PSYCHOTHERAPY'S EMPATHY AND INTUITION VERSUS MODERN DRUG STRATEGIES AND BRAIN INVESTIGATION TECHNOLOGY

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Psychiatry Came Late Into Medicine

Medicine is a hybrid profession; it embraces both science and art. All medicine includes the professional knowledge of pathophysiology, anatomy and molecular biology (the science) and clinical judgement, involving intuition (the art).

The medical specialty of psychiatry draws more on intuition and clinical judgement than the rest of medicine and less on evidence-based knowledge. There are two reasons contributing to this particular dual nature of psychiatry:

First, psychiatry had its beginnings long after the other medical specialties had begun to take shape - more than 1,000 years later. The demon/possession theory of mental disorder had been eliminated in the Age of Enlightenment, in the 16th and 17th Centuries. But the new reasoning was that mental illness could not exist because, if there was such an entity as the mind, it could not be sick since it was not material. There could not be an unmaterial sickness.

The French physician Pinel disregarded this unrealistic philosophy and, at the end of the 8th Century, started treating mentally ill patients, wrote the first textbook of psychiatry and squarely placed mental illnesses in the lap of medicine instead of leaving their care to the police and the church.

In the early 19th Century, also in France, Bailey discovered brain lesions in some mentally sick (syphilitic encephalopathy) patients. And in the mid-1800's, Griesinger, in Germany, postulated that there were no psychiatric, only brain diseases. Physicians were not up against more than an ideological obstacle. Was the psyche to be taken out of psychiatry and to be replaced entirely by the physical brain?

The second reason for the late appearance and special nature of psychiatry is that the brain is far more difficult to get at, and study scientifically, than any other part of the body. Although superb discoveries in brain anatomy were made in the latter part of the 19th Century, the physiology of the living brain remained for almost another century a mysterious black box.

Psychotherapy: Psychiatry's First Tool

Not until the shock therapies, in the 1930's, and psychopharmacology were developed, in the 1950's, was there any, even vaguely effective, biological treatment for psychiatric illness, except for a few sedatives and narcotics. Consequently, the only treatment available to psychiatrists, or "alienists", as they were known in the 19th Century, was psychotherapy.

Psychotherapy moved, during its first 100 years, through

three major phases: moral treatment, a mixture of milieu, cognitive and behaviour therapy; hypnosis and suggestion; and psychoanalysis, a complex theory and technique characterized by psychodynamics that were based on the concepts of unconscious mechanisms, symbolic defenses, the technique of interpretation, and, most importantly, the concepts of resistance and transference.

Although it is far more difficult to prove the efficacy of psychotherapy than other medical treatments, its sheer durability, over more than a century, suggests that it has some kind of viability and benefit to patients.

Nevertheless, there are today psychiatrists and psychologists, some of them experienced clinicians and researchers, who believe that psychiatric residents should be taught only subjects for which there is experimentally established evidence. Since such evidence is not deemed to be satisfactory in the case of psychotherapy, it should therefore not be taught to students of psychiatry. However, training by modelling of experienced clinicians should educate the students in appropriate skills and therapeutic behaviour in the presence of psychiatric patients. Students, however, should not be taught interpretive, psychodynamically oriented psychotherapy in the traditional sense.

How Effective is Psychotherapy?

In a current trend in medical science, - I do not know how widespread, but including even some top Ivy League

institutions, - certain universities are turning their backs today on time-honoured teaching of psychodynamic psychotherapy.

However, many studies in the field of psychotherapy suggest today the following conclusions regarding its efficacy (1;2;3).

