Biopsychosocial Advocacy

By Eric M. Plakun, MD, Associate Medical Director and Director of Biopsychosocial Advocacy

THE BIOPSYCHOSOCIAL ADVOCACY STRATEGIC INITIATIVE is intended to influence the field in three ways:

1. **Clinical advocacy** for the importance of psychotherapy and other psychosocial treatments as central parts of psychiatric practice and training within a biopsychosocial model.

2. **Social policy advocacy** for full implementation of the parity law, including careful review of the ethics of psychiatrist utilization reviews for insurance companies that are based on standards that do not comply with the parity law.

3. **Funding advocacy** for a shift in NIMH research funding from its current “either/or” focus emphasizing brain and biology research linked to biomarkers to a “both/and” strategy that restores meaningful access to funding for research into clinical treatment methods, especially psychotherapy research.

By way of context, the word “biopsychosocial” is a mouthful, but it is an important concept for psychiatry and other mental health disciplines. The term was introduced in the 1970s by Dr. George Engel to name the perspective in the field that mental disorders were caused by—and best treated by—a model integrating an individual's biology, psychology, and social context. Since the 1990s, the field has shifted dramatically toward a superordinate idea that mental disorders are more biomedical than biopsychosocial. Treatment and research shifted toward biology—with medications emerging as the mainstay of treatment in psychiatry.

Studying the brain and breaking the code of the human genome in 2003 were expected to reveal the biological and genetic underpinnings of and guide new treatment approaches for such mental disorders as depression, schizophrenia, and bipolar disorder. Although we have learned much—and in no way do we intend to disparage the importance of brain science and psychiatric genomics—the reality is that virtually nothing has emerged from several decades pursuing the biomedical model that improves patient outcomes. The same brain regions are involved in multiple mental disorders, no “biomarkers” of mental disorders have been found, and we tend to use the same...
From the Medical Director/CEO

I am very pleased to share with you the Summer 2017 issue of the ARC News, which continues to highlight new initiatives that have grown out of our recent strategic planning process.

I am proud of what our staff and Board of Trustees have accomplished in developing and launching these initiatives, and truly excited about the potential that they hold for extending both our reach and our impact on the profound mental health challenges we face in this country.

In this issue you will learn more about our efforts in biopsychosocial advocacy, psychodynamic psychopharmacology, and suicide research and education. Please be in touch—let us know what you think and be on the lookout for updates on these and our other initiatives in upcoming newsletters and on our blog, www.austenriggs.org/blog.

Thank you as always for your support of our work.

Best,

Andrew J. Gerber, MD, PhD

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75 medications for all disorders, while the genetic contributions to mental disorders turn out to be quite complex—with the focus now less on genes alone than on “gene-by-environment” interactions. We have learned, too, about the limits of medications, and about the salient contribution of environmental factors, like early adverse experiences, to later psychiatric and medical problems.

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Biopsychosocial advocacy calls for full implementation of the law, which means support for psychosocial treatments like psychotherapy and residential treatment, and the need for careful review of the ethics of managed care psychiatrists who implement utilization standards that are known to be out of compliance with the parity law.

There is also substantial evidence that several forms of psychotherapy are effective in treating patients with single, complex comorbid, and treatment-resistant disorders—and that psychotherapy may be the preferred treatment for those with histories of early adverse life experiences. There is a shift away from competition between schools of therapy toward recognition of a need to define shared elements of psychotherapy associated with change—regardless of school of therapy. It is also timely to re-emphasize the importance of psychotherapy as a more prominent part of the training and practice of psychiatrists. With this goal in mind, we established an American Psychiatric Association Psychotherapy Caucus that has grown in just a couple of years from 10 to close to 300 members.

Although the Mental Health Parity and Addiction Equity Act was passed in 2008, implementation of the parity law has been slow and incomplete. Biopsychosocial advocacy calls for full implementation of the law, which means support for psychosocial treatments like psychotherapy and residential treatment, and the need for careful review of the ethics of managed care psychiatrists who implement utilization standards that are known to be out of compliance with the parity law.

What we are learning suggests that the superordinate idea of the biomedical model may be too narrow, and that it is time to go “back to the future” to the biopsychosocial model that is actually more consistent with emerging science. After all, “gene-by-environment” is just another way of saying “biopsychosocial.”

We will be exploring the topic of biopsychosocial advocacy at this year’s Erikson Institute Fall Conference:

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MENTAL HEALTH PARITY, ETHICS, AND THE LAW:

What clinicians, patients, and advocates should know

Saturday, September 23, 2017

Visit www.austenriggs.org/2017FallConference for more information or to register.
Psychodynamic Psychopharmacology

By David Mintz, MD, Team Leader and Staff Psychiatrist

AS A PSYCHIATRIC FELLOW in the late 1990s, I found myself torn. I had come to Riggs to learn a psychodynamic perspective on treatment that focused on meaning-making, on the value of relationships, and on supporting patient authority. Meanwhile, mainstream psychiatry was moving in a completely different direction. In the ’90s, declared by presidential proclamation to be the “Decade of the Brain,” excitement about our burgeoning neuroscientific knowledge combined with the impact of managed care to produce a model of psychiatric practice that was largely the antithesis of what I was learning in my Fellowship. It felt as if my identity as a psychiatrist was being ripped in two.

