Obstacles to Early Career Psychiatrists Practicing Psychotherapy

Norman A. Clemens, Eric M. Plakun, Susan G. Lazar, and Lisa Mellman

Abstract: Though psychiatric residents are expected to be competent psychotherapists on graduation, further growth in skill and versatility requires continued experience in their ongoing career. Maturity as a psychotherapist is essential because a psychiatrist is the only mental health provider who, as a physician, can assume full responsibility for biopsychosocial patient care and roles as supervisor, consultant, and team leader.

Graduating residents face an environment in which surveys show a steady and alarming decline in practice of psychotherapy by psychiatrists, along with a decline in job satisfaction. High educational debts, practice structures, intrusive management, and reimbursement policies that devalue psychotherapy discourage early career psychiatrists from a practice style that enables providing it. For the early-career psychiatrist there is thus the serious risk of being unable to develop a critical mass of experience or a secure identity as a psychiatric psychotherapist.

Implementation of parity laws and the Affordable Care Act (ACA) will affect the situation in unpredictable ways that call for vigilance and active response. Additional service and administrative demands may result from the ACA, creating ethical dilemmas about meeting urgent patient needs versus biopsychosocial standards of care.

The authors recommend 1) vigorous advocacy for better payment levels for psychotherapy and freedom from disruptive management; 2) aggressive action against violations of the parity act, 3) active preparation of psychiatric residents for dealing with career choices and the environment for providing psychother-

---

Norman A. Clemens, M.D., Emeritus Clinical Professor of Psychiatry, Case Western Reserve University School of Medicine; Training and Supervising Analyst, Cleveland Psychoanalytic Center.

Eric M. Plakun, M.D., Associate Medical Director, Director of Admissions, The Austen Riggs Center.

Susan G. Lazar, M.D., Clinical Professor of Psychiatry: Georgetown University School of Medicine, George Washington University School of Medicine, and Uniformed Services University of the Health Sciences; Supervising and Training Analyst, Washington Psychoanalytic Institute.

Lisa Mellman, M.D., Samuel Rudin Professor of Psychiatry at Columbia University Medical Center, Columbia University College of Physicians and Surgeons.

Psychodynamic Psychiatry, 42(3) 479–496, 2014

apy in their practice, and 4) post-graduate training in psychotherapy through supervision/consultation, continuing education courses, computer instruction, and distance learning.

Will the psychiatrists of the future become seasoned, versatile, mature psychotherapists as part of their role as psychiatrists? On graduation from residency they are expected by the ACGME to demonstrate competence in psychodynamic psychotherapy, cognitive behavioral therapy, and supportive psychotherapy and knowledge of other psychotherapies (ACGME, 2007). Psychotherapy is an integral component of the biopsychosocial model of theory and practice that is fundamental to contemporary psychiatry. The psychiatrist is the only professional whose differential diagnosis includes consideration of medical conditions, with appropriate referral, who can prescribe psychotropic medications (in addition occasionally to other medications as needed as they impact sleep, appetite, thyroid function, alertness, attentiveness, etc.), and who also provides psychotherapy. The well-trained psychiatrist can be uniquely aware of dynamic factors in every aspect of the medical, pharmacological, social and psychological spheres germane for a particular patient.

However, residency has many inherent limitations on achieving the critical mass of experience required to develop a secure identity and a full range of skills as a psychotherapist. These limitations include multiple service demands, numerous competing subject areas, multiple rotations at a variety of sites, few faculty or supervisors with significant advanced psychotherapy training, and lack of continuity or insufficient longitudinal psychotherapy experience with a broad range of patients. Surveys of psychiatric residencies show wide variability in the amount of didactic time and especially the number of patient visits and supervisory sessions in the three required modalities of psychotherapy (Clemens & Notman, 2012; Sudak & Goldberg, 2012). Residency applicants choosing a residency program can assess their potential for developing a psychotherapy practice after residency by determining the emphasis placed by the program on psychotherapy training, particularly hours of supervision and patient care, and subsequent opportunities offered or available to graduates to practice psychotherapy in private practice, college health clinic, or other settings.

If the requirement to demonstrate competence is truly met despite such impediments, graduating residents should be off to a good start, but they are among the first to acknowledge that maturity as a psychotherapist is a long way off. For example, a study of Canadian psychiatric residents found that one quarter of graduating residents did not feel competent to practice psychotherapy without supervision

(Hadjipavlou & Ogrodniczuk, 2007). Especially for the psychodynamic and cognitive-behavioral therapies, supervised treatment of numerous cases is required to acquire comfort and security in using the distinctive techniques of each modality and systematically applying them to a variety of clinical conditions.

Years of experience with a variety of patients are essential to reach proficiency as a therapist—let alone as a teacher, supervisor, consultant, and psychotherapeutically sophisticated leader of a treatment team. Without the ability to offer psychotherapy to a variety of patients over time, technical skills, clinical judgment, and interest in engaging in psychotherapeutic relationships with patients will wither away.