1. Patients treated by psychotherapy in most cases fare better than untreated controls;
2. In general, the particular mode or technique of psychotherapy applied does not seems to make much difference;
3. However, a few special types of psychotherapy have been shown to be most effective for certain specific types of psychopathology, e.g. behaviour therapy for phobias and compulsions, cognitive therapy for depression;
4. The relationship between patient and therapist is an important factor contributing toward the outcome;
5. Psychosocial therapy combined with pharmacotherapy is more effective than either therapy alone. Among other things, psychosocial therapy is helping in depression and schizophrenia. More specifically, the comgination promotes compliance with pharmacotherapy, improves interpersonal relationships and decreases the frequency of relapses. (Table 1)

Anxiety and depression, the most frequent emotional disorders, respond well to psychotherapy alone in many cases, although pharmacotherapy works faster and more

reliably for these conditions and therefore is less expensive. However, many drugs cause toxic side effects and may induce dependence. In contrast, psychotic disorders do not respond to psychotherapy alone, but only when combined with psychopharmacology and/or electroconvulsive treatment.

On the other hand, personality disorders (4) and many post-traumatic stress disorders which are developing in ever increasing numbers, as well as eating disorders, alcoholism and other addictive disorders, respond most significantly to psychotherapy.

Should Psychiatry Rely Entirely on the Neurosciences?

As for the breakneck pace of recent progress in the neurosciences, in particular brain imaging, molecular biology and genetics, it is almost certain that these great discoveries will eventually lead to major innovations in psychiatric treatment. But during the last twenty years of important discoveries in these areas, they have until now generated more publicity than actual clinical benefit and, in the field of genetics, perhaps, so far, more iatrogenic problems than practical solutions to any mental health problems. In fact, these breakthroughs in genetics are now necessitating costly consultations with new breeds of genetic counsellors having to apply new psychotherapeutic techniques. What should patients do with a multitude of new data but no therapeutic and little preventive intervention?

Should all future psychiatric treatment now be based on rigid nosological (DSM IV; ICD-10) and biological criteria, all psychological treatment on completely consistent stimulus-response conditions - in oher words, solely on experimental evidence and objectively observed phenomena? Does psychiatry really wish to scrap the only psychiatric treatment which was available for nearly 150 years, in favour of psychopharmacology and hoped-for, but as-yet undefined, future clinical payoffs by the neurosciences?

The validity of psychopharmacological and other neuroscientific data erodes rather quickly nowadays, and practices based on such data change almost from year to year. Psychotherapy, on the other hand, has the advantages of possessing at least some timeless, unchanging components, like empathy and intuition, which are based on human understanding rather than physical explanation, and, furthermore, are aimed at individuals rather than statistical populations.

The beginnings of automated "psychotherapy" have already been reported. Could the interpersonal relationship of psychotherapy, the therapeutic alliance, really be replaced by the interactive relationships between a psychiatric patient and a computer?

The Components of Psychotherapy

To put the question into perspective we must analyze the major components of psychotherapy. Psychotherapy is, in

fact, all that is contained in the quintessential human interaction: that of a mother with her newborn infant, if therapy can be defined as the human support and succour given to a suffering human being. This "maternal" intervention, under a phenomenological analysis, is distributed over seven components, some of which - but not all - can be programmed for a computer.

The first component is the simple - but very complex - presence of another human being. Obviously this component cannot be digitized for a computer.

The second component is instinct: The mother naturally tends the newborn. Since instinct is genetically programmed, it might, in principle, be automated. A robot could, theoretically, clean, cuddle and feed a baby.

The third component is empathy; The immediate sensing of another person's emotional state. Although most researchers view empathy as unscientific and unreliable, it is nevertheless, still regarded by many of today's psychiatric clinicians as one of the most valid components of psychotherapy in certain, frequently occurring situations. To quote Karl Jaspers, the founder of modern psychopathology: "The empathic trembling of the researcher's own psyche with the events in another person challenges the research to transform such experiences into conceptual form." (writer's translation). (5)

However, if empathy can be conceptualised, it can certainly not be automated because of the continuous

interplay and feedback in a psychotherapeutic encounter. Transference and countertransference are continuously interacting with psychological defenses which, in turn, may distort pathological manifestations. It would be impossible to programme a computer for this infinitely complex sequence of instantaneous events, since it would have to be based on a calculus of continuous reprogramming from split second to split second. Such programming would also have to take into account such emerging contingencies as dreams, fantasies, changing physical states and the working-through of emotional reactions experienced just prior to the interview.

