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30 Years of psychiatry, with no fundamental progress

It is helpful, when evaluating any scientific proposal, to first examine underlying assumptions. In the editorial outlining 10 foundations of advanced care for psychiatrists (Do you practice sophisticated psychiatry? 10 Proposed foundations of care, CURRENT PSYCHIATRY, From the Editor, August 2015, p. 12-13), there are a number of assumptions that warrant discussion. I want to discuss just one of those assumptions: that psychiatric practice is better now than it was 30 years ago.

I argue that psychiatric care in America, as a whole, is *much worse* now than when I finished training in 1990, primarily because of changes in healthcare reimbursement. When I was in training, it was common for patients to stay in the hospital for a month or longer. One reason for the longer stays was because it takes weeks for antidepressants and antipsychotics to reveal their effectiveness. If, after 10 days, no improvement was seen, there was time to change medications.

With a hospital stay now averaging less than a week, today's inpatient psychiatrists must rely on faith that the first treatment will work; the patient must hope that he (she) does not fall through the cracks after discharge; and the outpatient psychiatrist, short on time and psychotherapeutic training, might feel more like an assembly line worker than a professional.

Longer stays also meant more intense and extended periods of psychotherapy and psychosocial support than is possible now. It was common, when I was in training, for the biological camp to dismiss the benefits of psychotherapy therapy. After several decades of research, that position is no longer tenable—yet hospital stays remain impractically short.

If all of the medications developed since 1990 disappeared, I believe I could be as effective a psychiatrist as I am today. The simple, sad fact is that there have been no major psychopharmacotherapeutic advances in the past 30 years. Yes, there have been changes in side-effect profiles and improvements around the edges, so to speak, but no fundamental changes in effectiveness since the introduction of clozapine.

What about advances in treating negative symptoms of schizophrenia, you ask? I have not been impressed.

The worst change in psychiatric practice in the last 30 years, and the one that threatens to undermine our profession the most, is relinquishing psychotherapy as a major component of our practice. I do not mean cognitive-behavioral therapy (CBT), although that paint-by-the-numbers set of tools is better than nothing. I mean psychoanalytic psychotherapy, because it is the only comprehensive developmental theory of the mind and its pathology. There is no CBT of development, for example.

To practice and research most effectively, we need good theories of both mind and brain. For all our advances, we are no closer to explaining the mind through a brain-based theory than when Sigmund Freud tried with his *Project for a Scientific Psychology*.

Ours is, by far, the hardest, most intellectually challenging medical profession. We must be masters of neuroscience to bring forth a future when something such as a *Project for a Scientific Psychology* will be possible; we must do the best by our patients with available somatic treatments; but we also must be masters at understanding human emotional development and the intricacies of relationships and how these influence the function and epigenetics of our brains. We must reinforce our understanding of the mind through doing psychotherapy with a significant fraction of our patients to further that understanding and its associated skills—or we risk becoming assembly line psychiatrists.

Over the past 25 years of practice, I have learned that the 2 most important tools we have are time and our evolutionarily determined empathic capacity to enter another human's subjective world. The first session should not be about ordering medical tests and gathering family history; it should be about establishing a relationship. It is on the strength of that relationship that the

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success of understanding and treatment, whether somatic or psychological, rests.

Thirty years ago, we had all the time we needed. That was, in some ways, a Golden Age of psychiatry. Imagine if we could bring together the greater availability of time of that era with the increasing biological and psychoanalytic understanding of the present. Then, we might have a new Golden Age. For that to happen, we must fight to change the reimbursement system. The quickest way—maybe the only way—to do that is to stop accepting reimbursement from healthcare insurance companies.

Jule P. Miller III, MD
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Dr. Nasrallah responds

Dr. Miller is correct: Insurance has defiled psychiatric care, both inpatient and outpatient, including minimizing hospital days of care and reducing psychiatric visits to med-checks with no time to provide even rudimentary psychotherapy—psychodynamic or otherwise. I believe that the optimal medical model of psychiatric care must incorporate empathic capacity, which establishes the indispensable therapeutic alliance with each patient we see.

Dr. Miller is harsh on the lack of psychiatric advances since completing training 25 years ago. I have been in academia throughout those years and I am thrilled by how much neuroscience we have discovered that is directly related to disorders of affect, thought, cognition, and behavior. The challenge continues to be in translating those discoveries into practical therapeutic interventions, which proves the point that psychiatry is the most challenging medical specialty, consistent with the brain (and its mind) being, by far, the most complex organ.

We cannot abdicate insurance reimbursement except for our well-to-do patients. Patients with severe and disabling mental disorders, who need our services the most, cannot afford to pay for care, and depend on Medicare and Medicaid, whose modest reimbursement would impoverish non-salaried psychiatrists. Because of the severe shortage of psychiatrists, who are the only specialists who can competently manage neurobiological disorders such as schizophrenia, bipolar disorder, and severe depression, I believe we should deploy our resources for those vulnerable patients and leave the worried well and walking wounded to other mental health professionals.

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This month's quickpoll

Mr. C, age 44, arrives in the ER complaining of abdominal pain. He has a history of severe alcohol use disorder, drinking a liter of liquor daily, while maintaining his job as a convenience store clerk. Mr. C states he started heavily drinking after his wife suddenly died 5 years ago. Imaging shows minor inflammation of the liver and he is diagnosed with asymptomatic hepatic steatosis, and is told that he needs to stop drinking immediately to prevent further, irreversible damage to his liver. **How would you proceed?**

- ☐ Prescribe naltrexone, 100 mg/d, and start cognitive-behavioral therapy (CBT) for depressive symptoms
- ☐ Initiate alcohol detoxification, request that Mr. C enroll at a residential rehabilitation program, and prescribe acamprosate, 666 mg, 3 times a day
- ☐ Prescribe disulfiram, 500 mg/d, and start CBT
- ☐ Prescribe paroxetine, 20 mg/d, and suggest Mr. C attend a 12-step program for substance abuse

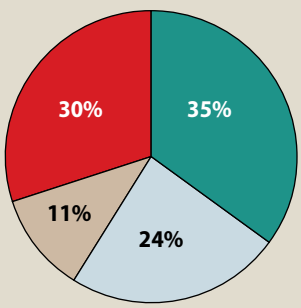
See **"Preventing drinking relapse in patients with alcoholic liver disease"** *pages 22-28,30-32*

Visit CurrentPsychiatry.com to answer the Quick Poll and see how your colleagues responded.

OCTOBER POLL RESULTS

Mr. B, age 35, is brought into the emergency room after a car accident that he caused by driving erratically. While taking his history, he has rapid speech and reports not being able to sleep for the last 3 days. Mr. B has a history of major depressive disorder, which has been well controlled with venlafaxine, 225 mg/d, for 7 years, and reports no previous manic episodes. **How would you treat his first manic episode?**

- **35%** Stop velafaxine, initiate quetiapine, 50 mg/d, and titrate to 150 mg/d
- **24%** Stop venlafaxine, initiate lithium, 1,800 mg/d
- **11%** Stop venlafaxine, initiate olanzapine, 6 mg/d, and fluoxetine, 50 mg/d
- **30%** Reduce venlafaxine dosage to 75 mg/d



SUGGESTED READING:
Goldberg JF, Ernst CL. Current Psychiatry. 2015;14(10):28-32,35-40.

Data obtained via CurrentPsychiatry.com, October 2015