But eager early-career psychiatrists (ECPs) face a bleak landscape for future development of this part of their professional identity. In a recent survey of U.S. psychiatric residents, only one-third believed that psychotherapy was a "potentially lucrative way to make a living" (Lanouette et al., 2011). Although 84% of the residents anticipated practicing psychotherapy in some capacity, the percentage of residents who plan to practice psychotherapy has been shown to decrease from the beginning to the end of residency training.

One might ask whether it matters that ECPs face challenges in developing psychotherapy skills. However, as demonstrated elsewhere in this series of articles, a growing body of evidence suggests that psychotherapy from multiple schools is an effective treatment for a range of single-diagnosis and combined comorbid disorders (Leichsenring & Rabung, 2008; Levy, Ehrenthal, Yeomans, & Caligor, 2014, this issue; Milrod et al., 2014; Roth & Fonagy, 2005). In contrast, the efficacy of biological treatments—usually medications, the prevalent treatment modality provided by general psychiatrists—has been overestimated by as much as a third, as in the case of antidepressants (Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008), while most of their effect is placebo effect (Kirsch et al., 2008). In addition, studies indicate that medication combined with psychotherapy is likely to be more effective than medication alone. For some disorders, as when chronic depression is accompanied by a history of childhood sexual abuse, psychotherapy appears to be an essential ingredient: psychotherapy alone is superior to medications alone, and the combination of psychotherapy and medication is only marginally superior to psychotherapy alone (Nemeroff et al., 2003).

PSYCHOTHERAPY BY PSYCHIATRISTS IS DECLINING

Ironically, even as the evidence for the efficacy of psychotherapy grows, there is evidence that the provision of psychotherapy by psychiatrists is declining. Mojtabai and Olfson (2008) report that over a ten-year period from 1996 to 2004-2005, the percentage of psychiatrist office visits involving provision of psychotherapy declined from 44% to 29%. In 2012 results of a survey carried out by the American Psychiatric Institute on Research and Education and the APA Committee on Psychotherapy by Psychiatrists (Perry, West, & Plakun, 2012) were reported at the Institute for Psychiatric Services. They found that from 2002 to 2010 there was a 20% decline in provision of therapy to patients by psychiatrists, with or without concurrent prescribing, from 68% to 48% of office visits reported by 394 psychiatrists. Those providing therapy to their patients tended to be over 65, White, and U.S. medical school graduates, and half their patients were self-pay or privately insured. Obstacles to provision of psychotherapy cited by psychiatrists included significant debt burden, lower compensation for psychotherapy compared to other services, and intrusive and time-consuming utilization review burdens.

The low fee scales and aggressive management techniques of insurance companies have driven almost half of psychiatrists in private practice out of accepting insurance at all (Bishop, Press, Keyhani, & Pincus, 2014). A study of national trends in the mental health care of children, adolescents, and adults by office-based physicians showed a significant rise in psychiatrist visits for youth but not for adults, and psychotropic medication visits more than doubled. Psychotherapy visits increased slightly for youths but decreased for adults (Olfson, Blanco, Wang, & Laje, 2014). Psychotherapy has increasingly been relegated to nonmedical providers, creating a necessity for maintaining coordination with prescribing psychiatrists or primary care physicians that is often much less than optimal. The decline of emphasis on psychotherapy in the United States is in significant contrast with a markedly growing investment in psychotherapy in the developing countries of the world (Weissman, 2013).

HOW WILL ECPs MAKE THEIR CHOICES?

As young psychiatrists make decisions about their future practice styles, they are influenced by a variety of economic and cultural factors along with lifestyle choices. Many are deeply in debt because of the

costs of college and medical school education; the average educational debt of indebted graduates of the class of 2012 was $166,750 (American Medical Association, 2014; American Medical Student Association, 2014). Salaried employment in public and private mental health facilities or multi-disciplinary practices offers assured income, benefits, and job security. Balancing work with family life is easier in a facility where part-time work with defined hours can be arranged. Even those young psychiatrists who wish to start a private practice are likely to start off working part of the week in an agency in order to secure some guaranteed income. In those organized settings, the pressure is on psychiatrists to use their time to do evaluations and provide medication management in brief visits for many patients, some of whom may be in psychotherapy with non-medical professionals.

Managed care practices by third-party payers have historically limited the number of psychotherapy visits and selectively steered potential psychotherapy patients toward non-physicians. Expenditures per psychotherapy service have declined over the years rather than growing with inflation; between 1998 and 2007 the mean expenditure per psychotherapy visit dropped precipitously from $122.80 to $94.59 ($p = 0.0001$ (Olfson, 2010). As a result, only 55% of psychiatrists in office-based practice, compared to 88% in other specialties, currently accept insurance (Bishop, 2014).

