The Role of Psychotherapy in Public Psychiatry Today

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It was the annual "changeover day" at the county adult outpatient clinic. The psychiatric residents with a year's experience, confident and well trained at their level, had left, and the current residents, anxious and new to the game, were arriving. The transition was moving along as expected.

The usual chaos ensued with the clinic's chronic psychotic patients, who were confused by staffing changes. They appeared at the clinic at unscheduled times looking for prescription renewals. New patients, who had been given appointments at staggered times throughout the morning, arrived en masse at 7 a.m. Some came with children. One was in a wheelchair, another was on crutches, and several were accompanied by distraught family members. Welcome to the beginning of a new academic year.

On the first day of the changeover, the staff psychiatrists evaluate the new patients, and the beginning residents observe them. After that the residents are on their own. First on my schedule was Jane, a 41-year-old single mother with her 14-month-old daughter in tow. With great urgency, agitation, and pressured speech, she told us that she had bipolar disorder and was a substance abuser who had been clean for five years. She had relapsed for one month in the sixth month of her pregnancy and had stopped taking her medication because she didn't want to believe she was "really bipolar." She had not resumed taking her medication, and now, she said, she was "falling apart." Her longtime boyfriend had left her after she had purposely become pregnant and decided to have his child. She needed to quickly manage her agitation and racing thoughts because in three days she would be starting a class that was expected to result in a steady job.

While Jane flooded us with this and other information, she was trying frantically to entertain her frisky toddler, letting her tear apart her pocketbook, including emptying and chewing her wallet. All the while Jane also apologized for her self-perceived inadequacies.

The next patient was Sam, a 54-year-old married, unemployed man who had been diagnosed 25 years ago as having schizophrenia. Sam was well groomed and neatly and appropriately dressed—in stark contrast to his thought processes. He had stopped taking his medicine several months earlier when his local mental health clinic had closed. He was now disorganized, alternately hostile, paranoid, and sadly depressed. He told us he lived with his wife, daughter, and two grandchildren in a one-bedroom apartment. Last night, he said, his wife of 27 years told him that she had filed for divorce and that he must move out.

As we listened to Sam's disorganized presentation, it was scary for us to imagine how he had managed to navigate the Los Angeles freeway system and arrive unscathed at the clinic. When he spoke of threatening to strangle his wife, we knew we had sufficient clinical and legal reason to hospitalize him. He would not be driving home.

What is the role of psychotherapy in understanding and treating Jane and Sam and the many other patients in the clinic with a panoply of diagnoses such as panic disorder, dysthymia, posttraumatic stress disorder, and major depression? For that matter, why am I, a psychoanalyst, working in this setting? Why, at this time, has *Psychiatric Services* decided to initiate a column on psychotherapy? Why wasn't there such a column before?

Fenton and McGlashan (1), clinicians experienced in the treatment of severe mental disorders, wrote of their concern about the "profit-driven erosion of compassionate care for psychiatry's most vulnerable patients." They underscored the importance for this group of patients of a psychotherapy that includes individualized interventions. To apply this model, we needed to know about the biopsychosocial aspects of Jane's and Sam's mental illness. Some knowledge of the patient's history, including the genetic and constitutional elements and the developmental history, as well as the current social and cultural stresses would permit us to offer patient-specific psychotherapeutic interventions.

For instance, why did Jane not adhere to her medication regimen? Why had she decided to have a child? In what way was the stress of motherhood specifically affecting her? Asking about her childhood, we learned that her mother was also "bipolar." Her childhood was a continuous nightmare because of her mother's screaming, erratic, and wild behavior. She moved frequently, from foster home to foster home. Today her mother is so bitter and nasty that no one wants to be around her.

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Gaining this information helped us understand why Jane was frightened by her own diagnosis of bipolar illness and why, terrified by this prospect, she used denial leading to medication noncompliance. In supportive psychotherapy, interpretations of the links between past and present provide explanations and give meaning to current behavior. This approach creates a basis for empathic reassurance.

For example, we were able to tell Jane that we could understand why, given her mother's experience, she wanted to deny the reality of her own illness, and that this response led to an expectable internal struggle. Hearing this, Jane felt understood, and her anxiety about anticipated criticism diminished. She had wanted a child, and at age 40 she purposely became pregnant. Her pregnancy caused the breakup of her relationship, which had always been abusive.

Seeing Jane struggling to deal with her 14-month-old during the interview and listening to her comments, it was clear that she was experiencing considerable stress rooted in guilt, anxiety, and concern about her daughter, whose high level of activity and exploration of her surroundings, like those of any healthy child of that age, were driving her mother crazy! Jane's comments helped us recognize that she was probably trying to create for her daughter a childhood that she had not experienced, but the reality of the situation was very different from her fantasies. She was tired, anxious, and upset with the child, and simultaneously she felt guilty and disappointed about these feelings.

