CHAPTER 23

Psychotherapy: The New Evidence

In the last 20 years, just as psychiatrists were running away from the talk therapies, particularly psychodynamically based ones, there's been a growing body of scientific evidence that shows talk therapies work. In fact, there is overwhelming evidence that nondrug therapies can be a powerful way to handle psychiatric conditions if we specifically define which therapies for which types of problems. Psychiatrists today have a wide array of treatments beyond medications to offer individual patients. There is a huge opportunity for psychiatrists, presuming we take it.

Talk therapies are making a comeback in a scientific age because the evidence shows they are effective for specific problems. Cognitive behaviour therapy (CBT), developed in Philadelphia by Aaron Beck and his colleagues, including Brian Shaw, who came to the Clarke in the 1980s, examines the types of distorted thinking that may affect emotions and behaviour.[1] Patients are helped by examining misguided thoughts and learning to challenge them. CBT has been proven to help people with depression, some anxiety disorders, and even bulimia. More than 70 clinical trials of CBT for unipolar depression leave no doubt that it's effective—better than placebo and equal to medications for mild to moderate depressions. CBT also reduces the rate of relapse as well as or better than medications. It is useful for the eating disorders and addictions when modified for the specific problem. It is now being adapted for use as an aid to treatments for schizophrenia and bipolar illness. Research has also shown that behaviour therapies are of value in specific circumstances, such as desensitization to phobias or for compulsions.

Another treatment for depression, interpersonal therapy, evaluates the patient's relations with other people from a psychodynamic perspective. It was first developed as a control condition in a trial of new antidepressants by Gerald Klerman of Boston and Eugene Paykel of London. When the surprising results began to show the treatment was beneficial, it was refined by Klerman and Myrna Weissman and their colleagues, in the New Haven–Boston Collaborative Depression Research Project for the treatment of moderately depressed patients. By the late 1980s, there was evidence for its real effectiveness, especially for depression in the context of acute relational problems, losses, and transitions.[2] Another form of psychotherapy, supportive psychotherapy, is useful particularly when combined with medication and rehabilitation. It aids the patient in developing a greater understanding of his or her current situation, defining alternatives and fostering adaptive coping and resilience. Supportive therapy helps to buttress the individual's self-esteem, encourages expression of feelings, and works to instil a sense of hope.

More recently, Marsha Linehan of the University of Washington developed dialectical behaviour therapy (DBT), a treatment she wished she had received when she was ill as an adolescent.[3] Originally used for suicidal adolescents with borderline personality disorder, DBT has been adapted for substance abuse and eating disorders. Linehan hypothesized that people with borderline personality disorders struggle to experience and integrate the dialectic, the opposing views. Self-destructive urges are commonly part of borderline syndromes. Suicidal behaviour, according to Linehan, is both harmful and maladaptive but may serve a useful purpose, perhaps to release emotion, or to alter feelings, or to convey distress. Thus, there is a need for both self-acceptance (Linehan calls this radical self-acceptance), and change, the latter for parts of the self that can be altered. Acknowledging that behaviour makes some

sense as a relief from suffering is important in providing validation for the person (they are not "just bad"). Although validation and acceptance of the self are important, modifying maladaptive behaviour is also critical. Linehan showed that entrenched behaviours can change, and when they do, can alter the person's emotional state (the opposite of what many people had intuitively thought). As part of treatment, people are taught "action opposite to emotion": when they feel an emotion is inappropriate, they are to act in a manner opposing that emotion. These interventions diminish impulsiveness and help people tolerate distressing "bad" feelings. Mindfulness has been an important part of this treatment, and has been since pursued for its own benefits.

Mindfulness-based stress reduction was first developed by Jon Kabat-Zinn at the University of Massachusetts Medical School in the late 1970s from experiences in the application of Buddhist meditation techniques.[4] A core goal of mindfulness meditation is to develop an ability to experience thoughts as purely mental events that can be allowed to pass through the mind without generating feelings or reactions. The focus is not to change "aberrant" thoughts but to learn to experience them as internal phenomena separated from the self. Mindfulness meditation has been shown to be effective in preventing relapse once a patient has recovered from depression. Mindfulness-based cognitive therapy (MBCT) was specifically developed by Zindel Segal and his colleagues to reduce the number of relapses in patients with recurrent major depression.[5] Mindfulness is also useful for people in recovery from substance abuse.

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After hundreds of studies, we now know that psychotherapy is effective for most people. One meta-analysis found that "the average person who receives therapy is better off at the end of

it than 80% of the persons who do not."[6] Another more recent meta-analysis of more than 50 controlled studies of adolescents and children, comparing evidenced-based therapies (such as CBT or family therapy) with general support, found a large benefit to the evidence-based therapies.[7]

The real issue, then, was not whether psychotherapy worked. The question was what kind of psychotherapy was useful for what sort of disorders, and when to apply it with other forms of treatment. Those decisions, I believe, should be based as much as possible on the evidence a priori and not on the theoretical biases of the individual psychiatrist.

