Keeping the Psyche in Psychiatry: Eight Years Later

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My first column as editor of this journal’s psychotherapy columns declared my prime objective in taking on the task: “Keeping the Psyche in Psychiatry.”1,2 I am concerned about the practice by psychiatrists of well founded forms of psychotherapy in all psychiatric settings. I am a senior psychiatrist and psychoanalyst in private practice with a longstanding involvement in medical education and in professional organizations. To counterbalance my own perspective, I have often tried to write in more general terms than my own psychodynamic orientation. Invited guest columnists have written from the perspective of other schools of psychotherapy as well as other professional environments.

Of course, I have not been alone in this quest. Numerous psychiatrists in leadership positions—from widely varying practice settings and all parts of the country, as well as academic psychiatrists and even some leaders in managed care—have expressed their concern about the fading role of psychotherapy and the decreasing interest in the patient’s personal narrative3 in psychiatric practice. They lament the decline of the psychotherapy skill set in many recently-trained psychiatrists.

In my initial column, I highlighted the American Psychiatric Association’s Commission on Psychotherapy by Psychiatrists (COPP), of which I had been chair. COPP is now a committee of the same name reporting to the Council on Quality Care. It comments frequently on psychotherapy issues, writes or revises position statements, reviews practice guidelines, contributes to the design of psychiatric practice surveys, makes presentations at scientific meetings of the American Psychiatric Association, and has completed a paper differentiating the common, often supportive denominators of psychotherapies and their divergence into distinctively psychodynamic and cognitive-behavioral methodologies. COPP continues to be a respected voice for psychotherapy by psychiatrists in the American Psychiatric Association. However, it is only one of many forces at work to advance the cause.

Now, almost 8 years later, what has been accomplished? In the past year, several major, longstanding efforts have come to fruition with beneficial implications for psychotherapy by psychiatrists. On the down side, a recent study shows that the trend continues for psychiatrists to provide psychotherapy for a smaller proportion of their patients, with more psychiatrists doing no psychotherapy at all. The well-rounded psychiatrist skilled in the full armamentarium of treatments is still an endangered species.

Like the proverbial three-legged stool, the viability of psychotherapy by psychiatrists rests on the complex interaction of three bases—scientific support, availability of training, and financial reimbursement. However, in the new healthcare environment, a fourth leg is equally essential—privacy.

The Science Base

The most solid foundation for the improved status of psychotherapy is the scientific basis on which it is considered a vital part of psychiatric care. Numerous studies have provided solid evidence that structured, manual-driven psychotherapies such as cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT) are effective for specific disorders such as depression, anxiety disorders, and obsessive-compulsive disorder.4 Some studies have shown that these treatment modalities are as effective as antidepressant medication in mild to moderate depression, and that the benefits may be more long lasting. Studies have proven that dialectic-behavioral therapy (DBT) and transference-focused psychodynamic therapy are efficacious for borderline personality disorder.5 A carefully designed study has shown that time-limited psychodynamic psychotherapy is highly effective for panic disorder.5 A recent meta-analysis of 23 studies of long-term psychodynamic psychotherapy (LTPP) included 11 randomized controlled trials.6 In the controlled trials “LTPP showed significantly higher outcomes in overall effectiveness, target problems, and personality functioning than shorter forms of psychotherapy,” especially for “complex mental disorders.” Studies have also shown that the combination of psychotherapy and

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medication is likely to be more beneficial than either one alone, and that psychotherapy confers long-term improvement.

From another direction has come neuroradiological evidence that psychotherapy has an effect on the function of the brain. Again the highly structured therapies such as CBT lend themselves most readily to research, and functional imaging shows distinct effects that parallel those produced by medication, although they are not in the same anatomical location. Newer concepts of the plasticity of the brain—its capacity for neurogenesis and formation of new synaptic networks—lend support to the supposition that psychotherapy experienced over time leads to new learning and realignment of neural networks.7–9

The net effect of these research efforts is seen in the higher standing given to psychotherapy as part of comprehensive treatment planning in practice guidelines for the disorders for which the evidence is strong. Psychotherapy now appears to be more routinely included as standard treatment in the literature. Even employers with whom I have spoken in the American Psychiatric Association’s Business Initiative appear to have an expectation that good psychiatric care includes some form of psychotherapy, and they are displeased when it is not available in their employees’ health insurance networks.

