A Physician's Experiences both as a Researcher and a Clinician

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The Psychiatric Times

June 2000, Vol. XVII, Issue 6

Throughout my 25 years as a psychoanalytic clinician and a central nervous system (CNS) researcher, I have often had opportunities to be a heretic in both camps. Perhaps that position would not suit others, but I have fun with it. No one actually accuses me of being insane, at least not to my face. When I attend meetings of either group, I always have something to talk about at the cocktail parties. "How could you be one of us and still do that?" I don't always give a serious answer to that question, but I would like to attempt one here.

I began my training in a fiercely eclectic psychiatric residency program about 30 years ago, wherein both psychodynamics and research-based biological psychiatry were taken very seriously. Educated with a deep respect for both viewpoints, I did not feel I could ignore either approach. They were both right, and both played an important part in delivering the best patient care. I also wanted to be the best professional I could be. So when I graduated from medical school and entered private practice, I pursued and completed formal training as a psychoanalyst and simultaneously involved myself in CNS research.

Though it may seem like trying to mix oil and water, I have pursued both enterprises since 1975. As a result of constantly straining to achieve an impossible binocular vision between the psychoanalytic and psychopharmacological viewpoints, I have not developed any clear insight into the mind/body problem. I have, however, developed a large part of my private practice centered on the assessment of challenging treatment failures: patients who have failed psychotherapy, numerous psychopharmacological interventions and managed care. Often I find the answer is that the three were not applied together intelligently; they were applied without recognizing the strengths and limits of each.

So what is it like to work in an eclectic private practice that includes psychoanalysis whilst working contemporaneously in a CNS research setting? Well, it is very interesting and only occasionally frustrating. I have always spent about 75% of my time in private practice. There are some obvious ways in which the one mindset intellectually washes and refreshes the other. Obviously, researchers are able to see new drug treatments years before they hit the market. For example, we started researching the selective serotonin reuptake inhibitors 20 years ago. This was a very exciting time in CNS research because

these new chemical entities were clearly much better drugs overall. Conversely, it was also frustrating for my private practitioner side because we had to wait many years before the first one was released to market.

Seeing new treatments ahead of the rest of the community is clearly a perk, whether in an eclectic private practice or one limited to biological psychiatry. It's fun to be on the cutting edge and to have some competitive advantage in today's tough private practice world. Another obvious perk comes when wearing the CNS researcher hat. It is very gratifying to treat needy, psychiatrically afflicted individuals, most of whom do not have the funds or insurance to get the treatment they need privately. While research protocols have their own rigidities and reasons for excluding patients, they are nothing like managed care. The rationale is almost always clear and scientifically based.

There are, however, some more subtle and interesting synergies and conflicts between the two practices. When evaluating patients for research studies, the psychiatrist's role is limited and quite different. Psychotherapy is usually precluded for the researcher because it would confound the evaluation of the outcome if both were given simultaneously. But even more radically, in order to determine if the patient meets all of the proper diagnostic criteria to qualify for a particular study, the interviewer needs to emphasize symptoms and minimize personal history. CNS research takes the diagnostic criteria and the disease model very literally.

Most anxious and depressed patients tend to be overly focused on their physical and cognitive symptoms; nevertheless, this is not always true. Some research applicants are so driven to tell their stories that it is very frustrating for them when their focus is returned to the detailing of their symptoms. It can be momentarily frustrating to the psychiatrist as well. Any question about their sleep, concentration or energy gets insufficiently answered as patients immediately jump back into their story about the stressful world in which they live. This should not, however, be frustrating to the experienced research psychiatrist for very long, especially if they also have a private practice; such a psychiatrist should be well acquainted and appreciative of such patients.

This inability to focus on symptoms and an overwhelming need to tell their story is actually important information. These patients may not be good research subjects because they are so strongly seeking a psychotherapeutic relationship. They may need to be referred out rather than entered in a trial. I explain this to many patients. It is helpful information to them, and it is part of the true informed-consent process. It also mitigates the frustration they may have felt during the evaluation interview.

