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NEWS

# Psychotherapy is Alive and Talking in Psychiatry

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The title of Gardiner Harris's front-page story in the March 6 *New York Times* was blunt: " Talk Doesn't Pay, So Psychiatry Turns Instead to Drug Therapy." For those of us who see our profession as a humanistic calling, this piece is likely to provoke a mixture of sadness and anger. After all, its depiction of psychiatric practice was one of grim, damage-control, in which maintaining the financial bottom line and keeping patients functional seem to be the prime directives. The main character in this sorry tale appears to be a decent soul, overwhelmed by the demands of his practice, and ashamed of his own therapeutic apostasy. The besieged and beleaguered psychiatrist, trained in the "old style" of in-depth therapy, describes his office as resembling "a bus station" and concludes that psychotherapy is no longer "economically viable."

The declining use of psychotherapy in psychiatric practice is unquestionably worrisome. Unfortunately, the *New York Times* article uses the anecdotal experience of one psychiatrist to create, at best, a partial picture of psychiatric practice, and at worst, a caricature that perpetuates a number of myths and misconceptions. Among the most injurious of these myths is that psychiatrists have essentially abandoned psychotherapy; that pharmacotherapy is something psychiatrists typically provide "instead of" psychotherapy; and that in the course of a 15-minute medication visit, there is little one can do for the patient's emotional suffering, beyond referring him to a "real" psychotherapist. The article also perpetuates the popular but mistaken impression that pharmacotherapy is a rather crude and simple-minded intervention. Perhaps worst of all, this saga of an overworked psychiatrist may leave millions of readers with the fear that most psychiatrists are now "training" themselves not to get "too interested" in their patients' problems.

First of all, what is the reality of psychiatry's use of psychotherapy in recent years? The *Times* cited a 2005 government survey showing that "just 11% of psychiatrists provide talk therapy to all patients. . . ." Presumably, this was a reference to the study by Mojtabai and Olfson,[1] based on data from the 1996 - 2005 cross-sectional National Ambulatory Medical Care Survey (NAMCS). Indeed, the study found a decline in the number of psychiatrists who provided psychotherapy to all of their patients, from 19.1% in 1996 - 1997 to 10.8% in 2004 - 2005. The study also found that the percentage of visits involving psychotherapy declined from 44.4% in 1996 - 1997 to 28.9% in 2004 - 2005, which ". . . coincided with changes in reimbursement, increases in managed care, and growth in the prescription of medications."

So far, all this is in line with the *New York Times* piece. But the article failed to mention that most psychiatrists (59.4%) *continue to provide psychotherapy to at least some of their patients.*[1] Moreover, when we read the discussion section of the Mojtabai-Olfson study, we find an important caveat. The design of their

study required that "psychotherapy visits" had to be longer than 30 minutes and had to be "explicitly designated as a psychotherapy visit by the psychiatrist or office staff." The authors added this telling observation:

*"Some visits likely involved use of psychotherapeutic techniques but were not classified as psychotherapy in the current analysis. Psychotherapeutic techniques can be effectively taught and used in brief medication management visits by psychiatrists and other health care providers."*[1(p968),2,3]

Furthermore, the NAMCS survey did not examine the *type* of psychotherapy provided. As Mojtabai and Olfson[1] note, "Examining the types of psychotherapy would be of special interest as there has been an expansion in the use of more structured short-term therapies in recent years." Indeed, not all psychotherapy corresponds to, or necessarily requires, the classic "50-minute hour" associated with psychoanalytically oriented therapy. My colleague, James P. Gustafson, MD, has developed a form of "very brief psychotherapy" that sometimes involves 5- or 10-minute interventions. Surprisingly, these very brief encounters can be transformative on a very deep level, for carefully selected patients.[3]

Indeed, while I am no fan of the 15-minute "med check," the critical issue is not so much the available minutes as it is the deftness and sensitivity of the psychiatrist's intervention. Faced with a patient who is experiencing a painful issue in her marriage or job, there is a good deal more we can do in 5 to 10 minutes besides saying, "Sorry, I'm not your therapist. That stuff is not in my bailiwick." We can offer understanding, empathy, and clarification—and I believe most psychiatrists do just that, during a medication visit. Similarly, Dr Glen Gabbard has described how psychodynamic principles and an understanding of the patient's urgent personal concerns are necessary parts of the much-maligned "15-minute med check." He notes that "psychiatry has probably made far too much of a distinction between psychotherapy and pharmacotherapy in training and in practice. Psychotherapeutic skills are needed in every context in psychiatry because the same phenomena that emerge in psychotherapy—transference, resistance, countertransference, schema, automatic thoughts—appear in other contexts. . . . *Psychiatry residents need to be taught that psychotherapeutic principles apply in all settings where psychiatric treatment is delivered.* [italics added]."[4]

The other unfortunate aspect of the Harris article is its implicit reinforcement of the "mind-body" split that has so bedeviled psychiatry for the past 50 years, as Tanya Luhrmann documented in her classic study, *Of Two Minds: The Growing Disorder in American Psychiatry.* Thus, pharmacotherapy is portrayed as something psychiatrists do "instead of" psychotherapy, rather than as part of an integrated and holistic form of treatment. But in my experience, many psychiatrists continue to provide such comprehensive medical-psychological care, although the Mojtabai-Olfson data do not tell us what percentage do so (M. Olfson, personal communication, March 8, 2011). In truth, there are often reasons—including cost-effectiveness—for preferring a "single provider" model of combined treatment. Dr Mantosh Dewan[5] showed, for example, that when treatment requires both psychotherapy and medication, combined treatment by a psychiatrist costs about the same or less than split treatment with a social worker psychotherapist and is usually less expensive than split treatment with a psychologist psychotherapist. Furthermore, with respect to the treatment of major depression, there is reasonably good evidence that the combination of psychotherapy and medication works better than either treatment alone, at least in chronically or severely depressed patients.[6,7]

