Does Psychiatry Have a Split Personality

ROBERT EPSTEIN: We're talking about zooming toward, you know, just giving someone a pill and hoping it'll work.

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SHOW OPEN

ROBERT L. KUHN: Psychiatry today has really two different, shall we say, approaches, a psychodynamic approach which is a long-term tradition, psychoanalysis, behavioral psychology, and a more recent approach which is a biomedical one. Let's take a specific condition, which is a very serious one in the world, depression, which affects millions of people, and discuss it from both ways of thinking.

NANCY ANDREASON: I have to jump in Robert, and point out that if we go back in history, people like Hippocrates conceptualized mental illnesses as physical in origin, and the psychodynamic way of thinking is an add-on that only really began in the late 19th and early 20th century.

PETER LOEWENBERG: I'd say there isn't a split today, that the two interact and everybody knows what depression's like, there's emotional causes and physical causes, and that big split, mind/body from 2,000 years ago, Plato, has now been closed.

ROBERT EPSTEIN: I don't agree with you because you're talking theory, when it comes to treatment, there's very definitely a split. For a while, for example in this country, when psychologists and psychiatrists, after Freud, were the people you went to for depression, what you mainly got was talk. Now, what's happening is you go to your HMO and you get a drug and that's it, and no one talks to you. So, the psychological side of depression is very often ignored and, in fact, what you could call the biomedical side is all people seem to care about, so there is a split when it comes to treatment.

NANCY ANDREASON: I don't think the picture is as bad as you're portraying it. I mean, for sure, people got psychological treatments for a long time before good drugs were available, then, once good drugs were available, beginning with Imipramine in the fifties, certainly in my training, I was taught to use psychotherapy for the more psychological or reactive depressions, and use drugs for the more biologically based.

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ROBERT L. KUHN: How could you distinguish a biological-based cause for depression?

NANCY ANDREASON: There are kind of classic signs and symptoms that are more biologically based: loss of appetite, severe insomnia, variations in diurnal rhythm, in other words, fluctuations in mood according to time of day, and they get messed up, and those tell you that there's something in the physical apparatus that isn't working quite right, that is related to what's going on in the mind. And those kinds of depressions are the ones that tend to respond best to medications.

ROBERT EPSTEIN: Well, I don't want to belabor this point, but I will insist that, in fact, what people really have now is very limited benefits through an HMO, which might give them 10 sessions a year that might be 15-minute sessions…

ROBERT L. KUHN: …with psychotherapy

ROBERT EPSTEIN: With a mental health professional, and that there's a bookkeeper somewhere in the background who says, no, this person needs to be on Prozac and, you know, people covered under that sort of plan, there are about a 135 million Americans who now get their mental health services through that type of plan.

NANCY ANDREASON: You're talking about economics and that's not what is psychiatry and what would psychiatrists like to do to take care of their patients well?

ROBERT EPSTEIN: You're not talking about reality, you're talking about the ideal.

PETER LOEWENBERG: You're also right about the training. About 50% of psychiatry residency programs do not train in psychotherapy anymore.

ROBERT EPSTEIN: That's right.

ROBERT EPSTEIN: And that, that is a trend.

NANCY ANDREASON: I don't think the statistic is that high, in fact, I'm almost positive it's not that high, because you can't get Board Certified in psychiatry without having demonstrated that you've had training in psychotherapy.

ROBERT KUHN: Because there's so much science to learn.

PETER LOEWENBERG: Young psychiatrists do not know how to talk to people, in fact, one cynical psychiatrist I know calls it cocktail mixing. You put in a little of this, this week and, if it didn't work, you change the cocktail next week and we'll do that, but, when you talk depression, and people have had a loss, a bereavement or a loss of a love

or a defeat at work, they need someone to talk to, they need a human relationship to work out what's going on and what they contributed to it and how they're going to cope with it and adapt to it and, uh, do better next time.

