Psychotherapy and its Financial Feasibility Within The National Health Care System

Formulated by the Committee on Therapy

Group for the Advancement of Psychiatry

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This is the first in a series of publications comprising Volume X. For a list of the other GAP publications on current topics of interest, see last page of book herein.
STATEMENT OF PURPOSE

The Group for the Advancement of Psychiatry has a membership of approximately 300 psychiatrists, most of whom are organized in the form of a number of working committees. These committees direct their efforts toward the study of various aspects of psychiatry and the application of this knowledge to the fields of mental health and human relations.

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1. To collect and appraise significant data in the fields of psychiatry, mental health, and human relations
2. To reevaluate old concepts and to develop and test new ones
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations

GAP is an independent group, and its reports represent the composite findings and opinions of its members only, guided by its many consultants.

Psychotherapy and its Financial Feasibility Within the National Health Care System was formulated by the Committee on Therapy which acknowledges on page 11 the participation of others in the presentation of this report. The members of this committee are listed below. The following pages list the members of the other GAP committees as well as additional membership categories and current and past officers of GAP.

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INTRODUCTION

This report has been written to provide a basis of scientific and professional knowledge regarding psychotherapy, and particularly long-term intensive psychotherapy, for public policy makers who are planning and designing health delivery systems. It is prompted by the concern that decisions made regarding the use of public dollars for the support of this form of treatment be based on a sound understanding of its nature, usefulness, and true costs.

Scientific problems exist in all fields of medical treatment. However, one scientific problem, although not unique to psychotherapy, is important in differentiating it from most other medical treatment; the patient's so-called "disease" can usually not be demonstrated by laboratory, X-ray, or "objective" physical findings. This difference makes it essential to clarify the humanitarian, distributive social justice, and cost-benefit issues that relate this form of treatment to the rest of medicine. The humanitarian argument has the longest history. It states that human pain and suffering are undesirable and medical techniques that alleviate suffering should be supported by society. Since psychotherapy is one such technique, it deserves full consideration along with other medical treatments. However, within the health care system, there is a long standing tendency to distribute resources in favor of acute care rather than chronic care, in favor of the treatment of established illness rather than for prevention, and in favor of services for physical illness rather than for psychiatric services in general and psychotherapy in particular.

Historically, the treatment of the mentally ill in the United
States developed outside the mainstream of medicine, in close association with the development of prisons, almshouses and orphanages.¹ Long before this, however, the exclusion of the psychiatrically ill from health care systems had been rationalized for centuries, beginning with biblical references to the mentally ill as being possessed of demons. This exclusion resulted from the same motive that has excluded patients suffering from alcoholism; both types of illness have been perceived as the consequence of moral deficiency. Furthermore, the development of the existing bio-medical models of illness, being entirely biochemically oriented, was incapable of including psychological or social factors in the genesis of disease.² While a bio-psycho-social model has been actively proposed for decades, most recently by Engel³, it has yet to become the general conceptual framework of physicians; only a few of whom have gotten away from the reductionism and dualism of the present "medical", i.e., purely bio-medical model. Considering the nature of this model, we can understand the misgivings of many in the medical profession about psychotherapy. The humanitarian issue is further complicated by the fact that psychotherapy is often prescribed for patients whose disturbance is not publicly apparent to an observer who is not aware of the patient's private suffering, or the toll inflicted on his children, spouse or colleagues.

The distributive social justice argument is that the potential for personal freedom and the pursuit of happiness should be distributed as equally as possible; and if some are impaired in this regard as a consequence of illnesses that can be alleviated by psychotherapy, society has an obligation to provide that treatment so that all will have a more equal opportunity in life, just as it has an obligation to provide treatment for other disabling conditions.

The utilitarian, cost-benefit argument is that for certain groups of patients this treatment, however much it costs, is less costly than any available alternative. The (more expensive) alternatives include lengthy or repeated hospitalization, the increased incidence of physical illness and disability, and the social sequelae of untreated or inadequately treated mental illness—diminished productivity, broken families, disturbed children, crime, etc.
Psychotherapy has been defined as a developing transaction between two people, one suffering from distress or exhibiting disordered behavior, the other offering amelioration as a professional activity. The transaction is structured and programmed by culture, as well as influenced by the individual histories and personalities of both participants. Amelioration presumes change and bearing on this broad general aim are certain common assumptions. The first is a humanitarian assumption about the desirability of change, namely, that subjective distress and certain forms of deviant behavior not only can be ameliorated but should be. Second, that a learning or developmental difficulty has played a causative role in the patient’s disturbance. Third, that this disturbance or distress is correctable by relearning. Fourth, is an assumption about the relevance of human relationships, both in giving rise to the defect and in remedying it, namely, that the therapeutic relationship will itself be helpful.