Yet in the *Times* article, there is a not-too-subtle disparagement of pharmacotherapy. Our harried psychiatrist, estranged from his psychotherapeutic training, opines that ". . . there's not a lot to master" in psychopharmacology, and that he often feels like "the ape with the bone." It's true that the kind of complexity involved in medication treatment is quite different from that of, say, psychoanalysis or object-relations theory. But psychopharmacology has its own complexity, if—to borrow a phrase from Woody Allen—"you are doing it right." Quite aside from the innumerable drug-drug interactions one needs to sort through, there are the issues of medicating patients with comorbid illnesses, such as diabetes or heart disease; understanding how psychiatric medications affect the very young and the very old; monitoring

potential metabolic effects of medications; and mitigating medication adverse effects without undermining otherwise successful pharmacotherapy.[8]

Then there is the realm of medication's "psychodynamics"—the hopes, fears, and fantasies the patient often attaches both to the physician's prescribing a medication and to the particular drug prescribed. A failure to understand these often unconscious issues can spell disaster for pharmacotherapy. As Dewan has put it,

*"Some patients derive a psychological benefit from being given medications, because they consider it a caring, nurturing act that feeds their dependency needs or validates their suffering as genuine. Other patients may see the prescription of medications as an imposition of external control, or as a statement by the therapist that they are not strong enough to solve their problems by themselves. These feelings may contribute to noncompliance with both medications and brief therapy."*[9(pp257-264)]

To be sure, given a 15-minute time slot, the harried psychiatrist focusing only on medication adverse effects is at a severe disadvantage—and so is the patient. Based on the principles of *beneficence* and *non-malfeasance*, one might argue that it is frankly unethical to limit an emotionally distraught or suicidal patient to such a procrustean time slot, if her medical and psychological needs demand more thorough evaluation and management. (Our beleaguered *New York Times* psychiatrist nearly fails to detect suicidal ideation in a patient who initially complained of "ADD" and, to his credit, winds up extending the session to 55 minutes.) Speaking of ethics: we should remind ourselves that there are still over 45 million Americans who lack health insurance, and that most patients with major depression do not receive any professional treatment[10]—never mind, psychotherapy.

Finally, even the constraints of a 15-minute session are no excuse for putting off patients with comments such as "I'm not your therapist." Like it or not, our patients often do not make a sharp distinction between "therapist" and "psychiatrist," and we continue to be seen by them as sources of advice, comfort, and solace.[4] As even our harried psychiatrist observed of his patients, "The sad thing is that I'm very important to them. . . ." But it really isn't sad, Doctor—it is hopeful, and our patients should not be discouraged from seeing us as compassionate healers. After all, this is probably the image we had of ourselves when we entered this profession, our humanitarian ideals still intact.

No, a brief medication check is hardly a substitute for the revered 50-minute therapy hour. But even in a 15-minute meeting, we can still engage in what Theodor Reik called "listening with the third ear." Furthermore, we can and must convey to our patients that we are intensely interested in their problems.

**References**

1. Mojtabai R, Olfson M. National trends in psychotherapy by office-based psychiatrists. *Arch Gen Psychiatry.* 2008;65:962-970.
2. Castelnuovo-Tedesco P. The twenty-minute "hour": an experiment in medical education. *N Engl J Med.* 1962;266:283-289.
3. Gustafson JP. *Very Brief Psychotherapy*. New York: Routledge; 2005.
4. Gabbard GO. Deconstructing the "med check." *Psychiatric Times.* September 3, 2009. http://www.psychiatrictimes.com/display/article/10168/1444238. Accessed March 8, 2011.
5. Dewan M. Are psychiatrists cost-effective? An analysis of integrated versus split treatment. *Am J Psychiatry.* 1999;156:324-326.
6. Keller MB, McCullough JP, Klein DN, et al. A comparison of nefazodone(Drug information on nefazodone), the cognitive behavioral-analysis system of psychotherapy, and their combination for the treatment of chronic depression [published correction appears in *N Engl J Med.* 2001;345:232]. *N Engl J Med* . 2000;342:1462-1470.
7. Friedman MA, Detweiler-Bedell JB, Leventhal HE, et al. Combined psychotherapy and pharmacotherapy for the treatment of major depressive disorder. *Clin Psychol Sci Pract.* 2004;11:47-68.
8. Jacobson SA, Pies RW, Katz IR. *Clinical Manual of Geriatric Psychopharmacology.* Washington, DC:

American Psychiatric Publishing, Inc; 2007.
9. Dewan MJ, Steenbarger BN, Greenberg RP, eds. In: Gabbard GO, series ed. *The Art and Science of Brief Psychotherapies*. Washington, DC: American Psychiatric Publishing, Inc; 2004.
10. Wang SS. Studies: mental ills are often overtreated, undertreated. *Wall Street Journal.* January 5, 2010. http://online.wsj.com/article/SB10001424052748703580904574638750777038042.html. Accessed March 9, 2011.

**Further reading:**

Manring J. No, psychiatry has not lost its "mind": here, psychotherapy training thrives. *Psychiatric Times*. June 2, 2010. www.psychiatrictimes.com/display/article/10168/1579811. Accessed March 9, 2010.

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