My solution was to try to find ways to take my learning at Riggs and apply it to the practice of pharmacotherapy, in the hopes of bridging the opening gulf between these two aspects of psychiatric identity. Having learned from our “treatment-resistant” patients that the failure of pharmacotherapy was, as often as not, connected to problems in the doctor-patient relationship or to the patient’s unengaged conflicts about medications or treatment, I began, with my colleagues at Riggs, to study and write about the impact of meaning on pharmacotherapy outcomes. We identified six core technical principles to provide integrated, psychodynamically informed, patient-centered pharmacotherapy. These were:

- Avoid a mind-body split in approaching the patient
- Know who (not just what) the patient is
- Attend to the patient’s ambivalences about illness, medications, and caregiving
- Foster the doctor-patient alliance and address negative transferences
- Address covert countertherapeutic uses of medications
- Contain irrational prescribing driven by countertransference

Our hope was that we could offer some kind of antidote to the objectifying pharmacomania trending in mainstream psychiatry. Our more modest hopes seemed to be achieved when our publications were incorporated into the curricula of a majority of psychiatric residencies. To have a broader impact in promoting a psychodynamically informed, patient-centered perspective, in this age of “evidence-based practice,” however, would require establishing a firm empirical footing for psychodynamic psychopharmacology. In this spirit, the Psychodynamic Psychopharmacology Strategic Initiative at Riggs was born.

With Riggs Medical Director Dr. Andrew J. Gerber’s encouragement and research expertise, what has emerged is a plan to explore potential benefits of psychodynamic psychopharmacology in randomized clinical trials, and to see if pharmacotherapy patients receiving this treatment have better outcomes than patients receiving treatment as usual. If this turns out to be the case, we can then offer an evidence-based argument that a psychodynamic, patient-centered perspective on prescribing is a key element of expert pharmacotherapy.

Such research is new territory for us at Riggs, as this methodology is not an easy fit for a small treatment center with a prevailing commitment to a particular model of care. Indeed, the bulk of this research will have to be carried out at other sites, as it would be inconceivable for us to create a comparison group where we prescribe for some patients as if the meanings of their medications were of no import.

The first step in developing such a research program will be to operationalize the technical recommendations of psychodynamic psychopharmacology into measurable prescribing behaviors (e.g., inquiring about the patient’s feelings about taking medications or exploring covert benefits that patients may derive from their illness). The result of this process will be a treatment manual that is able both to guide a research program and offer guidance for the practicing clinician. In fact, we have just signed a book contract with American Psychiatric Association Publishing for the Manual of Psychodynamic Psychopharmacology. Within mainstream psychiatry, this is the publisher with the greatest impact; they have an ability to market directly to the 36,000 psychiatric members of the association.

When completed, we hope to test the usability of the manual at Riggs. This “fidelity testing” will allow us to assess whether the manual offers recommendations that are user friendly. If adherence to some aspects...
Suicide Research and Education

By Jane G. Tillman, PhD, ABPP, Evelyn Stefansson Nef Director of the Erikson Institute for Education and Research

IN APRIL 2016 the National Center for Health Statistics reported that in the US, the suicide rate increased 24 percent between 1999 and 2014. Suicide is the 10th leading cause of death in the US, with just over 44,000 suicides per year in this country. For mental health professionals, the suicide of a patient is the worst possible outcome of treatment. While many causes of death are not preventable, suicide is one cause of death that often leaves survivors with the sad feeling that it could have been otherwise . . . if only.

Addressing this profound problem is the focus of our Suicide Research and Education Strategic Initiative, which builds upon what we have learned and experienced in our clinical work. The majority of patients at Riggs report experiencing suicidal ideation at some point in their life, and about half of the patients admitted report a history of at least one prior suicide attempt. Our patients have much to teach us about suicidal states of mind, and how a person moves from ideation to action, a process that, while critical to understand, has been somewhat elusive to researchers in the field.

This new initiative extends our ongoing efforts to study the process of suicide—including individual, interpersonal, developmental, biological, sociocultural, and psychological phenomena. Several projects are now underway as part of this initiative. The main research study, “Impact of Interpersonal Experiences on Maladaptive Thoughts and Behaviors,” is led by principal investigator and Riggs Research Psychologist Katie Lewis, PhD. Using state-of-the art technology, including Ecological Momentary Assessment (EMA), we are able to study our patients’ reactions to various interpersonal encounters over the course of a day for several weeks. Instead of measuring experience at one or two points in time, Dr. Lewis’ study will allow us to understand experience in real time, through repeated measures. Dr. Lewis is hoping that this study will illuminate the interpersonal vectors involved in changes in mood, impulsivity, and both adaptive and maladaptive coping responses. Dr. Lewis was recently named the next Robert S. Wallerstein Fellow in Psychoanalytic Research in support of this work.

Other aspects of the Suicide Research and Education Strategic Initiative include ongoing publication of research from the “States of Mind Preceding a Near Lethal Suicide Attempt” study. We also hope to conduct a follow-up assessment with participants from this study to see how they are doing and what has changed (or not) over the past five years. Understanding the developmental course of suicidal thinking and behavior remains a goal of this study, where we are still learning about what sorts of life experiences may contribute to chronic or episodic suicidal thinking.

In addition to the ongoing and new research projects at Riggs, the initiative includes a weekly study group focused on understanding the most recent research findings in the area of suicide studies. We are also continuing to present our research and clinical findings to professional audiences and to provide public education about suicide prevention, intervention, and postvention.

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