NANCY ANDREASON: Well, you know, it's ironic for me to be saying this because I'm a psychiatrist that was actually involved in the criteria for defining mental illnesses that are now being used to train people. And, you say young psychiatrists don't learn how to interview, and I actually, I'm afraid, I agree with that, often. They, the diagnostic and statistical manual lays out a set of criteria for every mental illness and, when we put them down, we thought, well, this'll help standardize things, clarify, create reliability, but, what's in fact happened is that they've become reified over the course of the last 20 years, and people think these are absolutes handed down from God, and again, the Board Certification systems, when they test young psychiatrists, they're expected to have memorized all these silly criteria and, basically, increasingly, their interviews are limited to asking about the signs and symptoms in those criteria and they don't ask about the people. But, most of our young psychiatrists aren't trained that way and that is a, you know, a real loss. I mean, every time I start interviewing a patient I always ask about, you know, where did you grow up, what did you study in school, what do you enjoy, and so on, and then I go on and talk about signs and symptoms, but, most of our young psychiatrists aren't trained that way and that is a real loss.

ROBERT L. KUHN: When does this pass from something all of us have to something that becomes a medical condition?

NANCY ANDREASON: I think when it gets to the place where the person has become extremely dysfunctional or is experiencing pain beyond what you would expect given the social setting, then it begins to move into a more clear medical condition. And then we can move on to extreme examples, the most salient of which, right now, is Andrea Yates, who had such a severe psychotic depression that she did one of the most horrible things one can imagine, a heartbreaking situation.

ROBERT L. KUHN: Is there a differentiation in depression between biologically based, deficit in the chemical system or the brain and, specifically event-induced depression, like loss of a loved one or a problem at work, do you find that?

ROBERT EPSTEIN: Well, there are depressions we tend to call reactive depressions, which are clearly initiated by some incidents in one's life. There are others that seem to come from nowhere and there's, there's lingo that describes those depressions, as well, and, for those, probably something has gone wrong in the brain, you still need social support and you still need better skills, and so on.

ROBERT L. KUHN: How widespread is depression today?

PETER LOEWENBERG: Very.

NANCY ANDREASON: Very, yeah!

ROBERT EPSTEIN: There, there are probably, right now, 20 million Americans who are, who are clinically depressed. And, it's only a small portion of those who are probably getting appropriate treatment, and when it comes to men the situation's even worse because men tend not seek treatment and they tend to use very destructive means for dealing with their depression.

NANCY ANDREASON: What's even more frightening is that the rates are increasing over time. There's a study done a few years ago showing that if you track the rates of depression in younger people versus older people over time, people in their fifties and sixties, the curves for people in the baby boom generation are going up so steeply that if you, if you trace them to the end, it looks as if everybody in that cohort is going to have a depression at some time in their life. It's also important to realize that people think mental illnesses are not mortal, but, in fact, depression has a 10% suicide rate.

ROBERT L. KUHN: Ten percent?

NANCY ANDREASON: Yeah.

PETER LOEWENBERG: And in adolescents you have an increased trajectory of suicides.

ROBERT L. KUHN: Why do we think that the baby boomer generation and the younger people today have a greater incidence of depression? Any study?

NANCY ANDREASON: Well, that topic is discussed in the studies that were done. There are multiple explanations, this is the group that is not going to be able to achieve at the same level, probably as their parents. There were so many of them and it looked at just cohort sizes, opportunities available and, basically, for the baby boomers, for a long time, everything was closed. You get a Ph.D. and you won't get a job because there are all those people who went before you who already filled up all the jobs. Things are easing up now because the parent level people have retired.

ROBERT L. KUHN: Tell us a little bit about the biomedical approach to depression, diagnostically and treatment.

NANCY ANDREASON: Well, if you're just very narrowly trained biomedically, a lot of times the psychiatrist is functioning within the context of an HMO, and he won't even get paid if he doesn't prescribe a medication, and so the patient will be denied the right to treatment or whatever. And so after a half-hour interview maybe, that should be an hour interview, the person is given a diagnosis of depression, a prescription is written and,

then might not be seen again for about three weeks, that's the extreme bad parody of the biomedical model.

ROBERT EPSTEIN: See, I don't think we should hide the fact here that there are trends in mental health which are very dangerous, very dangerous trends. You're talking about the lack of interviewing skills of young psychiatrists, there are bigger trends.

