

# Psychotherapy in psychiatry – reality, delusion or relic?

'If you talk about things you have not experienced, you are wasting your and other people's time. As you continue the practice of looking deeply, you will see this more and more clearly, and you will save a lot of paper and publishing enterprises and have more time to enjoy your tea and live your daily life in mindfulness.'<sup>1</sup>

Psychotherapy has been viewed as a core clinical activity of psychiatrists.<sup>24</sup> Is this still the case in our modern era, with more and more focus on pharmacotherapy? As we prepare for the Fellowship of the College of Psychiatrists of South Africa (FCPsych) to be the only exit examination to qualify as a psychiatrist in South Africa, it is prudent to reconsider this and related questions.

## Is psychotherapy still a necessary and wanted skill?

We live in an exciting age in which our understanding of the biological aspects of psychiatric disorders is rapidly expanding. Simultaneously psychotherapy has received more and more attention as a very important aspect in the holistic treatment of psychiatric disorders, e.g. as combination treatment together with pharmacotherapy or add-on treatment in bipolar mood disorders.<sup>27</sup> Furthermore, different types of psychotherapy have been proven to be effective as single treatment in some of the most common psychiatric disorders.<sup>7,8</sup> Despite this, a recent study in the USA showed that over the decade 1998 - 2007 a decreasing proportion of mental health outpatients received psychotherapy, and those who did made fewer visits.<sup>4</sup> During the same period, a large and growing number of outpatients received psychotropic medications without psychotherapy.<sup>4</sup>

Adding fuel to this dispute, Professor Juan Mezzich, immediate past-president of the World Psychiatric Association (WPA), writes, 'The status of practicing psychiatrists is being diminished by managed care systems that reduce patients to diagnostic codes and reduce psychiatrists to technicians who just prescribe drugs.' Mezzich advocates a highly personalised approach to mental health care and health promotion.<sup>9</sup>

If there is only an academic, intellectual interest in the question about the place and practice of psychotherapy, one could find reasons both for and against it. If, however, one has a real, existential understanding of the suffering caused by mental illness, of the suffering and loneliness of the patient, then there is only one answer. Yes, psychotherapy should always be a core clinical activity of psychiatrists. The importance of this is emphasised by the following comments made by a despondent physician who had just been interviewed by a psychiatrist: 'I don't think he heard me ... Depression may be the disease, but it is not the problem. The problem is my life. ... It's falling apart. My marriage. My relationship with my kids. My confidence in my research. My

sense of purpose. My dreams. Is this depression? ... I want this depression treated, all right. There is something more I want, however. I want to tell this story, my story. I want someone trained to hear me. I thought that was what psychiatrists did.'<sup>10</sup> An I – Thou relationship, as described by the philosopher Martin Buber, is the most that you can offer someone.<sup>11</sup>

Psychotherapy and the training thereof is also emphasised by the College of Psychiatrists. In the Regulations for the FCPsych (SA), March 2011, the following is mentioned: 'For admission to Part II the candidate must present evidence of having submitted to the CMSA a Certificate of Training in which case histories of 3 psychotherapy cases (e.g. brief psychotherapy, long psychotherapy, cognitive behavioural therapy, family therapy or group therapy cases) and descriptions of practical experience are certified by the head of department as being adequate.'<sup>12</sup>

In the registrar workshop organised by the College in February 2011 the following was stated: 'The expectation is that, at the completion of their training, registrars should be competent in supportive psychotherapy, have had adequate practical exposure to cognitive behavioural therapy (CBT) and at least a good theoretical knowledge of the psychodynamic therapies.'<sup>13</sup>

At this workshop it was, however, also mentioned that registrars should have some knowledge about interpersonal psychotherapy, group psychotherapy, family therapy and trauma counselling. They should also be knowledgeable about the usefulness of psychodynamic concepts in psychiatric practice and the integration of psychotherapy and pharmacotherapy (U Subramaney, unpublished lecture given at a workshop for registrars organised by the College of Psychiatrists, February 2011).

These are extensive requirements. Are they met at the various academic departments in our country? Do psychiatrists want to practise psychotherapy? Or is the reality that many focus on short consultations, driven further in this direction by managed health care, as stated by Professor Mezzich?

## Is it possible for psychiatrists to be trained adequately in and to practise psychotherapy?

The Department of Psychiatry at the University of Pretoria has over the past few years developed a formal psychotherapy training programme that meets the requirements of the College. The training consists of lectures, discussion groups and participation in group therapy, individual and group supervision. Coming from this experience, several problems and obstacles have been noted:

- The emphasis in psychiatry is still mostly on biological treatment, with psychotherapy often regarded as a luxury or even an unnecessary add-on.
- The academic programme (biological psychiatry, forensic psychiatry, research, postgraduate lectures, etc.) demands much from registrars, leaving little time and energy for training in psychotherapy.
- Registrars serve a high number of patients and the associated service delivery needs take their toll.
- There is a lack of patients in the state sector suffering from milder forms of mental illness who would be suitable for psychotherapy training of inexperienced registrars.
- The 4-monthly rotation cycle required to fit in the prescribed rotation in the different psychiatric fields as well as neurology is a hindrance to the development of therapeutic relationships.

