

Psychotherapy in the New Paradigms for Psychiatry

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Psychiatry is confronting challenges to create sweeping new paradigms for itself. The author contends that the psychosocial knowledge and psychotherapeutic skills of the psychiatrist must be integral to those paradigms. Abandoning crude, descriptive diagnostic categories in favor of discrete, dimensional measures that personalize selective neurobiological treatment for each individual is part of one proposed paradigm—but psychotherapy, especially psychodynamic therapies, have provided personalized therapy for over a century, using nature's own resources (human relationships and communication) to modulate the patient's unique, fixed patterns of thought, emotion, and behavior regardless of DSM diagnosis. Similarly, beyond the genetic core, the role of development and experience in shaping mental health and illness includes both neurobiological and interpersonal processes that dynamically modulate neural networks and their mental epiphenomena. Psychosocial interventions, using natural pathways, are vital for both prevention and treatment. Another proposed paradigm embraces closer coordination of psychiatric services with primary care in organized systems, which would probably include non-medical psychotherapists as well. Psychiatrists cannot effectively oversee, supervise, partner, or consult with other physicians or therapists if they have no psychotherapeutic awareness. Even when the primary mode of treatment is biological, skilled handling of the doctor-patient relationship is vital to adherence, to helping the patient manage his or her personal life, and even to effectiveness of medication at recommended doses. There is no substitute for instruction and extensive first-hand experience in learning to conduct psychotherapy or psychologically informed patient care. In a psychiatric residency curriculum that is likely to contain greatly increased attention to clinical neuroscience, time for the psyche must be preserved. The new paradigm might require a lengthened residency or additional fellowship years, which must include appropriate attention to psychosocial learning and psychotherapeutic expertise. (*Journal of Psychiatric Practice* 2012;18:205–207)

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The Director of the National Institute of Mental Health (NIMH), Thomas Insel, tells us that we must “rethink” mental illness.¹ Rubin and Zorumski write that it is time for a major paradigm shift in our field.² Maybe we must think up a new name for our specialty, says Dr. Insel. I agree that it is time for some radical changes—but let's not throw the baby out with the bathwater!

There are two major lines of thought in these proposals, although both spring from the respective writer's observations that our severely ill patients aren't recovering any more successfully than they did decades ago, despite great costs in money and quality of life. Insel points to serious deficiencies in our primitive diagnostic system, our knowledge of etiology, our trial-and-error treatment methods—our inability to “cure.” Prevalence and mortality have not decreased for any mental illness. Psychiatric treatment has not kept pace with neuroscientific discovery.

In addition to similar observations, Rubin and Zorumski also fault the current psychiatric care system that attracts and pays for too few providers, limits access to services of all kinds, and fosters “overreliance on polypharmacy” with far too little of the follow-up and psychosocial services that are vital to successful treatment of severe illness.

Who can argue with either premise?

The proposed remedies also lie in two directions. In our training, we must give much greater emphasis to clinical neuroscience, seeking the specific interventions in neural physiology that will cure or prevent illness. Insel calls for “transforming” diagnosis, treat-

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ment, and training through “standardization, integration, [and] sharing.” In the realm of service delivery, Rubin and Zorumski describe how we can maximize the multiplier effect of our limited resources through collaborating and integrating our services with primary care and physician extenders.

Can psychiatrists do this and still be therapists? I contend that we must! Whatever name we wind up calling ourselves, we must keep the “psyche” in any new paradigm of psychiatry. Not just the word, “behavioral,” because behavior is only the surface, the final common pathway for the output of mind and brain. Mental processes are complex and deep, and they affect all of our patients, not only those who are severely ill. If we as psychiatrists or clinical neuroscientists profess to use the full body of knowledge of the human mind and its underlying organ, the brain, we must be able to use the resources of psychoanalysis and cognitive psychology as well as neuroscience. That means that psychiatrists must know how to conduct formal psychotherapy. But dealing with the psyche—with subjective experience—is essential in a much broader sense as well.

The heading of a key slide in Dr. Insel’s talk is “Disruptive Innovations in Mental Health.” This slide presents three points: mental disorders are 1) brain disorders, 2) developmental disorders, and 3) the result of complex genetic risk plus experiential factors. Let’s think about “development” and “experience.” Dr. Insel addresses development in a neurobiological framework—but we know that the development of neurons and neural networks and systems is hugely dependent on experience at critical phases of childhood and adolescence. The examples are as simple as disuse amblyopia and as complex as the profound effects of faulty attachments with mother and father in early childhood. Relationships count! These findings have tremendous implications for the prevention of mental disorders or for their mitigation even when faulty genes are at work. Prevention of mental illness is not limited to neurobiology. And child psychiatry, especially, ignores at its peril the extensive knowledge of childhood psychic development within a family.