ROBERT L. KUHN: What?

ROBERT EPSTEIN: Well, let's talk about New Mexico. New Mexico became the first state in the country to give prescription privileges to psychologists who are not M.D.s. That is a trend, that's going to happen, five to ten years, psychologists are going to have prescription privileges probably nationwide.

ROBERT L. KUHN: How many psychologists in the United States, compared to psychiatrists.

ROBERT EPSTEIN: There are 50,000 members of the American Psychiatric Association, now they're probably more psychiatrists, but say 50,000…

NANCY ANDREASON: More like 40,000.

ROBERT EPSTEIN: Yeah. There are 150,000 members, three times as many psychologists. What's happening here is that drug companies are trying to expand their markets and they're finding big ways to do it. So, right now, you know, we're talking about moving farther and farther away from social support and talking and the people side of mental health, and moving, zooming toward, you know, just giving someone a pill and hoping it'll work.

ROBERT L. KUHN: Do you agree with allowing psychologists to prescribe drugs?

PETER LOEWENBERG: Depends how well trained they are, and do they know what they're doing.

ROBERT L. KUHN: Nancy, do you agree with that?

NANCY ANDREASON: No, I, absolutely don't, it's in the hands, right now, of the Board of Medical Examiners. Well, because you have to know so much biochemistry, neuro-anatomy, physiology, general medicine that it's very, very risky for somebody who doesn't have that extensive training to prescribe a drug that could interact with some other drug, that could affect some other illness that the person has and believe me, I train a lot of neuropsychologists and they don't know biochemistry or physiology or pharmacology.

ROBERT EPSTEIN: The reality is nothing is going to stop this. And that's because of powerful economic forces, namely these multibillion dollar drug companies. Nothing is going to stop this trend.

NANCY ANDREASON: There's another force behind it, which is the pharmacists. The reason that bill passed in New Mexico was that the pharmacists got behind it because next thing they're going to argue that they should be prescribing.

ROBERT L. KUHN: Oh, wow.

ROBERT EPSTEIN: Oh.

ROBERT L. KUHN: Are we headed to a brave new world, you wrote a book, "Brave New Brain," but is this a brave new world where everybody will be on drugs and kind of euphoric?

NANCY ANDREASON: That's a huge concern that I personally feel. I see us steadily drifting away from, to be a bit nostalgic, the kind of world I grew up in where the most important thing was values, relationships with other people, relationships with some higher purpose or goal and…

ROBERT EPSTEIN: And obligations to the community.

NANCY ANDREASON: And obligations to the community.

PETER LOEWENBERG: Responsibility.

NANCY ANDREASON: Moral responsibility. Wanting happiness all the time.

NANCY ANDREASON: Wanting happiness all the time.

PETER LOEWENBERG: There's an old proverb, "take what you want and pay for it."

ROBERT EPSTEIN: I want to get to the brain if we could, because there is a myth, I'd love to hear your comment on this, there is a myth that has been sold to us, largely by some big companies and some other forces, too, that the brain is behind who we are, it's, kind of that a faulty brain is behind our problems and, therefore, if we can just go in and fix the brain, we'll be fine.

ROBERT L. KUHN: They used to blame your mother for that.

ROBERT EPSTEIN: Exactly, it used to be your mother, exactly right, now they blame the brain and I think that's nonsense and I think it's wrong.

NANCY ANDREASON: I just was teaching a course this last week on the mind/body problem and, specifically, brain/mind relationships and it's way too complex a topic to discuss here and now…

ROBERT EPSTEIN: I'm not going to let you get away with that. THEY LAUGH

NANCY ANDREASON: Well, you're exhibiting dualism. THEY LAUGH. I mean, we can end up with a lot of terminology that you're assuming that the brain and the mind are different things and, in fact, I don't think they are. The brain and the mind are the same thing, there are different words to the same thing, the interaction is back and forth. We are our brains, I am my brain, my brain is a composite of the experience I've had my entire life from in utero to where I am right now, and my brain is different from your brain because I've had different experiences, as well as a different genetic endowment.

