Psychodynamic Therapy: A Guide to Evidence-Based Practice

by Richard F. Summers, MD, and Jacques P. Barger, PhD. Guilford Press, New York, NY, 2010, 355 pages, $45.00 (cloth).

Psychodynamic Therapy is an important book that is current, practical, evidence-based, and useful for the general psychiatrist. Divided into 5 parts, the volume begins by providing the context, defining pragmatic psychodynamic psychotherapy and its conceptual model as well as other psychotherapeutic approaches. The other parts deal with the opening phase, middle phase, and termination of treatment. Issues such as the therapeutic alliance, formulation, goals, narrative, change, and countertransference are discussed in generally nontechnical terms.

Probably the most relevant part for clinical psychiatrists is the section on combining psychopharmacology and psychotherapy. Without developing a new theory of integration of mind and brain, the authors discuss several helpful perspectives. Most of these converge into what is called the "top-down" cortical mechanism of psychotherapy as opposed to "bottom-up" pharmacologic treatment, which influences limbic areas, resulting in less cortical interference. The difficulty arises in knowing which patients should receive which treatment and how combined treatment might be developed. Several studies showing synergistic effects of the treatments and how combined treatment might be developed are discussed. Other studies that demonstrate negative interaction between the two treatments are referenced. Improvement with medication may increase new positive perceptions of the self. Medication can reduce patients' blame of self but also decrease the sense of responsibility for dealing with their problems.

A key table in the book outlines common attitudes to medication in several groups of patients. Those with depression,

obsessionality, fear of abandonment, low self-esteem, panic, and trauma are discussed in terms of clinical care. For example, to deal with negative transference to medication in depressed patients, those with low self-esteem, and those with panic disorder, active, careful, concerned management techniques are helpful. For obsessional patients, the clinician must relinquish control and act as a consultant or advisor.

In all patients, there are advantages and disadvantages to beginning or ending the session with medication issues. If medication is discussed initially, it does not force an awkward conclusion to an open-ended process to talk about side effects and dosages. However, medication talk at the beginning may precede the psychiatrist's learning of the patient's emotional state. If medication is discussed at the end, patients can have an opportunity to present important aspects of their narrative. Nonetheless, doing so may not leave adequate time for medication decisions. Flexibility and balance are thus essential on the part of the psychiatrist.

In most settings, such as managed care, community mental health centers, and Veterans Administration hospitals, treatment is usually split between dual providers. This requires collaboration between the clinicians for optimal care and to prevent patients from experiencing the effects of their infrequent or dysfunctional communication. Unfortunately, this is not always achieved. Another helpful table shows the distinct roles of psychiatrists and psychotherapists. Disagreements are destructive because of confusion for patients as well as the undermining of one or both clinicians.

One of the most intriguing sections describes positive psychology and psychiatry. The authors believe clinicians improve with time in expressing concern and optimism to patients. Effectiveness in treatment is greatly increased by personality strengths of the therapist such as happiness, kindness, social intelligence, creativity, open-mindedness, integrity, and humility. While most challenging, these are the recommended goals toward which all psychiatrists can strive!

Arthur M. Freeman III, MD
amfreeman3@gmail.com

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