The fact that the remaining 45% of private practicing psychiatrists can make their living providing services to self-paying patients may be possible because of high demand in the face of a prevailing shortage of psychiatrists, although these psychiatrists may make substantial fee adjustments if they offer services to patients with lower incomes. Private practice allows much more control over the way one works; it may thus be a more appealing alternative for ECPs who have a serious interest in providing psychotherapy. However, the lag time before a practice is full, along with the need to finance educational debt, office expenses, electronic records and prescribing systems, support services, health care, and retirement savings, are daunting to graduating psychiatric residents in a changing environment for healthcare.

An ethical dilemma also confronts psychiatrists in many practice settings because of the shortage of psychiatrists in many locales (Carlat, 2010; Thomas et al., 2009). With so many patients in need of care, they are pressured to see large numbers of patients for brief, symptom-focused evaluations, rapid initiation of medications, and brief follow-up visits without inquiry beyond the current symptomatic state. In addition, psychiatrists are often pressured into administrative and supervisory positions with much paperwork and minimal time with patients; just dealing with payer authorizations and utilization reviews is a de-

mand on any therapist that takes time away from patient care. There is little time for psychotherapy—for understanding and modifying underlying psychodynamics in the patient's current life situation or developmental past, or for systematic behavioral interventions and cognitive restructuring. Substantive work with personality factors is then beyond reach. More people are served, but evaluation, exploration of patterns of thought or behavior, or insightful work with the treatment relationship is limited and superficial.

The pressure is especially heavy when the psychiatrist works for a public facility that has a duty to a defined population, while likely to be understaffed. The ethical dilemma is akin to a situation where there is a limited supply of penicillin in the midst of an epidemic of pneumonia: does one give half the recommended dose to everybody or a full recommended dose to half? Fortunately, limited services and medication are sufficient for some, but many others are recurrently and chronically ill and need more intensive and/or extended psychotherapy, to include those with chronic depression (Blatt, Quinlan, Pilkonis, & Shea, 1995; Buchheim et al., 2012; Fava, Ruini, & Belaise, 2007; Huber, Zimmerman, Henrich, & Klug, 2012) and those with borderline personality disorder (Bateman & Fonagy, 2008; Stevenson & Meares, 1999) as well as other patient groups (Berghout, Zevalkink, & Hakkaart-vanRojen, 2010a, 2010b; Beutel, Rasting, Stuhr, Rüger, & Leuzinger-Bohleber, 2004; De Maat, de Jonghe, Schoevers, & Dekker, 2009; De Maat, Philipszoon, Schoevers, Dekker, & De Jonghe, 2007; Howard, Kopta, Krause, & Olinski, 1986; Leichsenring & Rabung, 2008, 2011; Sandell et al., 2000).

Those of the authors who present conferences on psychotherapy at psychiatric meetings have repeatedly been told of the agony of conscientious psychiatrists who are genuinely interested in providing psychotherapy but serve public facilities with overwhelming case loads. A study of career satisfaction of psychiatrists reported that "adequate time with a patient had significant positive impact on career satisfaction" (Demello & Deshpande, 2011). It is a dilemma worthy of Solomon's attention—or preferably, systematic remedies. Economic realities often trump desire to be maximally useful to patients. The net effect is that the practice of psychotherapy by psychiatrists is being strangled by hyper-aggressive management, inadequate funding, and a severe shortage of psychiatrists.

Not all the obstacles are external. Providing psychotherapy is hard work. It calls upon the therapist to be deeply empathic, attentive, alert, patient, containing, understanding, sensitive to nuances, attuned to his or her own personal issues and emotional reactions to the patient, willing to suspend judgment while entering another person's inner world, and able to tolerate negative transferences in the service of doing the

work. Being a therapist requires commitment and time, and the satisfactions of success may be slow in coming. There are emotional risks in getting so involved with people. The early career psychiatrist's own cultural or educational background may not value introspectiveness and self-awareness as an avenue of healing. Peers may disparage psychotherapy. Medications and a doctor's support are often helpful to patients, sessions are brief, and the psychiatrist does not have to be so engaged with the patient's personal life. It is easy and less anxiety-provoking to be more attentive to the symptom checklist and the electronic data entry system than to the person. Fortunately, many psychiatrists who see large numbers of patients are able to do so without losing their psychotherapeutic interest and ability to engage the patient, but it requires flexibility, perseverance, and skill. And nothing quite matches the satisfaction of seeing a patient achieve lasting change as a result of psychotherapeutic work.

THE IRONY OF DECLINING PSYCHOTHERAPY BY PSYCHIATRISTS

Psychotherapy is firmly established as an essential part of evidence-based psychiatry (Lazar, 2010; Levy et al., 2014, this issue). Evidence-based psychotherapeutic modalities are integral to practice guidelines for specific disorders. Residency training in psychotherapy is mandated as a core competence by the ACGME (2007). Residencies that have lagged seriously in providing it are under pressure to remedy that gap, which is a challenge in many regions that lack psychoanalytic or CBT communities that can provide qualified teachers and well-rounded psychiatrists as models.