Clinicians may not be changing their practices in response to psychotherapy research data. In the 1999 study I did with Christine Dunbar, Mike Bagby, and Barbara Dorian of Ontario psychiatrists, we found, that 40% of the physicians had altered their theoretical orientation—the belief system that guides understanding of a person—over the course of their careers. The majority did not. Whether they had incorporated these new therapies into their treatments is not clear from our study, but anecdotally it appeared that most had not. Psychiatrists can use different therapies in their practice even if they specialize in one area. It is possible to learn the skills of another approach to better tailor treatment to the individual patient, or at least to recognize when an alternative intervention would be effective.

Dynamic psychotherapy is a powerful treatment, but it is not useful for all conditions. Those with chronic depression or certain personality disorders can benefit from this treatment, but those with severe depression, OCD, or psychosis generally do not. Combining dynamic therapy with medications can enhance the results for conditions such as moderate depression and bulimia.

Psychologist Allan Abbas of Dalhousie University, in Nova Scotia, published a meta-analysis of more than 20 studies of the

effectiveness of psychodynamic treatments that lasted for fewer than 40 sessions.[8] These included almost 1,500 people suffering from depression, anxiety, or stress-related problems. The analysis demonstrated a very large beneficial effect from the dynamic therapies. Equally important was the finding that when people were followed up over the first year after therapy had ended, the positive effect had continued to grow. Psychodynamic therapy may set in motion processes that lead to further psychological growth and maturity.

Although there is strong evidence that talk therapy is effective in some cases, we don't know exactly how it works. (This is also true for many new medications that are introduced generally in medical practice.) Is it the therapist's interpretations (the formulations of the meaning of feelings and behaviour) that leads the patient to new insight and benefits, or something else? There is strong evidence that trust, faith, hope, consistent concern, and attention are important for the success of therapy. In studies where patients and therapists fill out notes after each session over one and a half years, it had been demonstrated that intellectual insights were not the only thing that produced change. Emotional interventions were considered to be most powerful, according to both therapists and patients. Other studies comparing CBT and dynamic therapy have shown that CBT is most helpful when therapists have incorporated components of dynamic therapy—exploring recurrent themes, emotions, and fantasies, as well as defences and relationship patterns.[9] The precise mechanisms that produce change may not be clear, but this doesn't undermine the strong case for the effectiveness of talk therapy.

Too many clinicians ignore the evidence for psychotherapy and rely too heavily on prescribing medications. This is a symptom of a major problem afflicting our profession. We have swung too far in the direction of prescribing drugs for mental illness and even for problems that are a normal part of the human condition. We

have traded the hours of therapy, and the search for meaning in a person's life, for the checklist diagnosis and the quick prescription.

This is hardly what we signed up for when we became psychiatrists and committed ourselves to helping people with mental illness. If we really want to serve our patients, we need to deploy the full scope of treatments to relieve pain, and intervene to help them live more fulfilling lives. Psychotherapies, as we have seen, have been proven effective for some people. Decent housing and jobs are essential to recovery. Above all, we need to treat our patients as complex individuals, not as one-dimensional figures. We need to devise layered treatments addressing their biological, psychological, and social needs.

Unlike other professionals working in the mental health field, psychiatrists potentially have the training and ability to integrate the complex and powerful interactions between biological and psychological makeup and experience. Ideally, we can balance the science of the brain with the art of managing the mind to produce innovations in treatment that merge these aspects in tailored and specific ways.

For psychiatry to be a strong profession, it must have a conceptual centre. The domain of the psychiatrist is the mind and the personal consciousness of the patient.[10] We study the physical brain as an index of the mind. We study behaviour as an index of the person's makeup. Psychiatrists should aim to understand the person, and why disorders of thinking, feeling, or behaving have evolved as they have in that person. The problems may involve some changes in the person's brain that impact thinking, memory, perception, and mood; aspects of temperament such as genetics, attachment, or intelligence; life experiences like loss, separation, abuse, or trauma; and the broader context, such as family, relationships, and work.[11] Only when all these factors have been considered does the ideal psychiatrist determine the necessary interventions. Many mental

health workers can provide good psychotherapies, and many general practitioners and internists can learn to be capable psychopharmacologists. Psychiatrists should provide a unique understanding, integrating medical knowledge, neuroscience, psychological models of the mind, and social determinants of behaviour.

Our domain is the interface of mind, brain, and body. We have to evaluate and integrate information, from the molecular, to the neurochemical, to the intrapsychic (within the mind), to the interpersonal, to the systemic, to the sociocultural. The territory is the broad science of human behaviour, including psychology, anthropology, and sociology, as well as the complex activities of the central nervous system. Our tools range from our capacity for empathic listening to sophisticated neuroimaging systems, such as PET scans and functional MRIs that show detailed pictures of brain functioning in health and disorder.