Computers may be able to play a mean game of chess, but keeping up with the fast moving human target in a therapeutic milieu becomes a truly awesome challenge by comparison. However, it must be remembered that rationality, as expressed in calculability and/or the possibility of being digitized, has never been shown to be a necessary criterion of the validity of all psychological interactions.

The fourth component is cognitive action or reasoning, based on logic, experience, memory and learning. This component might well be taken over by "artificial intelligence" built into future sophisticated computers.

The fifth component is intuition which may be defined as problem solving by non-rational means. Although intuition would strike many of my colleagues as unprofessional, unprovable and highly unscientific, it

enters into all kinds of clinical judgements. Sometimes intuition is even the decisive element in charting a clinical course for a particular patient. In some cases, all else fails to signal a therapeutic direction and intuition is all we have to lean on. Since intuition is not linked to a logical approach, nor to specific contents or contingencies of the situation, it cannot be programmed into a computer.

The sixth component is modelling, setting an example for a patient. This can certainly be automated for imitation. Modelling, of course, can encompass values, behaviours and attitudes.

The seventh component is bonding. Whether one bonds to a "transient object" e.g., a teddy bear or a vintage car, to an imprint or a mother to her baby, does not require a personal relationship and a computer could arrange for bonding to itself. Again, bonding could be automated. (Table 2)

What About the Nonrational Components?

Three of the above components - human presence, empathy and intuition - are not objectively reproducible in physical terms, by instruments or, more specifically, by a computer. Does that mean we should therefore ignore them altogether or should we simply accept them in their special non-scientific status and thus leave ourselves open to the accusation of

believing in vibes or returning to the Romanticism of the 19th Century?

Possibly, some day these three inexplainable components of psychotherapy may be folded into the future perspectives of sub-atomic quantum physics. (6) To quote the Oxford researcher Roger Penrose: "Quantum physics involves many highly intriguing and mysterious kinds of behaviour. Not the least of these are the (nonlocal) quantum correlations which can occur over widely separated distances. It seems to me a definite possibility that such things could be playing a role in conscious thought modes..." (7) I believe that this is the case. I do not, however, believe that all of our inner mental life will ever be explainable even by quantum mechanics. An important part will always remain a mystery.

For those who are committed to current scientific physicalism, psychotherapy in the future may not encompass these three unexplainable components.

It is a fact today that the new physics, i.e. quantum mechanics, cannot be as easily - if at all - grasped intuitively as the old Newtonian determinism, the hydrodynamic and thermodynamic clockwork-like explanation of our world. It was this kind of physical dynamics which also formed the ground for so much of Freud's deterministic psychodynamics. In contrast, indeterminism is one basis of modern physics in the form of Heisenberg's Principle of Uncertainty. Moreover, now local action (action at a

distance), i.e. instantaneous correlation over undefined distances without any local cause, is today fully accepted in modern quantum physics. It should be noted that even Einstein could never accept it and called it "ghostly and absurd." And modern physicists tend to grow rather silent when you ask them many questions about how to explain this rather mysterious phenomenon.

Future Psychiatry and Psychotherapeutic Practice

Now, in more operational terms, how will psychotherapy be practised in the future? It seems obvious that some kind of Managed Care will be bullying its way into medicine, not only in the U.S.A. but probably in all of North America. Managed Care already plays its most important role in the field of psychiatry.

Managed Care being a rapidly growing and profitable industry, its focus, many believe, will not be on care but on management, i.e. competition and cost-effectiveness. Cost-effectiveness implies that Managed Care psychotherapy will be directed more toward symptom relief than to a long-term approach to mental illness or personality disorders.

The Managed Care people will probably ask for experimentally demonstrated evidence for all allowable interventions and attack all practices that may be costly but are based solely on convention and Freudian tradition,

for instance the "50-minute hour".

Quite possibly, future research might demonstrate that for certain psychiatric conditions 30, or even 20, minutes of psychotherapy are as effective as the therapeutic hour established by psychoanalysis, which is only one form of psychotherapy among a myriad of others, even it is the most systematic and comprehensive one.