The practice of psychotherapy in private practice also suffers. Limitations placed by managed health care drive psychiatrists to see more patients, but for fewer visits and shorter consultation times per patient. A lack of training and the heavy emotional burden of seeing many patients suffering from serious problems may also contribute to a focus on pharmacotherapy and refraining from getting involved in challenging therapeutic relationships.

### How does one become a psychotherapist?

Even when, in spite of all these problems, psychiatrists want to be psychotherapists, is this possible? Can such training be fitted into an already demanding 4-year course? To become a psychotherapist is much more difficult than usually acknowledged; it is 'not a minor professional role which anyone with a bit of goodwill and desire to help people can acquire without too much difficulty'.<sup>13</sup> The psychotherapist and analyst Symington writes that in his opinion it takes at least 8 years of full-time training and education to become a psychotherapist. Even after such a strenuous course, however, he has his doubts whether a psychotherapist would emerge from this academic training, since a certain inner development is necessary to become a psychotherapist, something that can not be learned or transmitted in an academic way.<sup>13</sup>

Symington's statement will surely elicit a strong response, but should not be dismissed too quickly. What is necessary to become a psychotherapist? What is this inner development Symington talks about? Is our limited training of value?

### What suggestions can be made and what would be realistic in our circumstances?

- The College of Psychiatrists will in future set the standards and requirements for all training in psychotherapy. It is reasonable to expect that registrars should be competent in supportive psychotherapy, CBT and trauma counselling and should have a theoretical understanding of psychodynamic therapy. This should include being knowledgeable about the usefulness of psychodynamic concepts in psychiatric practice.

Only limited knowledge about interpersonal psychotherapy, group psychotherapy, eye movement desensitisation and reprocessing therapy (EMDR), systems theory and family therapy should be expected.

- Notwithstanding informal participation in psychotherapy and psychotherapy training, the College of Psychiatrists stipulates that all trainees have to complete a minimum of three formal therapies, the length of which is not specified. Some academic departments specify two short psychotherapies of 8 - 12 sessions each and one longer psychotherapy of 24 sessions. One study showed that in mixed samples of predominantly depressive and anxiety disorders, roughly half the patients improve after 13 - 18 visits.<sup>14</sup> If this is the case, we are not on the right track in stipulating fewer sessions. A registrar might also learn much more from seeing one patient for 40 sessions or more than from two short therapies. It also at times causes an ethical dilemma for a registrar if he or she realises the necessity to continue with a patient for longer than the required sessions, but the training requirements and other demands rather encourage ending the therapy.
- Individual and group supervision should be an important part of the training.
- Personal psychotherapy can be of great help and could be encouraged.
- Registrars should be encouraged to read. Profound psychological insights are expressed in the writings of Dostoevsky, Tolstoy, Hermann Hesse, George Eliot and Kazantzakis, to name just a few.
- The value of developing sub-specialties in psychiatry has been argued for a long time and several have been formally recognised.<sup>15,17</sup> The necessary work needs to be done to ensure that psychotherapy can be added to these. Through invoking the so-called 'grandfather clause', psychiatrists who have practised formal psychotherapy for many years and whose academic credentials in this area are clearly apparent should be recognised as sub-specialists to help with the establishment of postgraduate training programmes etc.<sup>15</sup>

Other avenues that may be of value are:

- More contact and communication between the different academic departments and the psychiatrists responsible for training about their experiences and how to address the training requirements.
- Better participation in the Psychotherapy Special Interest Group (SIG) of the South African Society of Psychiatrists (SASOP).
- Regular workshops by the different subgroups of SASOP.
- Postgraduate reading groups.
- Better interaction with other disciplines, e.g. psychology and other psychotherapeutic organisations.

We as psychiatrists are in a unique position to address the needs of the patient in a holistic manner. Psychiatrists need to heed the warning of the immediate past-president of the WPA and to emphasise the importance of psychotherapy and the training thereof. Training does not only involve lectures and supervision,

however; registrars perhaps learn more by observing how their consultants treat patients. Consultant psychiatrists who are actively engaged in holistic, empathic patient care are therefore needed, and this is of course only possible if enough posts are created and filled.

### M W Böhmer

Convener: *Psychotherapy SIG, SASOP*

*Weskoppies Hospital*

*University of Pretoria*

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