Numerous studies show that psychodynamic psychotherapy and its offshoots are efficacious (Levy et al., 2014, this issue) and cost-effective (Lazar, 2010; Lazar, 2014a, this issue). For example, a randomized controlled trial of a manualized psychodynamic psychotherapy for panic disorder showed efficacy (Milrod et al., 2007), as did comparison of two psychotherapies for social anxiety disorder (Leichsenring et al., 2013). The literature supporting manualized cognitive-behavioral psychotherapy and interpersonal psychotherapy for specific disorders is robust (Weissman, 2013). Other studies are meta-analyses of controlled studies such as a study of long-term psychodynamic therapy in people with severe, mixed disorders (Leichsenring & Rabung, 2011). In-depth single-case studies have long been seminal in the development of psychoanalytic therapies; they are presently being aggregated in an

international, searchable, online data base (Desmet et al., 2013; www.singlecasearchive.com).

Meanwhile, the popular press shows a renewed interest in psychoanalysis and psychotherapy: *Discover Magazine* recently published an article on "The Second Coming of Sigmund Freud." It describes the new field of neuropsychoanalysis showing how some of Freud's theories about mental processes anticipated new discoveries in neuroscience (McGowan, 2014)—a perspective voiced in recent years by Nobel-prize winning neuroscientist Eric Kandel (1998, 2013). Furthermore, powerful evidence supports the cost-effectiveness of psychotherapy (Lazar, 2010; Lazar et al., 2014a, this issue) with particular importance for work, depression, and the workplace (Sledge & Lazar, 2014, this issue). The alarming rise of suicide and mental disorders in the military and in veterans highlights a pressing need for more psychotherapeutically skilled psychotherapists for that cohort (Lazar, 2014b, this issue). Weissman (2013) notes that interest in psychotherapy and support for psychotherapy services and research are expanding in developing countries that face major public health challenges worldwide, with psychiatrists leading the way. On the other hand, Weissman reports that psychotherapy training has lagged in all mental health disciplines and psychotherapy research is severely underfunded in the U.S. and some other developed countries. In the face of increasingly robust evidence of the value of psychotherapy to patient care, the decline of its practice by American psychiatrists is senseless and harmful to a large group of people in need.

ENTERING A HEALTH CARE SYSTEM IN UPHEAVAL

This article is written at a time of two monumental changes in the health care system: mandated parity in third-party payment for treatment of mental disorders, and the initial implementation of the Affordable Care Act (ACA). Each has great potential for improving the availability of psychiatric services, including psychotherapy, but each also presents significant possibilities of an adverse outcome. Shaping the response to these changes is a challenge to psychiatrists everywhere. At stake is the biopsychosocial model of psychiatric practice, or "keeping the psyche in psychiatry" (Clemens, 2008). In less abstract terms, the individual human being must be the central focus of new health systems that are emerging. Systems would, after all, be meaningless without the people they serve. Psychotherapy works with the person first and foremost. It represents the humane side of psychiatric care.

Parity of third-party payment for mental disorders—parity with other medical disorders in all respects—is now the law of the land. Reimbursement practices must be the same as for other medical and surgical illnesses—fee scales, deductibles, co-payments, limits, utilization management, and so forth. A move in the direction of improving reimbursement for psychiatric treatment has recently occurred in the revision of psychiatric CPT codes and concurrent improvements in Medicare psychotherapy RVU (relative value unit) valuation for psychotherapy and psychoanalysis (Moran, 2013).

Notably, under the ACA and parity legislation, non-quantitative hurdles for authorizing payment for treatment, like utilization management, must be no more intrusive or restrictive than for comparable medical and surgical conditions. Theoretically, this has the potential to open access to care for many patients by reducing prejudicial and disruptive administrative burdens for psychiatric care and allowing treatment to proceed throughout a clinically appropriate course. However, there are indications that the parity law is already openly flouted and that the enforcement mechanisms are insufficient to stop it (Bendat, 2014, this issue). The same intrusive management and restrictions on meaningful psychotherapy could well continue as before. Therefore, vigilance on the part of psychiatrists, other mental health professionals, patients, and their organizations will be critical to ensuring the success of parity legislation. Inappropriately denied claims, arbitrary limitation of services, burdensome prior authorization procedures, and disruptive micromanagement of mental health care must be contested by providers and, if that fails, aggressively challenged through exposure by professional organizations or by legal action.

The promise of the Affordable Care Act is that millions of previously uninsured Americans finally have access to substantive health insurance. The outlook for people with psychiatric illness is dimmed, unfortunately, by the shortage of mental health care providers, especially psychiatrists, to meet the anticipated demand (Insel, 2011; Thomas et al., 2009). Access to psychiatrists is compounded by insurance companies' limiting the number of psychiatrists on their panels as a way of reducing claims and maximizing profits while making their premiums more competitive on the insurance exchanges (Beck, 2013).