We spoke with Jane about the tensions mothers experience in caring for toddlers. Having learned about her early years, we realized that there had been no role models in her life, no extended family, to help her understand how to deal effectively with both her child and her own feelings. Psychosocial interventions in this domain were a necessity. The psychotherapeutic interventions were psychodynamically informed. They were not designed, at this time, to search out and expose unconscious conflicts that might be causing problems. At a later phase in her treatment, when she was stabilized, deeper inquiry might be of value, particularly in understanding her frequent involvement in abusive relations.

As for Sam, in talking about his parents, he became emotional, disorganized, and momentarily unable to continue after he told us that his mother, although she didn't love his father, had stayed with him in spite of his many difficult ways. We inferred from his statement and the attached affect that the intense stressors in his current life were probably worsened by feelings of betrayal and failure that he was having because his wife was not living up to the model of his mother. This was not the moment to explore the connection. While we shepherded him from the clinic to the hospital admitting area, the resident assured him that when he was released from the hospital, she would be available in the clinic to meet with him for regular appointments. We did not choose at this time to explore his sense of his wife's betrayal but instead underscored the resident's availability. Knowing when and what not to say to a patient requires as much psychotherapeutic competence as knowing what to say.

Speculating on the role of psychiatry and psychotherapy in the year 2099, Sharfstein (2) predicted that by that time, "psychotherapy psychiatrists will combine the M.D. with degrees in psychology, education, religion, and the humanities [and will treat] age-old human problems of individuation and separation, grief and loss, insight and self-actualization." His prophecy implies that people with serious mental illness will be treated by the "neuroscientist psychiatrist," a specialist who will combine an M.D. with a Ph.D. and apply logarithms for biological and nonbiological treatments. He gives us much to think about.

Will logarithms provide the type of sensitivity necessary to help clinicians effectively use supportive, psychodynamic, or cognitive psychotherapy? In the 1950s and 1960s, psychoanalysts were a strong presence in the care of the seriously mentally ill. Being psychodynamically informed and appreciating the role of psychotherapy in the treatment of all patients was understood to be essential to the proper care of all patients. A journal such as *Psychiatric Services* would have no need for a column dedicated to the subject of "practical psychotherapy," because the subject would be an inherent part of most articles in the journal.

Advances in neurological research and the development of potent and effective medications gave hope that biological psychiatry alone could answer the needs of our patients. However, research in the past decade has described the fusion and molecular interaction of mind and brain, corroborating the experience of clinicians. The field has a reawakened sense of the value of being mindful of the mind and its effect on brain functioning, both in the etiology of psychiatric disorders and in their treatment.

Achieving this unity is a major challenge in today's practice of psychiatry (3). Many factors contribute to a clinician's developing a skilled supportive psychotherapy stance—understanding countertransference and transference, being psychodynamically informed, understanding cognitive development, and having a knowledge of learning theory. A working alliance is built by empathic comments, which are more effective when they reflect an appreciation of both the overt and covert meanings of the stress patients endure. Restatements that help to focus the work are fine-tuned by listening to the unspoken concerns contained in a patient's rambling commentary.

How do we work to achieve this competency in our residency programs? Without the leisure we had in years past, our teaching must be focused. I teach a seminar for our second-year residents using Beitman's time-efficient modules for learning psychotherapy (4). His manual presents in an organized fashion the basic tools common to all psychotherapies. Using case material, residents learn to identify the various types of therapists' verbal interventions and the intended effects. They also learn the definition of and tools for creating a working alliance. They learn to identify patients' patterns of behavior, resistance, transference, and countertransference. Other parts of the curriculum include a seminar that helps

residents arrive at a dynamic formulation (5), a survey of psychodynamic theory (6), and courses taught by experts in cognitive and interpersonal therapy. Finally, with a course on brief integrated psychotherapy, we pull together all the therapies, using case examples.

Can this information be applied in the pressure cooker of today's clinical setting? Yes, if the psychiatrist is attuned to the material. The information about Jane and Sam was easily and rapidly gathered in the first meeting with them. It required only focusing the interview on the relevant areas, being alert to affects and latent content, and providing an empathic setting. But it is true that in today's world an effective clinician must be sophisticated in the workings of the mind in order to catch on early in the interview to what is obvious and what is nuanced, because sometimes only brief contacts in which to respond sensitively and effectively are available.

In this issue, *Psychiatric Services* introduces a column on psychotherapy. I am delighted to have been asked to edit the column. I will present issues that are alive in our work in public-sector psychiatry. I urge you to e-mail me your comments, criticisms, and suggestions for future columns. Together we will see that despite the exigencies of health care economics, we have a paradigm that allows us to provide our patients with individualized high-quality care. ♦

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