This relearning occurs with varying proportions of insight, conditioning and corrective emotional experiences, depending upon the specific form of psychotherapy.

Three dimensions: “depth,” length of treatment and frequency of sessions help to describe various types of psychotherapy. Depth means the extent to which the therapist tries to explore the patient’s attitudes and feelings that have been excluded from conscious awareness. “Deep therapy” is synonymous with exploratory, and usually with long-term intensive, psychotherapy, and includes psychoanalysis. The latter is a lengthy (three-five years), frequent (three-five times per week), therapeutic process, with each session lasting 45–50 minutes. It is characterized by two phases. In the first of these, the patient reacts to the intentional ambiguity with which the treatment is organized with an effort to comprehend his relationship with the analyst and achieve gratification from him by methods he has used in the past. This makes “the here and now” experience between patient and therapist a vivid human situation that reveals the ways in which past conflicts are still active in the patient’s current perceptions and behavior.

A common concern about this form of treatment is that it induces an unnecessary and deleterious dependency relationship as a consequence of this first phase. Actually, the task of the second phase is to enhance the patient’s autonomy by helping him grasp the ways in which the present is different from the past, and the reasons for his wishing to cling to the past.

By contrast, therapies ranging from less exploratory to completely supportive do not aim to alter habitual modes of coping or underlying basic conflicts within the patient’s personality, but rather to strengthen those existing mental functions that are adaptively more effective, so as to enable the patient to cope more successfully with whatever inner or outer stress gave rise to his problems. Such therapies are in no way less valuable than therapy that explores conflicts which are less accessible to awareness; the terms are schematic and descriptive, not evaluative.

This form of therapy often works through a corrective emotional experience and conditioning that occur when the patient is able to experience and express previously unacceptable feelings in the presence of a benign authority figure (the therapist). This results in a rise in self-esteem that is reinforced when the patient also expresses these feelings outside of treatment and finds that his fears are not realized. This form of treatment usually does not involve insight into the patient’s past or his unconscious mental life.

For purposes of this report, treatment extending for more...
than 50 sessions or lasting longer than 12 months, will arbitrarily be defined as "long-term." Although intensive, exploratory psychotherapy, of necessity, is always long-term, often, the longest of long-term therapy is supportive and usually infrequent, i.e. two to four sessions per month. The goal of such supportive therapy is usually to help the patient cope with an unstable situation and the prevention of deterioration in chronically ill patients. It is in many ways analogous to the chronic use of insulin in the maintenance therapy of diabetic patients.

ILLUSTRATIVE CASE EXAMPLES

Four clinical examples follow. The first two are examples of brief psychotherapy, the second two are of long-term psychotherapy. All illustrate the mingling of supportive and exploratory strategies in therapy, but the third case is primarily an example of long-term supportive treatment and the fourth of exploratory therapy. The principal differences are in the way the therapeutic relationship is utilized in the treatment.

