Religion/Spirituality and Depression

To the Editor: The editorial by Dan Blazer, M.D., Ph.D., in the January issue (1) deserves commendation for highlighting an important issue we tend to avoid. Depression is a leading cause of disability worldwide, and in light of high rates of insufficient response to antidepressants, nonpharmacological treatment approaches should be more fully explored and implemented.

Dr. Blazer's editorial raises the question of how a psychiatrist should incorporate an assessment of the patient's religion and spirituality into the overall clinical evaluation. Although reimbursement limitations and other practical considerations are typically blamed for the limited discussion of these issues, there may be other reasons as well. Studies have shown, for example, that psychiatrists are less religious and show less religious affiliation relative to their patients or to the population in general (2–4). Omitting an assessment of the patient's religious views and spirituality, however, can result in deeply misunderstanding the patient's values and preferences.

Today we acknowledge that faith, belief, and trust strengthen the backbone of psychological well-being. Religious and spiritual beliefs and values can influence the course of psychiatric disorders. Rapprochement may best be achieved by raising psychiatric awareness and knowledge of the basic concepts of religion and spirituality and by having a willingness to embrace intellectual, cultural, and religious pluralism (5). The need for understanding has never been greater than at present, when our world's very survival is threatened by conflicts associated with the clash of cultures and values.

This article highlights the importance of providing such knowledge to psychiatrists in training. Our patients, our profession, and ultimately our world stand only to gain from such increased understanding.

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The Flight From Primary Care in Psychiatry

To the Editor: I read with interest the article by Samuel F. Law, M.D., F.R.C.P.C., and colleagues in the December issue (1) and applaud the initiative. We would like to point out that primary mental health care is lacking in other Asian countries too, but for reasons other than political. In Singapore, an urban city-state in Southeast Asia with a population of 5.18 million, these reasons are rooted in a rapid development and expansion of health care services. A rapid shift to medical specialization and subspecialization and increasing health care consumerism for specialized care have drawn patients away from primary health care to readily available specialist care at tertiary centers. While initially not undesired, the shift has gradually taken a toll on primary care physicians. In psychiatry, the gradual erosion of expertise and clinical skills in dealing with mental health issues has left primary care physicians reluctant and sometimes unwilling to handle even minor psychiatric problems. The population also continued to seek help for mental health issues from faith healers and from the nonmedical community.

In Singapore, major efforts have been made to remedy the situation, with postgraduate training programs for primary care physicians and allied health professionals and the setup of general practitioner partnership programs that allow for a two-way flow of patients for more appropriate allocation of care. Additionally, public health efforts to reduce stigma associated with mental illness have also been expanded.

Beyond this, recent calls to review undergraduate training and the relevance of clinical training in psychiatry should be heeded. Much can be done during early medical training to provide necessary skills for lifelong learning and change the attitudes of our medical students for their future practice (2–4).

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Response to Mahendran Letter

To the Editor: We thank Dr. Mahendran's attention to this concerning topic, as one of our goals for the article was to point out how psychiatric training and competence are sorely missing in a growing number of primary care physicians around the world for a diverse range of reasons. In China, this has been largely because of historical, political, and resource-limitation reasons, most notably for singling out psychiatry as a nonpriority in the delivery of a shorter, less intensive rural physician training program. The attendant significant negative impact over the years on the mental health of the coun-

try's rural population is well documented in our article. In Dr. Mahendran's report, this absence of competence is related to medical modernization that lost sight of the centrality of psychiatry as part of general medicine. We advocate that as psychiatrists, we cannot lose sight of this and should increase our championing of psychiatric training at all levels of medical education, lest psychiatry become irrelevant at the most basic level of medical care.

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Extended Psychotherapies

TO THE EDITOR: We would like to comment on the Introspection by Michael W. Kahn in the September issue (1). We recently conducted a study of older therapists and their practices with particular emphasis on those patients being seen for a very long time. We interviewed 11 psychotherapists between 70 and 90 years old who had between two and five patients. This totaled a group of 35 patients whom the therapists had seen for periods of 10 to 50 years. Dr. Kahn's patient is similar to these patients who are still seen "after years of therapy" (MW Kahn, personal communication, 2012). The therapists were surprised to learn that those in their age group were seeing similar patients. The patients either were self-payers or had flexible insurance, and most, although working, were socially isolated. The patients were mostly well educated, and about two-thirds were men. Two-thirds were married or had a live-in partner, and about half had adult children, some estranged. However, less than half of the sample had friends, and of these, just six had a confidante. As one therapist commented, "These patients have few or no friends, and not one has what I would consider an intimate trustworthy other in their lives. None has a confidante other than me."

How did these therapists view their work with these patients, what Dr. Kahn has called "palliative psychotherapy"? They mostly came to view their role as that of a trusted adviser, counselor, or coach. As one therapist said, "Although I am trained as a dynamic psychotherapist, very little of my work with these people would be recognizable as anything resembling insight oriented.… In short, I have acted as a guide and mentor." Several therapists commented that they missed the intellectual challenge of more interpretive therapies. They all felt that they were being useful to the patient, and many acknowledged that they were also benefiting from the relationship. Sessions had the flavor of a regular meeting with an old friend who gradually had come to know a fair bit about the therapist's life. For the oldest therapists in the sample, there was some suggestion that continuing to see a few patients enabled them to feel that they were still working and productive.

We believe that there is a group of patients who, instead of forming a diagnostic group (as none of our cases had serious mental disorders), form a functional group arising out of the patients' need for social support and their ability to afford continuing psychotherapy. Younger therapists begin with such patients, but only gradually does it become clear that the patients are members of this group.

Apfel and Grondahl (2) called the relationship an "abiding friendship" and observed that "therapists acknowledge these lifelong connections reluctantly," perhaps out of shame. None of the therapists in our sample expressed any shame about their work but rather, like Dr. Kahn, felt that they were helping some patients get through life. What to call therapy with this group of patients remains a question. Perhaps a relationship—simply by virtue of being "extended"—is transformed into a real-world attachment to both therapists and clients and takes the form engendered by that particular dyad and their historical context.

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