The four articles related to psychotherapy in this issue of the *Journal of Psychiatric Practice* may indicate trends towards a welcome reintegration of psychotherapy within its own domain as well as with the rest of psychiatry. This development is heartening to me, in light of the concerns about the diminishing role of psychotherapy in psychiatry that I expressed in my column in the November 2008 issue of this journal.1

The term “biopsychosocial” has been a staple of psychiatric leaders declaiming lofty principles for several decades, but managed care, economic incentives, and heavy pressure from the pharmaceutical industry have worked against that unifying principle. A recent study confirms the impression that fewer psychiatrists offer psychotherapy as part of work with patients, and that those who offer it, do it less often.2 There is little time in a “med check” for attention to the patient’s thoughts and feelings, let alone his or her social milieu.

In this issue, Julius et al. present compelling evidence for what I view as a psychotherapeutically informed approach to help psychiatric patients achieve medication adherence.3 Based on their review of the English-language literature, they concluded that psychoeducation is not enough. Their findings highlight the importance of the therapeutic alliance (a term that originated in psychoanalytic psychotherapy), devoting time specifically to address medication adherence, assessing the patient’s motivation to take prescribed medications, and identifying and addressing potential barriers to treatment adherence.

All of these strategies require psychotherapeutic expertise to interview skillfully, listen to the patient, look beyond the surface, and respond insightfully in a way that fits the patient. They are arguments for the well rounded, flexible, resourceful psychiatrist—and for more time for medication visits. Such strategies are not so well served by rapid-fire symptom checks and prescription writing by a psychiatrist, while all psychotherapy is split off to non-medical therapists. In contrast, individual psychotherapy with medical evaluation and management, which only a psychiatrist can offer, works very well for medication management and fostering adherence.

Treatment adherence of another kind is the focus of a study by Chiesa et al. in this issue.4 Superior adherence and reduced impulsive behavior were outcomes of a psychodynamic, community-based program for treatment of patients with borderline personality disorder. The flexibility of psychodynamic interventions tailored to the needs of the patient comes across in the use of intensive individual therapy, group therapy, team approaches, and adaptation to the social situation of patients with borderline and other severe personality disorders. Results on all outcome measures were superior to those achieved by long-term, inpatient treatment in the same facility. Communication and coordination among the various parts of the treatment team are key to the success of such a specialized program geared to the treatment of patients with this diagnosis.

The world of psychotherapy, now increasingly the realm of psychologists, social workers, counselors, and psychiatric nurses, has splintered into a variety of methodologies that are often considered to be antithetical to each other. Cognitive-behavioral therapy (CPT) is way out in front in the competition to build an evidence base for efficacy for specific disorders, with interpersonal therapy (IPT) and dialectical behavioral therapy (DBT) making a respectable showing as well. Psychodynamic psychotherapy (PDP), based on psychoanalytic principles, often long-term and looking beyond symptoms to the whole patient, is much harder to study, especially by the gold-standard methodology of a randomized, controlled, double-blind trial of a manual-based therapy for a specific disorder. However, PDP is catching up, as evidenced by favorable findings in a blue-ribbon study of PDP for panic disorder5 and a recent meta-analysis of studies of long-term PDP6 published in leading journals. Other forms of psychotherapy, such as gestalt therapy, eye movement desensitization...
and reprocessing (EMDR), and Jungian psychoanalysis, also compete for attention and acceptance. The situation lends itself to rivalry and polarization between schools of psychotherapy.

Two articles in this issue bring together the major schools of psychotherapy. Horowitz and Möller study the phenomenon of transference in cognitive and dynamic psychotherapies using a role relationship model called configurational analysis. Forty-one experienced psychotherapists from one or the other school rated the transference manifestations of one of their own patients by formulating them along the dimensions of 12 simple positive and negative transferences. The frequencies of transferences of each kind were roughly similar for both types of psychotherapists. Most of the psychotherapists who participated in this study found the role relationships model configuration to be useful.

Again, the concept of transference originated in psychoanalytic experience with patients, where it is viewed as a repetition with the therapist (or other significant persons) of relationships from early in life. While the paper by Horowitz and Möller introduces transference in that framework, their study reflects a broader usage of the term transference, which has come to refer to any notable emotional pattern the patient demonstrates in his or her relationship with a therapist (or conversely with counter-transference, the therapist’s emotional reaction to the patient). The 12 items used in this study descriptively identify strong emotional reaction patterns without reference to their origins in the patient’s life experience (i.e., whether they are strong responses that are appropriate to the here-and-now treatment relationship or, on the other hand, they appear to be derived from early life relationships). Nevertheless, the study suggests that the two forms of therapy have something in common, and the parameters identified in the study may lead to fertile observations.

That PDP and CBT have something in common is the focus of the paper by Plakun et al. on the “Y Model” approach to teaching psychotherapy competencies. (Full disclosure: I am on the committee of the American Psychiatric Association that contributed to this paper.) The Y Model is an integrated framework for teaching psychotherapy competency across the three types of psychotherapy identified as core competencies by the Psychiatry Residency Review Committee—supportive, psychodynamic, and cognitive-behavioral. The model draws on studies that sort out which qualities are characteristic of both PDP and CBT (the stem of the Y) versus which are distinctive to one or the other (the branches of the Y). The qualities held in common, such as the therapeutic alliance, are also found in supportive psychotherapy. The paper concludes that the Y Model is “a conceptual approach for teaching residents about psychotherapy in a way that frees them from the competition between schools that has often characterized such training in the past—to the detriment of learning.” That may well be the foundation of the psychotherapeutic component of training the “complete” psychiatrist, which is relevant to the work described in all four of the papers discussed here.

References