Case #1
A young married woman was referred to a psychiatrist by her internist, who failed to find any physical causes for recurrent headaches which had begun during the second year of her three-year marriage. The psychiatrist quickly surmised and shared with his patient the observation that the headaches always followed occasions of feeling irritated or mistreated by her husband, but that she had internal injunctions against expressing these feelings. Armed with this information and emboldened by the tacit consent of the psychiatrist, she successfully experimented with more direct modes of expression, thereby informing her husband of behavior of which he had been unaware. Improved communication in the marriage ensued, the headaches disappeared, and a course of brief treatment was successfully ended. This is an oversimplified but not an uncommon clinical history for patients who demonstrate relatively circumscribed symptomatology and flexibility of responses.
Case #2
An even simpler example of altering the balance of mental organization is seen in the case of an eighteen-year-old high school senior who suddenly became withdrawn from his family and friends and developed symptoms of anxiety, insomnia and nightmares. He had secretly become involved with an older woman and, in response to her urging and teasing, had experimented with certain illicit drugs and associated with a delinquent social element engaged in borderline criminal activities. Initially, he felt pride in this sexual adventure but later trapped by it and by the threat of seeming ridiculously juvenile if he expressed any of his reservations. Nor could he discuss his dilemma with anyone. An astute teacher noticed the boy's sudden onset of distractedness in school, sensed his discomfort, and tactfully suggested he consult someone at the local mental health facility. Out of desperation, the boy took the advice. When after a few meetings he felt it was safe fully to unburden himself to the psychiatrist, he did so. In the very process of telling the story, not only did his self-esteem rise, but it also became clearer to him what the issues were underlying his dilemma. Thus, by the time he came to the critical question: “What should I do?” the therapist had only to point out that he already seemed to have decided. Thereby, the therapist lent his support to that decision which brought the boy back into harmony with his own internal standards of behavior and helped him avoid moralistic self-recrimination about his temporary fall from grace. Simultaneously, the symptoms disappeared. This response confirmed the psychiatrist's initial diagnostic impression of a Transient Situational Disturbance which could be dealt with on a brief, supportive basis.

Case #3
A thirty-year-old welfare recipient, an unemployed carpenter, had spent two of his last five years in numerous admissions to various state mental institutions. He had become psychotic after his wife ended their brief and stormy marriage. Between hospitalizations he had drifted up and down the West Coast, occasionally working, drinking too much, and often on skid row. During his last hospitalization, a psychiatrist began psychotherapy and was impressed not only by the patient's motivation to get better, but also by his capacity to become involved in a working relationship with the therapist—strengths in this man's battle against his severe mental illness.

The patient was the only son of a strict fundamentalist preacher, and he had been raised to follow in his father's footsteps. Early in his adolescence, he began to experience great difficulty in containing either his resentment against his father's untempered harshness or his own intrusive sexual fantasies. Through rigid religious obedience, daily ritualistic prayer, study and physical exertion, he managed to get by. At the earliest possible moment he fled into a marriage to a demanding, cold and ambitious woman, but the marriage was a disaster. Immediately after his wife left him, he became drunk, went to a prostitute for the first time in his life, and then became psychotic.

His first hospitalization lasted over a year, and thereafter he could not long remain out of an institution without again confronting the forbidden perils of freedom. Although unable to face going back home, his relationships were always patterned by the search for an older “protector.” He either found a religious figure who enjoined him to a faith and celibacy he could not maintain, or else he found a “liberator” who attempted to loosen his sexual constraints. Both roads led back to the hospital. The psychiatrist through his clinical understanding was able to steer a course between both hazards. By being directive with patient firmness instead of harshness, the therapist was able to help the patient reestablish communication with his family and to learn that his
father was more tolerant and understanding than he had been or had seemed during the patient's earlier years. In the setting of the therapeutic relationship, a schedule of psychotropic medication was prescribed and maintained for the first time. After a year of weekly therapy meetings (with occasional extra sessions for emergencies) the patient's self-image as incurably insane became modified by the experience of his longest period out of a hospital. Subsequently, he entered a vocational rehabilitation program to become a welder. He continues to see the psychiatrist once a month and calls for extra sessions whenever something unusually stressful occurs. The sexual conflicts were tactfully discussed over a period of time, but were essentially let alone. The patient came to accept the fact that occasional masturbation was a psychological and physiological necessity, and that without that outlet, he could expect terrifying erotic nightmares. In time, perhaps, he will marry again, the only course which will afford him any alternative sexual gratification acceptable to the religious convictions which remain a source of great stability, reassurance and solace.

No short course of treatment could have accomplished these goals and without this therapy the probability is that this man would have deteriorated into a chronic psychotic alcoholic, a lifetime ward of the state, living a wretched, narrow existence between whorehouse and hospital. This case also provides the backdrop against which to speak once again to the paradox that long-term intensive psychotherapy is generally not for the most seriously ill, except in the hands of a relatively small number of specially trained clinicians whose practice is devoted almost entirely to this type of patient. Exploratory, "depth" psychotherapy might have increased the risk of another psychotic episode for this man.