The Affordable Care Act and related legislation encompass enormous structural changes now taking place in the healthcare system. These range from Health Insurance Exchanges to performance measures and "medical homes" in which psychiatric services are integrated with general medical care. They augment already heavy economic and societal pressures toward organized healthcare delivery systems in which employed physicians are cogs in the wheels of a highly systematized ma-

chine and have little control over their style of practice. The tendency to relegate the employed psychiatrist to the rapid evaluator, prescriber, and administrative roles already prevails. Individual psychiatrists who want to fully serve their patients will have to resist the trends and insist on carving out a place for the psychotherapeutic part of their professional development and satisfaction.

Although continuity of care and access to central information are the ultimate promises of electronic health information systems, pressures are high to adopt these while they are still seriously flawed. They are deeply imperfect in their ability to protect the privacy of confidential psychotherapy-related information for patients (Clemens, 2012). Likewise, the inability of any one electronic health information system to communicate effectively and reliably with another is far from resolved. The incipient development of huge, all-encompassing regional data bases compounds the dangers to privacy and confidentiality. Dissatisfaction rages in the medical profession around the cost of these systems, inefficiencies of data entry, and vulnerabilities in the supporting hardware and software. There have been numerous, large-scale violations of the privacy of individuals' personal health information (Clemens, 2012). Solo private-practicing psychiatrists have been slow to engage in electronic health records systems because of the cost and grave concerns about privacy, so that psychiatrists' participation is relatively low. Fortunately, the unique protection of psychotherapy notes in HIPAA and the 1996 U.S. Supreme Court decision in *Jaffee v. Redmond* affords security for the personal information disclosed by patients in psychotherapy. It must be recorded in psychotherapy notes maintained as part of the medical record but kept separate from the rest of the medical record. Access to this material without the patient's consent is prohibited for any purpose including insurance review and legal proceedings, except for very limited disclosures to prevent imminent harm to the patient or others (American Psychiatric Association, 2013). Unfortunately, mental health providers are often inadequately informed and unaware of this recourse.

As the ACA swings into full implementation, there are reports that insurance carriers are reducing or culling their provider networks to reduce their exposure to medical "losses" (Beck, 2013). Patients are angry about the threat of losing their long-term relationships with their doctors. Past experience indicates that insurance companies have favored inclusion of psychiatrists who do not provide much psychotherapy. Payment scales of the new insurance vehicles will have to be scrutinized to assure that they are comparable to other medical services in keeping with the parity act. In other words, the use of private insurance vehicles mandated by the ACA leaves the system prone to all the

devices by which insurance companies attempt to minimize payments for patient care and maximize profits. As state Medicaid rolls increase, the out-sourcing of Medicaid to private managed care organizations by some states may lead to similar maneuvers that are focused more on saving money than delivering effective treatment.

The ACA also includes more sweeping innovations in reimbursement schemes, the effects of which on psychotherapy by psychiatrists remain to be seen. Performance measures could introduce a whole new dynamic into psychotherapy services by gearing payment to objective measures of improvement by the patient, with potentially destructive implications for transference relationships. Introduction of integrated care involving psychiatrists in general medical care could enable novel ways of engaging patients in elements of psychotherapy on a short-term or even long-term basis, but would probably be based on a salaried staff rather than fee-for-service arrangements. Whether all of these changes in the healthcare system will have positive or negative effects remains to be seen. A mixture of outcomes is likely.

Psychiatrists determined to keep psychotherapy as a vital part of their therapeutic armamentarium must be engaged in the process of molding these evolving systems. Psychotherapy by psychiatrists needs diligent and effective champions.

RECOMMENDATIONS

The GAP Committee on Psychotherapy recommends four avenues of response to these challenges.

(1) We urge vigorous advocacy by psychiatric organizations to bolster payment levels for psychotherapy as part of psychiatric and other mental health services, using Medicare as the trend-setter, so that increasing numbers of psychiatrists can afford to participate in third-party payment mechanisms. Both the opportunity costs and the work relative value unit need to reflect the intensity and complexity of providing medical psychotherapy and the training that goes into it. Scandalously low Medicaid payment scales must be addressed; this affects many of the most severely afflicted and underserved patients. Appropriate remuneration would make it more attractive to young physicians to become psychiatrists and reduce the shortage in that specialty, especially if it is clear that psychotherapy can be a significant part of what they do. Aggressive advocacy with insurers, managed care systems, healthcare delivery systems, and clinical service directors in organized settings is also essential, to allow psychiatrists to use their full array of skills in caring for patients. The message is this: in the long run psychotherapy

as part of an overall treatment plan is the most cost-effective way to treat mental disorders because it goes beyond episodic care to underlying malfunctioning processes. Furthermore, psychotherapy enables patients to function better and make better use of other treatment modalities, such as medication and behavioral interventions. Finally, public information efforts are needed to heighten public awareness of the value of psychotherapy as an essential part of good psychiatric care. Such efforts will reach a receptive audience, as many patients and their families intuitively seek—or long for—a psychotherapeutic dimension in their care.