Many times research subjects are recently unemployed and, as a result, they lack the money or insurance to be seen in traditional private practice consultation and care. So it is good to be reminded of how important it is to their self-esteem for people to work or somehow feel like they are making a contribution. This is evident when we see how meaningful it is for many subjects to feel as if they are making a contribution to science and therefore, in a small way, to mankind in general. These happy feelings can even induce some degree of placebo response, which is a challenge unto itself.

Admiration and respect for the placebo response phenomenon is another thing that the research experience provides to the private practitioner. Because of the general research methodology, patients may not be started on active (double-blind) treatment for a couple of weeks as they are screened, washed-out from other medications, medically worked-up and so forth. While they are waiting to receive active treatment, a percentage of them actually begin to get better. So doing CNS research can help keep the private practitioner appropriately humble.

From my conversations with other psychiatrists in private practice, I think they often underestimate how the very act of reaching out for help and making an initial appointment can in and of itself be an act of hope and self-assertion that improves self-esteem and mood.

Even more generally, conducting CNS research keeps us anchored in the scientific method. We were all given a scientific education in medical school, but over the years those lessons may fade unless we are reminded of them. This may happen without our being aware of it because true scientific reasoning can run counter to the commonsense view that I see re-emerging in the isolation of private practice.

We assume that the responses we see, both positive and negative, are almost certainly a consequence of the medication or other intervention we have initiated. This is the point of view our patients take, and we are necessarily inclined to try hard to understand and accept their point of view. Understanding and accepting the patient's view of causal connection is material to a successful treatment. Accepting the patient's point of view, however, does not mean believing-although it can easily end up that way. After all, as private practitioners we are trying to run a business and satisfy our "customers." How many of us in private practice might back off from using a new drug if four out of the first five patients we tried on it thought it was horrible, felt no improvement, or blamed the drug for their increased headaches or gastrointestinal upset? I know from my research experience that such initial impressions may very well be meaningless. Being involved in systematic placebo-controlled studies keeps one quite humble. Furthermore, knowing how the studies are conducted makes it easier to sort out marketing claims from the real, substantive scientific data. When we see how much patients improve by simply visiting a treatment setting, it can even make us more realistic about our psychodynamically oriented interventions.

There are also obvious frustrations in both types of practice and in trying to combine them. Research is almost always rigidly controlled by a protocol and is often placebo-controlled. So while a patient may have an opportunity of getting on a newer and possibly better medication, they also have the possibility of being on a placebo. At our site we softened the pain of this decision a long time ago by offering all research subjects (time-limited) free aftercare in which we worked hard to get them on a marketed drug that worked for them. Nearly all of the major pharmaceutical companies have seen the wisdom of free aftercare. Now several of them supplement such efforts. This provides an even better opportunity to work with the patient, especially compared with what most managed care settings provide. Even with the free aftercare option, deciding whether or

not to put a seriously depressed patient in a placebo-controlled study still can be an agonizing decision for the researcher and potential patient. We exclude them if it is too dangerous and, with the others, we inform them again and again, over and beyond the necessary informed consent, until everyone is comfortable with the decision and the expectations. While not all studies preclude concurrent psychotherapy if it has been ongoing for several months, some studies do prohibit it, for obvious methodological reasons.

When the CNS researchers return to their private practice, there can be other frustrations and dangers. For instance, there is a danger that the private practice psychiatrist conducting CNS research will bring too much of the symptom-focused research role into private work. This may lead to the danger of focusing too narrowly on the patients' symptoms and perhaps not encouraging them to talk about their stories-which is a necessary part of treatment in private practice. Similarly, private patients who do not respond well to the standard marketed medications usually cannot try the new exciting drugs that are being researched, as doing so would clearly bias our results.

Nevertheless, in spite of these relatively few frustrations and dangers, conducting CNS research has made me a better private practice psychiatrist and even a better psychoanalyst. From the changes I have observed in research patients, I am constantly reminded of how a negative and depressed outlook can influence a person's constructions and psychological theories about themselves, their intimates and even their childhood memories. Like our view of the future, our view of the past and what is remembered is governed to a significant degree by our mood. All of this helps keep me humble and open-minded as a clinician, which is so essential for effective psychoanalytic work.

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