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## Trends dynamics in Psychiatric Systems today <sup>1)</sup>

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The author makes some epistemological considerations on the urge to spread psychosomatics. To begin with, the heavy burden of mental disturbs in health care systems today lead to an absolute need for a proper psychosomatic training of general practitioners.

Then the 50 years of increasing psychopharmacological treatments available account for the mainstream split-care model; as the number of psychiatrists who focus on logotherapy decreased systematically while the professional body of nonmedical therapists has grown. Hence the impending need of psychosomatics as a counterbalance to adequately deal with the bio-psychosocial aspects involved both in health and in disease.

Finally concluding that, between physicalism and panpsychism, Psychosomatic Medicine has to find its way by getting rid of the outdated cartesian dualism.

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### **Psychosomatics as a counterbalance of trends dynamics in Psychiatric Systems today**

Psychiatry is a profession in transition; and while the role of psychiatrists is changing, it remains to be seen what their place is in mental health today, and what is the impact of that on patient outcomes.

In terms of global burden of disease, 4 out of the 10 most important causes worldwide are psychiatric in origin. Within this context, either as a primary disorder or as a co-morbid condition, mental disorders are very common in medical practice. Its prevalence is approximately 30% (USA); however only one-third of these individuals are actually getting some sort of treatment. And here is where the 'psychosomatic approach' first comes in.

In other words, changes in health care delivery underscore the need for other physicians, and primary care physicians in particular, to assume responsibility for the initial diagnosis and treatment of the most common mental disorders. Prompt

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diagnosis is essential to ensure that patients have access to appropriate medical services and to maximize the clinical outcome. A physician who refers patients to a psychiatrist should not only know when it is appropriate to do so, but also how to refer. He should base referrals on the presence of signs and symptoms of a mental disorder (e.g. psychotic symptoms, mania, severe depression or anxiety; symptoms of PTSD, suicidal or homicidal preoccupation; or a failure to respond to first-order treatment) and not simply on the absence of a physical explanation for a patient's complaint [1].

In the US 11% of women and 5% of men take prescribed anti-depressants. What results, from where I stand, more than depression itself, from distress; malaise if you will, and eventually conjunctural malaise as in the case of economic-financial pressures. Emotional states have starting points deeply rooted in evolution; but are unchained by actual concrete cultural situations. Furthermore emotional responses are socially elaborated, up to a point in which interpretation of emotional reactions is profoundly conditioned by culture. What implies a clinical approach that not only cannot ignore the cultural dimension, as it has to recognize itself as conditioned by that very same culture.

Historically, psychiatrists dealt with all aspects of patient's care; and many were trained heavily in psychoanalytical techniques. During the 60's it was not uncommon for psychiatric patients to consult with their therapists five days a week. But, as drugs moved in, the number of psychiatrists who focus on logotherapy has been decreasing systematically in a dramatic way [2].

In fact, since their introduction in the 50's, the pharmacologic treatments available have increased all along the years on an almost permanent basis; while also reducing considerably their main adverse side effects. The result is an armamentarium of useful treatments (antipsychotic drugs, antidepressant drugs, lithium,

benzodiazepines and anticonvulsants) for many common disorders; leaving psychiatrists with their hands full, simply by managing prescriptions just to meet the increased demand.

However there are no cures for psychiatric disorders; they are frequently recurrent, chronic and commonly marked by residual symptoms. Hence the still standing demand for talk therapy, which has been left over to an ever growing professional body of nonmedical therapists — psychologists and social workers —; that somehow keeps pace with the growth in pharmacologic treatments available. Notwithstanding, health insurance, through reimbursement policies, tends to encourage arrangements leading to shorter sessions, such as those for medication management, as compared with the psychotherapeutic ones. Lobbying influences such as these are well documented, as in the reported case on the exchanged mail while discussing the categories to be included, or not, in the DSM version to come; where one of the outcomes is the ominous influence of insurance providers [3].

What is mental disorder? Are types of mental disorder natural kinds? That is, are the distinctions between them objective and of fundamental theoretical importance? Since there is not a well-defined neuropathology for psychiatric disorders, nor are there biologic markers, what happens here is that psychiatric research fails to delineate well-defined disease entities and to reliably assign individuals to affected versus non-affected categories. As a result, there are no objective diagnostic measures for any of the common psychiatric disorders. In fact the diagnostic classification scheme, upon which both research and clinical practice rely, is derived from expert consensus based on clusters of symptoms and signs and on the disease course. That is the case with DSM: the clinical entities diagnosed are not sufficiently homogeneous to warrant independent recognition. The boundaries currently drawn around disorders don't

provide any certainty on what concerns an underlying and distinguishable set of neurobiological factors [4]. Despite these problems with current classifications in psychiatry, there is a general agreement on the core symptoms and strong cross-cultural similarity of manifestations. Suggesting that the central criteria for diagnosing major psychiatric disorders, although imperfectly, identify distinctive natural occurring brain diseases [4]. However there are also some epistemic flaws that must be taken into account as pointed out by Rachel Cooper [5]; for even if types of mental disorder are natural kinds, there are reasons to doubt that DSM come to reflect their natural structure. She examined the extent to which it is theory-laden, and looked in particular at how it has been shaped by social and financial factors. Ultimately concluding that, although widely used and of immense practical importance, DSM is not likely to become the best possible classification of mental disorders [5].