Individual psychiatrists should know how to advocate through their professional organizations, patient advocacy groups, the public media, and individual dealings with third parties including payers, reviewers, hospitals, mental health agencies, and other parts of the medical profession. Preparation for engaging with the Affordable Care Act and new processes in Medicare would include understanding such new features as Medical Homes, Accountable Care Organizations, and oversight boards. Medicare reimbursement penalties for failure to use electronic prescribing, electronic records, or performance reporting raise special problems for psychiatric practice and the doctor-patient relationship; the potential benefits and detrimental effects of these innovations must be objectively explored, and psychiatry residents advised about how to deal with them as they come increasingly into play. Changes are inevitable, so great care is necessary to preserve the essentials of good practice.

(2) Psychiatrists or their staff also may have to help patients find appropriate vehicles for their own advocacy or legal protection. Psychiatrists should have access to advice about when and how to use legal action when other means of patient protection fail, and professional organizations should organize programs to inform patients. Advocacy in common cause with colleagues from other medical and mental health professions may enhance effective action, with due respect for the particular capabilities, client or patient constituencies, practice styles, and concerns of each field of practice. However, they must approach all advocacy activities with full regard for the doctor-patient relationship, ethical principles, and maintaining the environment for effective psychotherapeutic work. If there were a means by which patients could be directed to resources provided by medical or consumer organizations to fight interference with appropriate treatment by insurers, it would reduce the pressure for direct intervention by therapists that would damage treatment relationships and undermine the treatment process.

(3) Psychiatric training should include education on the array of practice options and their effect on quality of practice, including psy-

chotherapy. Such instruction should include understanding of (a) varieties of third party payment, the nature of appropriate and inappropriate utilization management, and how to recognize and oppose parity violations; (b) confidentiality, patient consent, disclosure, HIPAA and protection of privacy including psychotherapy notes; (c) psychiatric ethics and legal issues; and (d) the psychodynamics of money and the business relationship with patients. They should also know the pathways for advocacy and patient protection through professional organizations and patient advocacy groups on the local, state, and national levels, as well as how to respond to unacceptable and illegal practices by third party payers.

(4) The committee also recommends a strong emphasis on lifelong learning to enhance psychotherapy skills. In this endeavor, psychiatrists can make common cause with the psychologists, social workers, and counselors who help to meet the widespread demand for psychotherapy services. This should be a rising tide that floats all boats. A common form of deepening therapeutic attunement is individual supervision or consultation with another psychotherapist. Another is peer group supervision, in which therapists present and discuss cases in a confidential, professional ambience. No therapist is too skilled to benefit from consultation with peers. Practical, experience-near continuing education in psychoanalysis, psychodynamic psychotherapy, cognitive-behavioral therapy, supportive and interpersonal psychotherapy are increasingly offered by universities, independent institutes, or professional organizations.

New technology enables distance learning and innovative teaching methods that broaden the reach of such programs beyond academic centers. Both psychotherapy didactics and supervision might be offered using web-based psychotherapy teaching services for the use of residency training programs with limited psychotherapy teaching resources. More advanced courses can meet the needs of individual early career psychiatrists, as well as more experienced clinicians who are increasingly aware of the limitations of a biologically reductionist treatment model and who seek greater proficiency in providing psychotherapy.

At this critical moment in our evolving healthcare system, psychiatry must work vigorously on many fronts to influence evolving medical and psychiatric care in a favorable direction. Only that way can we assure that the psychiatrists of the future will provide the best that the full biopsychosocial range of psychiatric expertise can offer.

REFERENCES

Accreditation Council for Graduate Medical Education (ACGME). (2007). Retrieved from https://www.acgme.org/acgmeweb/Portals/0/PFAssets/ProgramRequirements/400_psychiatry_07012007_u04122008.pdf, p. 13, para. IV.A.5.a)(3)(e).

American Medical Association. (2014). Retrieved from http://www.ama-assn.org//ama/pub/about-ama/our-people/member-groups-sectionis/medical-student-section/adv~.

American Medical Student Association. (2014). *Medical student debt.* Retrieved from http://www.amsa.org/AMSA/home.

American Psychiatric Association. (2013). *HIPAA Privacy Rule Manual.* Exhibits 26 and 27 (pp. 152-159).

Bateman, A., & Fonagy, P. (2008). 8-Year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry, 165*, 631-638.

Beck, M. (2013, November 17). United Health culls doctors from Medicare Advantage Plans. *Wall Street Journal*, p. B1.

Bendat, M. (2014). Obstacles to parity and advocating for equal coverage of mental health treatment. *Psychodynamic Psychiatry, 42*(3), 353-375.

Berghout, C. C., Zevalkink, J., & Hakkaart-vanRojen, L. (2010a). A cost-utility analysis of psychoanalysis versus psychoanalytic psychotherapy. *International Journal* of *Technology Assessment in Health Care, 26*(1), 3-10.

Berghout, C. C., Zevalkink, J., & Hakkaart-vanRojen, L. (2010b). The effects of long-term psychoanalytic treatment on healthcare utilization and work impairment and their associated costs. *Journal of Psychiatric Practice, 16*(4), 209-216.