ROBERT L. KUHN: I don't think you need to be dualistic to say what Robert is saying, in terms of blame the brain. I think what that's saying is it's trying to seek a physiological or a biochemical rationale for every problem that you have.

ROBERT EPSTEIN: But the implications, in my opinion are, at least as they get misinterpreted by the public at large, are really dangerous because the implication, as the public sees it, oh, therefore, my problem is actually my brain's problem.

NANCY ANDREASON: But, I mean, that's a very simpleminded way to think because you're the carrier of your brain.

ROBERT EPSTEIN: No, I understand, and what you're saying is very reasonable, but it's also sophisticated, and the fact is, that's not the message that the public is getting, that's not the way everyday people are looking at this, and it's not the message that's being sold by certain large industries. The message that's being sold is, if you are depressed or you are anxious, there's something wrong with your brain or, if you have an autistic child there's something wrong with his or her brain and we're going to fix it.

NANCY ANDREASON: In that sense we're not disagreeing, but you're saying experience affects the brain, and I would totally agree. I mean, I say it all the time, on the other hand, it's the brain that experience effects and the brain interacts with the world. Now, if you want to complain that a lot of people are either being taught to think in a simple-minded way or are doing it naturally, I would agree with that, too. We shouldn't be saying, you have obsessive-compulsive disorder just because of a seratonin imbalance, or you have depression because of a norephinephrine imbalance.

ROBERT EPSTEIN: That's the message that's being sold. And people LOVE that message because, and now we get to cultural values, because in our culture, we want a quick fix, we want to go POPPING SOUND, pop a pill and we're fine. Or we wouldn't mind probably is someone could come up with a surgical technique and you'd be out in 15 minutes, we would subject ourselves to that by the millions.

NANCY ANDREASON: Oh, I hope not.

ROBERT EPSTEIN: I think this is wrong, wrong, wrong. I think we're moving in the wrong direction when it comes to mental health, and to concretize this, I was at, a couple of years ago, the first-ever White House Conference on Mental Health, I don't know if you guys were there, it was a two-day affair, it was incredible, they had wonderful scientists talking. Do you know that in the entire conference, only on one occasion did one person up on that stage mention psychotherapy. The rest of it was all brain, drugs, brain, drugs. Fortunately, the guy who mentioned psychotherapy was the director of the National Institute of Mental Health, that was good. THEY LAUGH. But he only mentioned it briefly.

ROBERT L. KUHN: But I think the caution is well taken.

NANCY ANDREASON: Yeah, the caution is absolutely well taken.

ROBERT EPSTEIN: And the fact is, everything that happens to you changes your brain, including if you go through a year of psychotherapy and there are controlled studies showing this reasonably well, your brain changes.

PETER LOEWENBERG: In one session.

ROBERT L. KUHN: Have there been any, long-term studies relating a psychoanalytical approach to other types of therapies, like cognitive or behavioral or drug approaches?

ROBERT EPSTEIN: Yeah, there are actually, a number of studies for a while, some of the early studies seemed to indicate that various kinds of psychotherapy, including the psychodynamic type, were not that effective, then we started finding some studies and I think the first major one was actually done by, "Consumer Reports" a number of years ago, it was quite an excellent study, showing that, actually psychotherapy is effective, we probably have a problem I call the matching problem. We're not very good yet at matching up particular clients or patients with particular therapists, that's kind of done randomly and that's probably not a good idea, if we could match better, we'd probably do much better in outcome.

ROBERT L. KUHN: The question is, does the psychotherapy help the condition? And compare that to either a placebo or a drug regime or different kinds of psychotherapy.

NANCY ANDREASON: There have been, in the last, nine months or so, three different interesting studies showing that placebos, using neuroimaging techniques, that placebos have effects on the brain similar to those that are produced either by, similar to those that are produced by other kinds of stimuli or by drugs.

ROBERT L. KUHN: Well, the placebo is triggering a reaction that causes the hypothalamus in the brain to secrete drugs that are similar to chemicals similar to those kinds of drugs, I mean, I think that's a natural interaction.