**The Training Base**

With the proliferation of information on neurobiology and psychopharmacology, psychiatric residents have been inundated with material to absorb. The expanding array of specific psychotherapy techniques has placed additional pressure on the curriculum. The tendency to schedule multiple short rotations in many practice settings has reduced the opportunity for residents to obtain in-depth clinical psychotherapy experience over time with the same patients. In 2002, the psychiatry Residency Review Committee (RRC) implemented a special requirement that residents be able to demonstrate competency in five core psychotherapeutic skills: LTPP, CBT, supportive psychotherapy, short-term psychotherapy, and psychotherapy combined with medication. COPP played a part in recommending this reinforcement of psychotherapy training standards, along with the American Association of Directors of Psychiatric Residency Training (AADPRT). In 2007, the psychotherapy competency requirement was made part of the standard patient care skill set and reduced to three types of psychotherapy: psychodynamic therapy, CBT, and supportive therapy. This is the description in the psychiatry RRC requirements: “Residents... should develop competence in... applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as to assuring exposure to family, couples, group and other individual evidence-based psychotherapies.”10

Residencies have scrambled, probably with varying success, to find staff to teach these skills, welcoming back psychoanalytically trained volunteer faculty who had often been exiled to the outer reaches during the great swing to biological psychiatry. Often the residencies have had to turn to skilled psychologists, social workers, and counselors to conduct the training. Although their teaching and supervision may be of high quality, the role model of the psychiatrist who is also an effective psychotherapist is missing in that arrangement, and the residents are at risk of coming out with the model that the psychiatrist does the medically oriented evaluation and manages somatic treatments, while referring most patients who need psychotherapy to a non-psychiatrist. All too often, coordination of care is lacking in split treatment of that sort. Graduate psychiatrists often then enter practice settings in which the split treatment model is the norm, so that they must make a determined effort to avoid losing their identity as psychiatric psychotherapists.

Whereas residents may now graduate with better theoretical knowledge about psychotherapy, it is unlikely that they have had the depth of experience to solidify their skills and to develop more than a minimum level of basic competence. (Looking back, did any of us have much more than that when we graduated, even if we had hundreds of hours of psychotherapy experience?) Some newly minted psychiatrists go into specialized training courses in psychotherapy or psychoanalysis and/or enter therapy themselves. Others obtain supervision either in an agency staff training program or through individual arrangements with a more senior professional. But for many, their graduation from residency is the end of their development in psychotherapy skills or the related personal growth.

**The Financial Base**

The great news in the financial dimension is parity at last! 2008 was a banner year. Medicare led the way. Congress voted to end the tragically discriminatory “psychiatric reduction” for outpatient psychiatric services that effectively raised the patient’s co-payment to 50%.11 The damage done by that inequity, which has
existed since the inception of Medicare in 1965, disproportionately affected patients who had no supplemental insurance—those least able to make the mandatory copayments and thus least likely to get treatment. It’s a sad final twist of the knife that rectifying this offense against elderly and disabled psychiatric patients will be phased in very slowly over 6 years—but at least it will happen at last.

Then, on October 3, 2008, came Congressional action to end discrimination in private group health insurance. Ironically, the bill, the gist of which had been passed by large margins in both the House and Senate but not reconciled by the two bodies, became the vehicle by which the Senate slipped new tax provisions related to the huge economic recovery bill past a constitutional restriction that prevented the Senate from initiating tax legislation. Thus parity finally became law in the waning days of this past Congressional session. The American Psychiatric Association describes the bill as the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, included within the Emergency Economic Stabilization Act of 2008, H.R. 1424. It mandates that health plans that offer mental health coverage must have the same benefits, copayments, and service limits as other medical and surgical coverage.

These breakthroughs are the culmination of literally decades of advocacy by the American Psychiatric Association, other mental health professional organizations, the American Medical Association, consumer groups such as the National Alliance on Mental Illness (NAMI) and Mental Health America, and individual patients and professionals with Congress, state legislatures, employers, professional groups such as the National Business Group on Health, and the media. Parity is a crowning achievement that should be beneficial for the care of all outpatients. It is good news for psychiatrists who provide psychotherapy to their patients—but its salutary effect may be limited by other serious inequities that afflict the healthcare system.