Would the patient have to be seen once or more times a week or, if there is a cap on the number of sessions per year, could visits for psychotherapy be stretched out at certain intervals throughout the year? Or should an expert psychiatric - not managerial - authority tailor make the therapeutic plan for every case? Personally, running singlehandedly a "no frills" outpatient clinic at a Montreal hospital, - no nurse, no receptionist, no waiting room - I have found that for acutely ill patients weekly visits, lasting from one-half to one hour, and for less acute patients visits distributed from one month to every 3 months, can be quite effective. Many, but not all, of these patients also receive psychoactive drugs.

Fewer and fewer solo practices and more and more group practices will develop, comprising two or more psychiatrists to share emergency and holiday coverage; a psychologist to help with testing, and psychotherapy, and a social worker to make home visits, and provide ancillary social services. Such practice is a sort of self-managed mini-HMO. Only a quarter - at most a third, of all mental health care

practitioners today are psychiatrists. Since only psychiatrists can legally prescribe physical treatments, like drugs, we may conclude that three quarters of all mental health practice is psychotherapy. Outnumbered, as they are, should psychiatrists still practice psychotherapy in the future, now that they also have the powerful tools of psychopharmacology and ECT at their disposal and all the promises by the neurosciences for the future?

Although expert psychotherapy by psychiatrists is underrated today, I believe it will remain one of our most important tools, along with psychopharmacology, for crisis intervention.

Liaison psychiatry - in-hospital consultations requested by non-psychiatrists (colleagues) - requires a thorough medical background as well as psychotherapeutic expertise. This field is expanding, albeit slowly.

Geropsychiatry is a whole new and very challenging field for psychiatrists and, again, clearly calls for both medical and psychotherapeutic background. Since the population of the elderly is so rapidly growing worldwide - from the 65 year-old retirees to the active centenarians - it will be necessary to develop a novel type of psychotherapy for this generation of the old and very old. This psychotherapy would require new techniques, new principles and new values. It would be as different from traditional psychotherapy as child psychotherapy is from psychotherapy for adults. (Table 3)

Much of traditional long-term psychoanalysis and long-term, (lifelong) treatment of personality disorders as well as training analysis might have to be left to the psychologists who are competently handling this type of therapy today.

The primary physician is usually the best person to oversee patients with chronic schizophrenia and manic-depressive diseases in periods of remission. Only if complications develop should the patient be referred back to the psychiatrist.

Do we really dare to delegate entirely, and thus fragment, psychotherapy to those who are trained in the psychological but not the medical aspects of this type of treatment? Such fragmentation may sometimes be the best we can do, but it often disintegrates into piece work.

As for the question of whether the up-to-date psychiatrists should continue to learn, practise and respect psychotherapy, including human empathy and intuition, which can never be systematized, manualized, automated or digitized -

I would say, simply, yes.

References

1. Smith, ML; Glass, VG: Meta-analysis of psychotherapy outcome studies. Am. Psychol. 1977;32;752-1760.

2. Handbook of Psychotherapy and Behavior Change, 4th ed, edited by Allen E. Bergin and Sol L. Garfield. New York; John Wiley and Sons, 1994.

3. Paykel, ES: Psychotherapy, medication combinations and compliance. J. Clin. Psychiatry 1995; 56 (Suppl. 1):24-30.

4. Oldham, JM: Personality Disorders: Current Perspectives. J. of the Am. Med. Assoc. Dec. 14, 1994, 272(22): 1770-76.

5. Jaspers, K.: Allgemeine Psychopathologie. Berlin, Springer Verlag, 1959, p. 19.

6. Zohar, D.: The Quantum Self. William Morrow and Company, Inc., New York, 1990.

7. Penrose, R.: "Minds, Machines and Mathematics", In: Colin Blakemore and Susan Greenfield, eds, MINDWAVES. Oxford, Basil Blackwell, 1987, p. 274.