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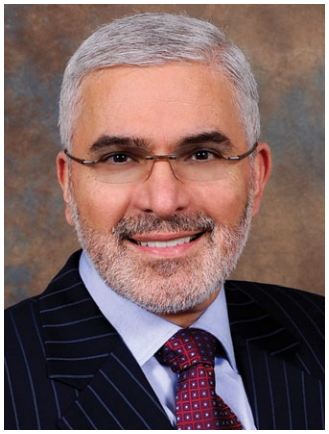

Henry A. Nasrallah, MD
Editor-in-Chief

Out-of-the-box questions about psychotherapy

As a National Institutes of Health-trained psychopharmacologist who also received substantial psychotherapy training during residency, I value both as pillars of psychiatric practice.

Should psychotherapy be subjected to the same research paradigm as clinical drug trials?

However, often I think about the evidence-based conduct of psychotherapy, which I regard as a neurobiologic treatment similar to drug therapy, and then I ask research questions that remain unanswered, such as:

- What is the therapeutic "dose" of psychotherapy? Does it differ by type of therapy or the patient's diagnosis?
- Is the dose measured in the number of sessions or the time the patient is in a therapy session? Is there a loading dose? What is the maintenance dose?
- What is the optimal schedule for psychotherapy? By what established criteria does a therapist determine how often to administer psychotherapy? Why weekly and not daily? Why not 2 or 3 times a day intensive psychotherapy for acutely ill patients? Is the scheduling based on the cost to the patient, the therapist's availability, or insurance coverage rather than the patient's needs?
- How long should a session be? How was the weekly 50-minute session determined? Why not 10, 20, 30, or 40 minutes? Is 15 minutes 3 times a week more or less effective than 50 minutes once a week?
- What is the primary indication for a given psychotherapy? Why do therapists use the same psychotherapy for many different psychiatric disorders? Isn't that like giving the same drug to everyone with any psychiatric illness? Is there such a thing as using a psychotherapeutic technique "off-label"? Why don't therapy techniques come with a label like drug therapy?
- What is the best time of day to conduct psychotherapy to achieve maximum benefit? Patients are assigned a slot almost randomly between 8 AM and 5 PM, but is early morning psychotherapy more effective than, say, mid-afternoon? Could going to sleep immediately after a session help consolidate memories, insights, learning, and emotional processing more than returning to one's work setting or home, where many distractions may disrupt or erase the salutary neurobiologic effects of psychotherapy? If this could be proven with controlled studies then perhaps patients could schedule a nap right after a session in a dark cubicle adjacent to the therapist's suite? This could result in a boom of "psychotherapy motels!"

continued

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• What effect does food have on psychotherapy efficacy? Is an empty stomach and hunger better or worse for patients? Would the borborygmi be distracting to some therapists? Is there a possible benefit for a postprandial session when serum glucose levels are higher? Could cognition be sharper for assimilating psychotherapy after eating vs before?

• Does ambient light intensity impact psychotherapy? Could ultrabright light that is used for seasonal depression (10,000 lux vs the usual 100 lux fluorescent bulbs) placed in a patient's field of vision during a session accentuate psychotherapy's beneficial effects?

• What are the side effects of psychotherapy? Why is it assumed that psychotherapy exerts efficacy without any tolerability or safety problems? Can certain types of psychotherapy cause somatic adverse effects—such as headache, nausea, dizziness, or appetite and sleep changes—that are unwittingly attributed to the psychiatric illness rather than the treatment?

• Is there such a thing as psychotherapy overdose? What is it and what are its symptoms? Is it initiated by the patient, the therapist, or both?

• Could co-administration of modest doses of neurogenesis-enhancing drugs such as a selective serotonin reuptake inhibitor or lithium potentiate the effects of psychotherapy, because learning and memory are improved with neurogenesis-associated hippocampal growth?

• Does psychotherapy work differently in different age groups (adolescent vs adult vs middle age vs elderly) because of ongoing brain circuitry and neuroplastic changes throughout the life cycle?

• Are there "me too" psychotherapies similar to "me too" drugs?

• Can a combination of 2 or 3 different psychotherapies work better than a single psychotherapy? Could cognitive-behavioral therapy combined with psychodynamic psychotherapy exert higher efficacy then either alone?

• Assuming that ongoing psychotherapy costs about $100 per session and a patient receives 40 to 50 sessions a year for a total of $4,000 to $5,000 a year, why the outcry about medications that cost a similar amount?

• Is the adherence rate to psychotherapy similar to that of pharmacotherapy? Do some patients "intellectually cheek" an occasional psychotherapeutic dose?

• Is there a generic psychotherapy? Is it cheaper? Is it as good as "brand-name" psychotherapy?

I am sure readers realize that some of my questions are serious while others are tongue-in-cheek, but I hope my musings prompt you to join me in thinking outside the box about psychotherapy and the many gaps of knowledge that persist. Rigorous research is needed to substantiate or negate some current assumptions about the use of psychotherapy.

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