Beutel, M., Rasting, M., Stuhr, U., Rüger, B., & Leuzinger-Bohleber, M. (2004). Assessing the impact of psychoanalyses and long-term psychoanalytic therapies on health care utilization and costs. *Psychotherapy Research, 14*(2), 146-160.

Bishop, T., Press, M., Keyhani, S., & Pincus, H. (2014). Acceptance of insurance by psychiatrists and the implications for access to mental health care. *JAMA Psychiatry, 71*(2), 176-181.

Blatt, S. J., Quinlan, D. M., Pilkonis, P. A., & Shea, M. T. (1995). Impact of perfectionism and need for approval on the brief treatment of depression: The National Institute of Mental Health Treatment of Depression Collaborative Research Program revisited. *Journal of Consulting and Clinical Psychology, 63*, 125-132.

Buchheim, A., Viviani, R., Kessler, H., Kachele, H., Cierpka, M., Roth, G., et al. (2012). Changes in prefrontal-limbic function in major depression after 15 months of long-term psychotherapy, *PLoS One, 7*(3), e33745.

Carlat, D. (2010). 45,000 more psychiatrists, anyone? *Psychiatric Times*, Aug 3, 2010 (pp. 1-4).

Clemens, N. A. (2008). Keeping the psyche in psychiatry: Eight years later. *Journal of Psychiatric Practice, 14*(6), 389-392.

Clemens, N. A. (2010). Privacy, consent, and the electronic mental health record: The person vs. the system. *Journal of Psychiatric Practice, 18*(1), 46-50.

Clemens, N. A., & Notman, M. T. (2012). Psychotherapy and psychoanalysts in psychiatric residency training. *Journal of Psychiatric Practice, 18*, 438-443.

De Maat, S., de Jonghe, F., Schoevers, R., & Dekker, J. (2009). The effectiveness of long-term psychoanalytic therapy: A systematic review of empirical studies. *Harvard Review of Psychiatry, 17*(1), 1-23.

De Maat, S., Philipszoon, F., Schoevers, R., Dekker, J., & De Jonghe, F. (2007). Costs and benefits of long-term psychoanalytic therapy: Changes in heath care use and work impairment. *Harvard Review of Psychiatry, 15*(6), 289-300.

DeMello, J. P., & Deshpande, S. P. (2011). Career satisfaction of psychiatrists. *Psychiatric Services, 62*, 1013-1017.

Desmet, M., Meganck, R., Seybert, C., Willemsen, J., Van Camp, I., Geerardyn, F., et al. (2013). Psychoanalytic single cases published in ISI-ranked journals: The construction of an online archive. *Psychotherapy and Psychosomatics, 82*, 120-121.

Fava, G. A., Ruini, C., & Belaise, C. (2007). The concept of recovery in major depression. *Psychological Medicine, 37*, 307-317.

Hadjipavlou, G., & Ogrodniczuk, J. (2007). A national survey of Canadian psychiatry residents' perceptions of psychotherapy training. *La Revue Canadienne de Psychiatrie, 52*(11), 710-717.

Howard, K. I., Kopta, S. M., Krause, M.S., & Olinski, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41*, 159-164.

Huber, D., Zimmermann, J., Henrich, G., & Klug, G. (2012). Comparison of cognitive-behaviour therapy with psychoanalytic and psychodynamic therapy for depressed patients: A three-year follow-up study. *Zeitschrift fur Psychosomatische Medizin und Psychotherapie, 58*(3), 299-316.

Insel, T. (2011). Retrieved August 1, 2014 at *http://www.nimh.nih.gov/about/director/2011/psychiatry-where-are-we-going.shtml*.

Insel, T. (2014). *Director's blog: Psychiatry: Where are we going*? Retrieved from http://www.nimh.nih.gov//about/director/bio/psychiatry-where-are-we-going.shtml.

Kandel, E. R. (1998). A new intellectual framework for psychiatry. *American Journal of Psychiatry, 147*, 455-469.

Kandel, E. (2013). The new science of mind and the future of knowledge. *Neuron, 80*, 456-560.

Kay, G., & Myers, M. F. (2014). Current state of psychotherapy training: Preparing for the future. *Psychodynamic Psychiatry, 42*(3), 557-573.

Kirsch, I., Deacon, B. J., Huedo-Medina, T. B., Scoboria, A., Moore, T. J., & Johnson, B. T. (2008). Initial severity and antidepressant benefits: A meta-analysis of data submitted to the Food and Drug Administration. *Public Library of Science: Medicine*, *5*(2), e45. doi: 10.1371/journal.pmed.0050045, February

Lanouette, N., Calabrese, C., Sciolla, A., et al. (2011). Do psychiatry residents identify as psychotherapists? A multisite survey. *Annals of Clinical Psychiatry, 23*(1), 30-39.

Lazar, S. (2014a). The cost-effectiveness of psychotherapy for the major psychiatric diagnoses. *Psychodynamic Psychiatry, 42*(3), 423-458.