On another hand, medical specialization, while an absolute need after the exponential growth of medical knowledge, came to hinder the holistic approach required to adequately deal with the psycho-behavioral aspects involved both in health and disease. And that is yet another aspect that lays stress on the absolute need of a 'psychosomatic approach'. On this matter I would only bring up, merely as one example among many others, the so-called type A behavior pattern, as observed by Meyer Friedman and Ray Rosenman [6]; which is clear and unambiguously associated — throughout randomized controlled clinical trials — with a much poorer prognosis in men with Coronary Heart Disease. Or the more recent work by Janice Kiecolt-Glaser [7] showing that behavior, such as in hostile marital interactions, can influence health outcome and its immunological substrate. After this way, the required 'psychosomatic approach' is nothing else than the bio-psychosocial integrative model, as postulated back in 1977 by Engel [8, 9], both for research and

medical intervention.

Klaus Krippendorff [10], in line with the pragmatics of human communication [11, 12], argues that "meaning is a structured space, a network of expected senses, a set of possibilities ... [that] emerges in the use of language". Then within the healthcare systems of today, the meaning of "care" has been defined to be the eradication of a problem. Within this framework some spokespersons for the current mainstream split-care model argue that psychiatrists do better handling the medical side of patient care, while delegating psychotherapy to non-medical professionals. But while recognizing that patients do not wish to be regarded merely as a problem requiring eradication, some others, in the track of Engel, actually consider that an all-inclusive care model works best for patients. Among them Letiche is opposed to the very idea that complexity reduction can address the humanity of each individual healthcare situation [13]. He argues that, through narratives and through complexity based social theory, the complexity of each individual situation must be transcended through mindful listening and engaged dialogue. Letiche suggests that in the absence of such mindfulness, the lack of time for true listening, and the inability of providers and systems to allow for patients and family to engage in dialogue lies both the roots of the problem and the potential for its solution. If complexity theory has a role in the analysis understanding and betterment of social systems, then approaches such as the one Letiche undertakes will become essential tools of the trade.

Although it still remains to be clearly established beyond any doubt what model benefits patients more and in which circumstances, there is already some empirical evidence supporting — at least for disorders such as depression — that a combination of both psychotherapy and medication works better than either treatment alone. But psychiatry must undergo a profound change, in order to make patients'

psychotherapy need financially feasible. And the way I see it, as previously mentioned this is where psychosomatic reasoning must come about.

Talk of psychological, social and biological factors integration within health care is one thing; to actually have them integrated in clinical practice is something else. In fact, what we usually have, when everything goes for the best, is the confluence of those perspectives — psychological, social or biological — within a multidisciplinary health care environment. However, the clinical approach to the patient still is performed by specialists; who are deeply conditioned by their highly differentiated knowledge.

In a bottom-up approach, Psychiatrists claim themselves from a biological field. The underlying assumption being that human behavior may be reduced, in a last instance, to the ongoing cosmic ballet of neurotransmitters and other elemental molecules at a cellular level. Thus remitting themselves to analytically diagnosing imbalances at this level, and to prescribe accordingly.

However, although some of the more disruptive, and even dangerous behavioral problems, are effectively dealt this way, the fact is that the underlying condition remains unaltered. The achievement is to bring the patient to a level of functioning where communication is made possible; while considering social reintegration as well. And here is where the top-down intervention fits in: logotherapists and social workers. The assumption here, in turn, is that from the complex synthesis of systems such as the human being, new properties emerge that can no longer be fully explained, solely through decomposition to subsystems or base elements. In other words, elementary mechanisms fail to elucidate the functioning as a whole; they simply can't be detailed enough to realistically predict behavior of such complex systems and validate the model. Moreover, changes in behavior are also assumed to bi-directionally

influence, onto some extent, what goes on at biomolecular level; illustrated by cases such as the 'pink spot' in schizophrenia [14, 15] which has been reproduced at will with the urine of monks who underwent deep meditation. However, on the other hand, these higher level models seriously risk being delusional, or merely interpretative, if you may; having per se a much lower predictive power and requiring some further proof of reality.

Either way, although both approaches complement each other, the model remains infirmed by Cartesian dualism; and this brain-ghost dissociation still is probably the major handicap to be overcome by psychosomatic workers: may they be clinicians, researchers or philosophers. This being the case, Psychosomatic Medicine has to find its way between physicalism and panpsychism; which has been paved somehow in the past two decades by developments in neurosciences that allow us today to inform a more effective psychotherapy; and so we must.

In fact neuroscience no longer supports the mind-brain identity theory, because the brain cannot be isolated from the rest of the nervous system; moreover, there is evidence that the mind is hormonal as well as neural. In other words, according to nonlinear neurodynamics — the new cognitive science paradigm of dynamic systems theory —, the borders of mental embodiment cannot be neatly drawn at the skull. Mental phenomena emerge, not merely from brain activity, but from an interacting nexus of brain, body and world. The mind can be seen, not as an organ within the body, but as a 'behavioral field' that fluctuates within this brain-body-world nexus [16].

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