NANCY ANDREASON: Most people would not predict that, most people would say placebos are inert substances, and so they will not have an effect on the brain. What this is saying is that placebos maybe are inert substances, but because people have expectations as to what they're going to do, their brains respond the same way as they would if they got an active substance. The fact that people are already doing those imaging studies of placebo effects shows that they're thinking about the interactions between non-biological and biological interventions. I mean, it's already being thought about, it's being published, we're discussing it here and now, so there is hope for getting people to think in more sophisticated ways, and every time people hear about those placebo studies, they're fascinated, excited about it.

ROBERT L. KUHN: Nancy, would you say there could be a time when sophisticated neuroimaging techniques would allow you to see certain kinds of brains that would be more susceptible to different types of psychoanalytic approaches. So if you had an obsessive-compulsive anxiety disorder and a certain type of neuroimaging would show that it is more susceptible to cognitive therapy or a behavioral therapy. Do you think that's possible?

NANCY ANDREASON: It's definitely possible, it will be farther down the road than studies that are purely disease-driven because, first, these, it's kind of like, it's working with cancer or heart disease or whatever, first these technologies get used to study the most serious mental illnesses, like Alzheimer's disease or schizophrenia, and then manic-depressive illness, and then they move on down. And the emphasis is on what are the mechanisms of this illness so that we can produce better treatments and prevention, so it's really almost a matter of priorities in the use of these imaging tools. If I wanted to design a study looking at the effects of psychotherapy on the brain, I could probably start it now and finish it in two or three years and probably show something fairly conclusive. But the wonderful thing about imaging research is that it lets you ask all kinds of questions, like the one that you asked or questions, I have a friend who's doing a study of what happens in the brain during forgiveness, which is, I mean, there are all kinds of wonderful, complex things that you can ask about and answer with imaging. We have

done, neuroimaging studies of the effects of medication on the brain and how that relates to the change of symptoms, and we see in patients that they have symptom relief, we thought that when they get medication they would also have reversal of abnormalities in blood flow that we see during the height of symptoms and that doesn't necessarily happen.

ROBERT L. KUHN: What does that mean then?

NANCY ANDREASON: Well, we're still pondering that, but…

ROBERT L. KUHN: That's interesting.

NANCY ANDREASON: There's a mismatch for sure.

ROBERT EPSTEIN: Well, sometimes it means you're masking whatever is really going on.

NANCY ANDREASON: No, I mean, when we got our first results, it was so sobering that it took us about three years to even publish them because we didn't expect to have that finding.

ROBERT L. KUHN: That's very interesting.

NANCY ANDREASON: Neuroimaging isn't a treatment, I mean it's a way of understanding how the brain works that then can help us understand how treatments work or how, I mean, I say over and over, my goal in life is for the one disease I've worked on most of my life, schizophrenia, to not just understand mechanisms for better treatment, but to ultimately figure out how to prevent it, because schizophrenia is a disease of adolescence, young people, and it's the most tragic disease I think of any human disease because it strikes people at this very young age and takes away their creativity and thoughtfulness, and so on. And because it has this age of onset in the teens, in kids usually who were normal, what we want to do is figure out what the developmental mechanisms were in the brain that caused that illness and figure out how to intervene so it doesn't happen. I mean, that's the goal of the tools of neuroimaging.

PETER LOEWENBERG: You know, Robert mentioned social support and, what do you say, Nancy, to those Boston studies on schizophrenia that, when there's a job, family, home, social support, they actually, it's a wide statistic, 44 to 68% improvement.

NANCY ANDREASON: I can't say anything except I agree. I mean, I think, more or less we're all agreeing, it's not that good treatment, we shouldn't say good treatment should be subdivided into psychological and biological domains, they should very much

be integrated. It's rather that there are all these social forces that are preventing that from happening, some of them in training, as you point out.

ROBERT L. KUHN: Some of it economic, as well.

NANCY ANDREASON: Some of it economic, some of it ideological.

ROBERT KUHN: What are some of the ideological disruptions between the two?

NANCY ANDREASON: Just something like these neurological biologists are simple minded reductionistic and don't understand the human spirit, and those psychoanalysts are making up a bunch of theories that can't be tested and wasting an awful lot of time taking care of people who could be treated much more quickly and effectively with drugs.