Lazar S. (2014b). The mental health needs of military service members and veterans. *Psychodynamic Psychiatry, 42*(3), 459-478.

Lazar, S. (Ed.), and The Committee on Psychotherapy of the Group for the Advancement of Psychiatry. (2010). *Psychotherapy is worth it: A comprehensive review of its cost-effectiveness.* Washington, DC: American Psychiatric Publishing.

Leichsenring, F., & Rabung, S. (2008). Effectiveness of long-term psychodynamic psychotherapy: A meta-analysis. *Journal of the American Medical Association, 300*, 1551-1565.

Leichsenring, F., & Rabung, S. (2011). Long-term psychodynamic psychotherapy in complex mental disorders: Update of a meta-analysis. *British Journal of Psychiatry, 199*, 15-22.

Leichsenring, F., Salzer, S., Beutel, M., von Consbruch, K., Herpertz, S., Hiller, W., et al. (2013). Psychodynamic therapy and cognitive-behavioral therapy in social anxiety disorder: A multicenter randomized controlled trial. *American Journal of Psychiatry, 170*, 759-767.

Levy, K., Ehrenthal, J., Yeomans, F., & Caligor, E. (2014). The efficacy of psychotherapy: Focus on psychodynamic psychotherapy as an example. *Psychodynamic Psychiatry, 42*(3), 377-421.

McGowan, K. (2014). The second coming of Sigmund Freud. *Discover Magazine*, April, pp. 55-61.

Milrod, B., Leon, A. C., Busch, F., Rudden, M., Schwalberg, M., Clarkin, J., et al. (2007). A randomized controlled clinical trial of psychoanalytic psychotherapy for panic disorder. *American Journal of Psychiatry, 164*, 265-272.

Milrod, B., Markowitz, J., Gerber, A., Cyranowski, J., Altemus, M., Shapiro, T., et al. (2014). Childhood separation anxiety and the pathogenesis and treatment of adult anxiety. *American Journal of Psychiatry, 171*, 34-43.

Mojtabai, R., & Olfson, M. (2008). National trends in psychotherapy by office-based psychiatrists. *Archives of General Psychiatry, 65*(8), 962-970.

Moran, M. (2013). Government accepts higher work values for psychiatry codes. *Psychiatric News* (December 30). doi: 10.1176/appi.pm.2014.1a13

Nemeroff, C. B., Heim, C. M., Thase, M. E., Klein, D. N., Rush, A. J., Schatzberg, A. F., et al. (2003). Differential response to psychotherapy versus pharmacotherapy in patients with chronic forms of major depression and childhood trauma. *Proceedings of the National Academy of Sciences, 100*, 14293-14296.

Olfson, M., Blanco, C., Wang, S., & Laje, G. (2014). National trends in the mental health care of children, adolescents and adults by office-based physicians. *JAMA Psychiatry, 7*(1), 81-90.

Olfson, M., & Marcus, S. (2010). National trends in out-patient psychotherapy. *American Journal of Psychiatry, 167*, 1456-1463.

Perry, J., West, J., & Plakun, E. (2012). *Why psychiatrists don't do psychotherapy even though it works.* Presentation at APA Institute for Psychiatric Services, October 7, 2012, New York.

Roth, A., & Fonagy, P. (2005). *What works for whom?: A critical review of psychotherapy research. Second edition*. New York: Guilford.

Sandell, R., Blomberg, J., Lazar, A., Carlsson, J., Broberg, J., & Schubert, J. (2000). Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy: A review of findings in the Stockholm outcome of psychoanalysis and psychotherapy project (STOPPP). *International Journal of Psychoanalysis, 81*, 921-942.

Sledge, W. H., & Lazar, S. G. (2014). Workplace effectiveness and psychotherapy for mental, substance abuse, and subsyndromal conditions. *Psychodynamic Psychiatry, 42*(3), 497-556.

Stevenson, J., & Meares, R. (1999). Psychotherapy with borderline patients: II. A preliminary cost benefit study. *Australian and New Zealand Journal of Psychiatry, 33*, 473-477; discussion, 478-481.

Sudak, D. M., & Goldberg, D. (2012). Trends in psychotherapy training: A national survey of psychiatry residency training. *Academic Psychiatry, 36*, 369-673.

Thomas, K. C., Ellis, A. R., Konrad, T.R., Holzer, C.E., & Morrissey, J.P. (2009). County-level estimates of mental health professional shortage in the United States. *Psychiatric Services, 60*, 1323-1328.

Turner, E. H., Matthews, A. M., Linardatos, E., Tell, R. A., & Rosenthal, R. (2008). Selective publication of antidepressant trials and its influence on apparent efficacy. *New England Journal of Medicine, 358*(3), 252-260.

Weissman, M. J. (2013). Psychotherapy: A paradox. *American Journal of Psychiatry, 170*(7), 712-715.

Norman A. Clemens, M.D.
2258 Lamberton Road
Cleveland Heights, OH 44118
naclemens@cs.com