psychotherapy, provide more benefits than psychoanalytically-oriented therapy, especially around the themes of empathy, identity, and meaning.
- The view that the MD psychiatrist provides the best integrated treatment of combined psychopharmacology and psychoanalytically-oriented psychotherapy conflicts with the greater benefit found in many patients with existential psychotherapy or with CBT, for which non-MD mental health professionals tend to be better trained.
- The integration model is based on a Freudian heritage and an eclectic conceptual model of psychiatry.
- The alternative approach that accepts split treatment in many cases is less Freudian and more Jaspersian and is based on a method-based model of psychiatry, emphasizing the key schools and methods of the profession, each of which with strengths only within a limited scope.

Psychotherapy

Understanding cognitive-behavioral therapy

A baseball metaphor

From Michael Otto: 10-Minute CBT Oxford University Press, New York, 2011, pp 25-27

This is a story about Little League baseball....It starts with Johnny, who is a player in the outfield. His job is to catch fly balls and return them to the infield players. On the day of our story, Johnny is in the outfield and crack! - one of the players on the other team hits a fly ball. The ball is coming to Johnny. Johnny raises his glove. The ball is coming to him, coming to him....and it goes over his head. Johnny issues the ball, and the other team scores a run.

Now there are a number of ways a coach can respond to this situation. Coach A is the type who will come out on the field and shout: "I can't believe you missed that ball! Anyone could have caught it! You screw up like that again and you'll be sitting on the bench! That was lousy!" Coach A then storms off the field.

"...while we may all select Coach B for Johnny, we rarely choose the voice of Coach B for the way we talk to ourselves..."

At this point, Johnny is standing in the outfield, if he is at all similar to me, he is tense, tight, trying not to cry, and praying that another ball is not hit to him. If a ball does come to him, Johnny will probably miss it. After all he is tense and tight and may see four balls coming at him because of the tears in his eyes. If we are Johnny's parents, we may see more profound changes after the game. Johnny, who typically places his baseball glove on the mantel, now throws it under his bed. And before the next game starts, he may complain that his stomach hurts, that perhaps he should not go to the game. This is the scenario with Coach A.

Now let's go back to the original event and play it differently. Johnny has just missed the ball, and now Coach B comes out on the field. Coach B says: "Well, you missed that one. Here is what I want you to remember: high balls look like they are farther away than they really are. Also, it is much easier to run forward than to back up. Because of this, I want you to prepare for the ball by taking a few extra steps backwards. As the ball gets closer you can step into it if you need to. Also try to catch it at chest level, so you can adjust your hand if you misjudge the ball. Let's see how you do next time." Coach B leaves the field.

How does Johnny feel? Well, he is not happy - after all, he missed the ball - but there are a number of important differences from the way he felt with Coach A. He is not as tense or tight, and if a fly ball does come to him, he knows what to do differently to catch it. And because he does not have tears in his eyes, he may actually see the ball and catch it.

So if we are the type of parent who wanted Johnny to make the Major Leagues, we would pick Coach B, because he teaches Johnny how to be a more effective player....But if we didn't care

whether Johnny made the Major Leagues...we would again pick Coach B because we care whether Johnny enjoys the game.....

Now while we may all select Coach B for Johnny, we rarely choose the voice of Coach B for the way we talk to ourselves. Think about your last mistake. Did you say, "I can't believe I did that! I am so stupid! What a jerk!" These are Coach A thoughts and they have many of the same effects on us as Coach A has on Johnny....During the next week, I would like you to listen to see how you are coaching yourself. If you hear Coach A, remember this story and see if you can replace Coach A with Coach B thoughts.

PL Reflection

The psychiatric resident has to learn four tasks to become a good psychiatrist:

1. Help someone mourn a loss.
2. Leave people alone.
3. Hang up the phone.
4. Encourage people.

Leston Havens MD

A final farewell

The mission of the Psychiatry Letter

By Nassir Ghaemi

When I started PL, I felt that there was information that I wanted to share with the clinical community in a way that I could not share in scientific articles or books. I realized that many clinicians turned to newsletters for guidance, and after some consideration of the effort in time and cost, I decided to try this mechanism of communication. I had some things I wanted to say. Over the past four years, I have said those things. Now, I'm finished.

Over half a century ago, one of the core founders of psychopharmacology in the United States, Frank Ayd MD, decided to start a newsletter. He described the plan to another key founder of the field, Harvard psychiatrist Gerald Klerman. Klerman predicted the newsletter wouldn't last long, because Ayd would run out of things to say. Ayd recalled this discussion 40 years later, in the 2000s, when his International Drug Therapy Newsletter had outlived Klerman and would soon outlast its founder Ayd too. Klerman's prophecy applied to me, not Ayd.

I wanted to present a new approach to psychiatry, one that was not present in any other newsletter, and in fact not present in any textbook, nor in most books or scientific articles. This is an approach that is disease-oriented, not symptom-oriented, in treatment as well as in diagnosis. It rejects 20th century American psychiatry's emphasis on DSM for symptom-based diagnosis and standard neurotransmitter-based psychopharmacology for symptom-based treatment. It goes back to the 19th century for an emphasis on disease and forward to the 21st century for an emphasis on non-neurotransmitter-based psychopharmacology.

Four years of PL archives will remain available on the PL website to allow all visitors to find and read the articles that lay out this approach. Further, these PL articles laid the basis for much of the material in my new textbook of psychopharmacology. In that sense, the material of PL will live on. Further, in the website, we plan to make e-books available so that this material is accessible more easily, and I plan to continue to provide analyses and commentary on new scientific articles as they are published.

PL never was destined to continue just for the sake of continuing. It didn't exist, like other newsletters, just to fund itself. Recently, another newsletter approached PL to buy its subscriber base. PL wasn't for sale.

It had a mission.

Mission accomplished.

PL Reflection

When making a decision of minor importance, I have always found it advantageous to consider all the pros and cons. In vital matters, such as the choice of a mate or a profession, the decision should come from the unconscious, from somewhere within ourselves.

In the important decisions of our personal life, we should be governed, I think, by the deep inner needs of our nature.

Sigmund Freud

The Psychiatry Letter, P. O. Box 400536, Cambridge MA 02140. Editor and Founder: Nassir Ghaemi MD. Managing Editor: Alcides Albuquerque MD. The Editorial Board can be found on www.psychiatryletter.org. A monthly independent newsletter not owned, operated, or affiliated with any organization. It receives no financial support from any source other than subscribers. Disclosures: Dr. Ghaemi is employed by Novartis Institutes for Biomedical Research. In the past 12 months, no relationships with the pharmaceutical industry exist for any other members of the PL Editorial Board. Disclaimer: The medical information provided in this newsletter is information based on general scientific knowledge and/or clinical experience. It is not specific advice intended for individual treatment of a specific patient as would be provided in an in-person professional consultation. If users need specific medical advice for specific treatment decisions, they should consult an appropriate medical professional. No warranties are given in relation to the medical information supplied. No liability will accrue to the