One difficulty is that managed care remains unfettered. While it appears that most managed care organizations are aware of the scientific evidence for psychotherapy and will pay to provide it, their referral and reimbursement policies are likely to direct patients to non-medical therapists to whom they can pay lower fees. Fee scales reward psychiatrists much more generously for seeing multiple patients an hour for medication checks than for 50-minute psychotherapy sessions with medical evaluation and management. This occurs despite evidence that combined treatment with psychotherapy and medication management performed by a psychiatrist is more cost-effective. As a result, many of those psychiatrists who remain committed to offering psychotherapy when needed have left the panels of insurance companies and see patients on a self-paying basis. Access to psychotherapy by psychiatrists is much easier for those patients who can afford to pay for it out of pocket.

Even the fee scale of Medicare, in which most psychiatrists participate, reimburses psychiatrists over twice as much for four services of CPT 90862 (medication management with no more than minimal psychotherapy) in an hour than for one service of 90807 (50 minutes of psychotherapy with medical evaluation and management.) This skewing of payment scales is a powerful incentive to psychiatrists to shift towards a medication-management practice.

In addition, psychiatrists are caught up in the general trend of physicians towards salaried hospital, agency, or group-based practice rather than independent private practice. In such settings, they may not be free to follow preferences to spend more time with patients in psychotherapy. Anxieties about practice costs, especially premiums for malpractice liability insurance and self-purchased health and disability insurance, are strong disincentives to enter private practice for young psychiatrists burdened with educational debts who are making career decisions at the end of residency training.

The Privacy Base

To the three essential elements discussed above must be added a fourth—privacy for work with patients. Concern for confidentiality goes back to Hippocrates, and psychiatrists may have always taken it as a given. However, the engines of the information age endanger privacy and confidentiality as never before. Two major forces are at work: the demand for system-wide access to individual medical records and the powerful electronic means of storing and communicating practically infinite quantities of data. Since the implementation in 2003 of the privacy regulations mandated by the Health Insurance Portability and Accountability Act (HIPAA), physicians who use electronic means of communicating protected health information have been “covered entities,” who are free to divulge patient information for purposes of treatment, payment, or healthcare operations without patient consent, although they must inform the patient of the right to request that this not be done. This provision
has been the source of great concern to privacy advocates, and the American Psychoanalytic Association has taken the lead in fighting it.

On the positive side, HIPAA privacy regulations do establish unique protection for private psychotherapy notes maintained as a separate part of the patient’s medical record. The content of these may not be divulged without the patient’s specific authorization. In that way, HIPAA respects the 1996 decision by the U.S. Supreme Court in *Jaffee v. Redmond,* which established an absolute privilege that protects psychotherapy records in federal court proceedings.

The physician conducting psychotherapy is thus confronted with the need to pay extra attention to issues of documentation and to the privacy and security of any sensitive data placed in electronic medical records. There are many links in the chain of security for medical records, especially psychotherapy notes. HIPAA requires measures to protect electronic health records, but the ultimate aim from the viewpoint of the psychiatrist is to protect the patient and the viability of the psychotherapeutic work. Private medical offices and large medical systems face these challenges equally, especially with regard to information gathered in psychotherapy.

**The Current Trend**

The developments discussed here all add up to discouraging statistics on trends in the amount of psychotherapy practiced by psychiatrists. Data from 1996 through 2005 show that the percentage of office-based visits to psychiatrists that involved psychotherapy declined from 44.4% to 28.9%. The number of psychiatrists providing psychotherapy to all of their patients dropped from 19.1% to 10.8%. Psychiatrists who provided more psychotherapy were more likely to be working with self-pay patients. This trend was attributed not only to financial incentives, but also to the growth in medication treatment.

It remains to be seen whether new developments in the scientific evidence base, renewed efforts by residency programs to provide their residents with high quality training in psychotherapy, the achievement of parity, strong protection of confidentiality, and advocacy for more equitable reimbursement of psychiatrists for psychotherapy will ensure that robust, competent psychotherapy will be a routine part of what the psychiatrist of the future can provide. It is up to the psychiatrists of the present to make it happen, so that we can offer future patients the best in well rounded care.

**References**

2. Between 2001 and 2008, Dr. Clemens has written 39 columns, including this one, for the Journal of Psychiatric Practice. They have covered topics such as advocacy with government and professional organization leadership; the biological interface; numerous clinical and ethical issues; documentation, privacy, and informed consent; specific environmental issues; and theoretical, historical, and general clinical process issues. Nine invited guest psychotherapy columns by other writers have also appeared in those years. A full listing of Dr. Clemens’ columns, with links to pdf files of each of them, is available on his web site (http://drewclemens.net/publications/psychotherapy-columns-in-journal-of-psychiatric-practice). All columns can also be accessed on the Journal’s web site (www.psychiatrpractice.com).