The discovery of neuroplasticity in adult life, through neurogenesis and the building of neural networks through learning and experience, provides a compelling scientific basis for psychotherapy.³ As Insel acknowledges, experience plays a significant role in determining how the mind and its underlying

neural infrastructure develop and function throughout life. I can’t think of any psychology that looks at human beings over the life cycle, from psychoanalysis to sociological research, that doesn’t verify the role of experience. Most of the influences that make a significant difference do so over months and years of repetition, although overwhelming catastrophic events also play their part.

Psychotherapy utilizes nature’s way of changing the neural networks that underlie patterns of thought and emotion.⁴ In contrast to flooding the entire organism with agents that alter neurotransmitters, psychotherapy allows precise, focused attention to particular patterns and interactive systems of mental function. Specific, evidence-based psychotherapies exist for a wide variety of diagnostic conditions, and they are often the primary mode of treatment for milder depressions, borderline personality disorder, some anxiety disorders, and many states of comorbidity.^{5,6} Long-term psychotherapy has been shown to be clearly superior to short-term psychotherapy in treating “complex, mixed mental disorders,” and its beneficial effect continues even after therapy ends.⁷ Psychotherapy is cost-effective.⁸ Psychotherapy can go beyond our crude diagnostic generalities to the particular dimensions of mental functioning. Psychotherapy helps us work with patients as unique individuals—another highly researched way to “personalize” psychiatric care, to use Dr. Insel’s word. Do we want to give up or weaken this fundamental part of our armamentarium?

To be sure, psychologists, social workers, and counselors can offer effective psychotherapy to our patients. If they do that as part of an interdisciplinary team, psychiatrists are likely to be at the head of the team, at least in a medical setting. How can we oversee, supervise, or consult meaningfully on a skill with which we have no working knowledge or experience? Would we be content just to be the neuroscientific technician, the prescriber and medical expert? Like psychotherapy itself, becoming proficient in psychotherapy takes time. It is more than a matter of didactically learning theory and principles of technique. There is no substitute for clinical experience over months or years with many patients, along with developing awareness of one’s own inner life—often through one’s own therapy—while being engaged with that of others. We change, too, as we become good therapists and better psychiatrists. This process of change continues well beyond residency

training. Since the enhanced neurobiological focus in the proposed new paradigm will presumably require additional instructional time and experience with imaging and research techniques, I can foresee the need for a longer residency in our field, or incorporating psychotherapy training in advanced fellowships for any sort of psychiatric specialty that involves direct patient care.

So far I have been writing about formal psychotherapy, but the perspective of psychotherapy enhances all kinds of work with patients. Understanding personality development and psychodynamics is a vital skill in dealing with any sort of patient, even when psychotherapy is not feasible or part of the treatment plan. There is more to our patients than their identified psychopathology. Knowing that, and knowing ourselves, is vital to the doctor-patient relationship, including in the primary care settings where we are encouraged to expand the role of psychiatry. Relationships sustain people. In my practice in a full-service medical building it could not have been otherwise, and ending those relationships with some patients who were doing very nicely in managing their illnesses (psychiatric and/or medical) was a very difficult part of closing my practice when I retired. The relationships were associated with a high rate of compliance with medications and generally with good results at recommended dosage levels.

When I was deciding what specialty to go into from Harvard Medical School, I chose psychiatry because I felt that, far more than anything else, psychiatry used the whole of my liberal arts education. It brought the power of science together with the wisdom of literature, the arts, philosophy, history, and all the rest. The University Hospitals of Cleveland

residency appealed to me more than the others that I matched with because it was full of the fervor of integrating psychiatric knowledge with patient care throughout the then new curriculum of Western Reserve's medical school. What goes around comes around: now the great psychiatric systems thinkers are talking again about collaborating and integrating with primary care; and the Medical College Admission Test (MCAT) will require knowledge of social sciences (although it ought to include great literature as well). I have never regretted my career choice. I hope the proposed new paradigms for what we now call PSYCHIATRY will still appeal to medical school graduates who have a liberal-arts sensitivity and like to work with people.

References

1. Insel T. "Rethinking" mental illness. Grand rounds at University Hospitals of Cleveland, February 24, 2012 (similar to recent presentations by Dr. Insel reported elsewhere).
2. Rubin E, Zorumski C. Upcoming paradigm shifts for psychiatry in clinical care, research, and education. *Acad Med* 2012;38:261-5.
3. Kandel E. A new intellectual framework for psychiatry. *Am J Psychiatry* 1998;155:457-69.
4. Cozolino L. *The neuroscience of psychotherapy: Healing the social brain*. New York and London: Norton; 2010.
5. Summer R, Barber J. *Psychodynamic therapy: A Guide to evidence-based practice*. New York: Guilford; 2010.
6. Shedler J. The efficacy of psychodynamic psychotherapy. *Am Psychol* 2010;65:98-109.
7. Leichsenring F, Rabung S. Effectiveness of long-term psychotherapy: A meta-analysis. *JAMA* 2008;300:1551-65.
8. Lazar S, ed. *Psychotherapy is worth it: A comprehensive review of its cost-effectiveness*. Washington, DC: American Psychiatric Publishing; 2010.