What an amazing time to enter the field of psychiatry. We now know how common the mental illnesses are. There is a real need for new, well-trained people in our field; jobs will be plentiful. As well, there is great variety in the type of work, and it is never boring. We are now able to draw understanding from complex fields to make psychiatric care and treatment comprehensible to patients and families, and to engage the public and our colleagues. We are becoming more able to battle the prejudice to our patients and the field, and we are advancing treatments dramatically. Someone entering the profession today will be certain to see remarkable increases in knowledge and continual therapeutic advances throughout their careers.

One of the distinguishing features of psychiatry is in the diversity of models we use to understand the human conditions. They provide us with a frame of reference to appraise a problem. Take a 12-year-old boy, James, who is afraid to go outdoors at his father's farm. He is afraid of horses, convinced they might kick or bite him. The traditional Freudian analyst might see the boy as gripped

by an Oedipal fear, which in this case is a displacement of a fear of his father onto the horse. A more modern dynamic psychiatrist could highlight a problem in attachment, associated with anxiety in being separate from his mother and fears of abandonment that keep the boy indoors.

The behaviourist would focus the problem from a different point of view. Perhaps the little boy went outside a long time ago and a horse snapped at him. This caused anxiety that led to a fear, which has now generalized to all horses and places with horses. An interpersonal framework might focus on the issue of unresolved conflict between the father and son, and on the fear and avoidant behaviour as representing the boy's ambivalent struggle with anger and wishes for independence. The geneticist might evaluate the family to see whether any blood relatives were predisposed to high levels of anxiety. There could be an inborn defect in the brain's neurotransmitters and receptors that regulate anxiety. Ultimately, one may propose a dimensional model—the boy was born with a vulnerability to anxiety and stress, which is stimulated by certain circumstances that have a specific meaning to the boy and thereby influence his avoidant behaviour.

Six psychiatrists, six different but possibly overlapping explanations. Each one might be convinced that his or her model provides the complete and only answer to the mystery posed by the boy's fear of going outside and being with horses. In real life, though, one explanation rarely provides a full view of one person, let alone all people who present with suffering in a particular way. People are complex, and each individual's presentation is impacted by different life circumstances, temperament, and experiences, and psychiatrists' ability to vary and integrate the models of understanding enriches our experience of the clinical situation.

By using the model that best fits the situation, we can gain a more comprehensive understanding of the problem, which will

lead to a more thoughtful and effective treatment plan. Ideally psychiatrists of the future will have the training and knowledge to use various models of the human psyche to improve the quality of life for our patients. This understanding will open the door to all kinds of strategies, from prescribing drugs, to interpreting unconscious motivation, to meditation and cognitive behaviour therapy, to helping the patient find a home and a job.

A Comfortable Home Is Good for Therapy

The traditional view of housing for people with addiction and mental illness has been that they should cut out drugs first, then get into treatment, then training, and then finally, find a place to live. In the early 1990s in New York City, psychologist Sam Tsemberis and researcher Ronda Eisenberg tried the opposite approach based on what homeless people told them.[12] They began providing the housing and rent supplements, and then individualized supports based on the person's need. After five years, 88% of the program's tenants remained housed, whereas only 47% of the residents in the city's residential treatment system remained housed. A large multisite Canadian study program called At Home/Chez Soi, run by the Mental Health Commission of Canada, with Paula Goering as the academic lead investigator, has shown not only better outcomes for the homeless who received housing as a first step in treatment but also significant monetary savings for the health care system.

A Job Is a Part of Good Treatment

A job is good therapy too. There has been a striking evolution from the old vocational rehab approach (think wicker baskets) to supported employment strategies, which provide job coaches, job development and training, transportation, individually tailored supervision, and

support on the job. There is good evidence that these interventions are effective and promote confidence, self-esteem and well-being. According to a 2004 review by Indiana University psychology professor Gary Bond, 60% of patients enrolled in these programs found jobs, compared with 20% in other programs.[13]

Research demonstrates without a doubt how powerful work, income, housing, and social support are to recovery. Friends and family who develop mental illnesses need us more at those times than any other, and our very presence has a strong mitigating influence on their symptoms. The common social distancing that accompanies mental illness and addiction can be as devastating as the illness itself, if not more so. Human beings are social animals who need to connect and belong. Care, attention, and connection are even more important if we have an addiction to painkillers or a serious depression. We don't stop needing a comfortable and safe home because we have an alcohol problem or schizophrenia. In fact, how could we begin to recover without this essential security? Eugene Paykel and others have summarized the strong scientific evidence for social support playing a critical role in the outcome of mental illness.[14]

There is no doubt that effective treatments now exist for people with mental illnesses. These have been evaluated in many scientific trials, and the results are overwhelming, if only psychiatrists use this evidence for the benefit of reducing the suffering of their patients.