Again, the position in this report issues from a pragmatic as well as a theoretical point of view: long-term therapy is indicated only when a successful, enduring result cannot be achieved with briefer therapy.

Next we turn to a particular form of long-term intensive, individual, outpatient psychotherapy: psychoanalysis.

**Case #4**

At thirty-five, Mrs. T. was, to all external appearances, the very model of success. She was the beautiful mother of two beautiful daughters, the wife of a successful professional man of rising prominence. She had graduated with honors from a fine school, and although she had begun graduate school in architecture, she forsook career plans in order to marry and to raise her children. Sexual problems were manifest early in the marriage, but her husband took an understanding view of her lack of sexual desire, and over the ten years of their marriage infrequency of intercourse became an accepted fact about which little was said and nothing done. In the second and sixth years of the marriage, shortly after the birth of each child, the patient became severely depressed. However, her husband became concerned only when the second child was a year old and his wife expressed suicidal ideation, confessing that for the previous year she had been consuming a pint of whiskey each afternoon before their regular late afternoon cocktail. At his insistence she consulted a psychiatrist who saw her once a week for three months with marked symptomatic relief. However, she stopped treatment when she began to feel better, and her husband did not insist that she continue. Over the next two years the husband took on additional committee work which even further diminished the time he had available for his family. The patient's drinking increased, and she became more irritable with her children, especially with the older daughter. Over that period of time she turned the care of her children
totally over to a live-in housekeeper and began an affair with a friend and colleague of her husband. When the affair came to light, her husband was "hurt" but "forgiving." That is, he did not respond with jealous concern or even anger as she had hoped he would. That night she attempted suicide by an overdose of sleeping pills.

During four consultative interviews, the treating physician ascertained that psychoanalysis was indicated. During the course of a psychoanalysis that required four sessions each week over a period of four and a half years, the patient learned that since childhood she had remained locked in battle with her mother and brother over the affections of her remote, emotionally isolated father. Mother was a depressed, bitter and verbally abusive woman who had been pushed into marriage by her socially prominent family when she became pregnant with the patient's older brother. The brother was a handsome, charming, spoiled child who excelled both scholastically and artistically without apparent effort. He was the favorite of both parents, and the patient's only method of gaining her father's attention was through teasing or misbehavior. Her husband was unlike her father in being kind and forgiving, but resembled him greatly in the emotional remoteness which characterized all his extraprofessional interests.

The course of the treatment followed a sequence of behaviors that recapitulated her most significant early-life experiences within the therapeutic relationship. At first, she was coy and competitive with the therapist, as she now realized she had also been with her first therapist, her husband and her father. Then, as a result of this regression to an earlier-life mode, she realized that the past was indeed "alive in the present" in the therapist's consulting room, and that her provocative behavior defended her against her still intense longings for her father's love and approval.

Eventually, she came to grips with her fantasy that her father, and now the analyst, failed to meet her needs only because he was afraid of his wife's anger. As these feelings emerged in the relationship with the therapist, they were spontaneously followed by early memories which confirmed the existence of the fantasy that she indeed had been special to her father as she now hoped to be to her therapist. She became aware that her depression after the birth of each of her children and later her suicidal attempt resulted from anger at her husband's lack of responsiveness and the pain of having given up her own career for him. This re-awakened similar feelings of helpless anger and depression at her father who had remained aloof despite her craving for his affection.

After these issues came into focus in the treatment, she could come to grips with her past and present feelings of unworthiness. These came to be understood as the result of guilt of which she had not previously been aware, because of her rage at her unfulfilled longings toward her father and husband in the past and therapist in the present, as well as of guilt she felt toward her depreciated mother.

Finally, she achieved some objectivity in this regard and was able to reassess her mother in the light of the mother's life situation at the time the patient was growing up. This resulted in her gaining a measure of tolerance, forgiveness and resignation with a new awareness of the underlying bond of affection between them. Long before these insights were fully integrated into conscious behavior, however, and while the patient was still thoroughly miserable inside the consulting room, she developed a sense of responsibility for herself and an increased capacity for dealing with the many difficulties in her life outside the consulting room. As in the far simpler case of the young wife with headaches, some difficult issues in the marriage had to be exposed and faced both by the patient and by her husband. He had to take responsibility for the ease with which he had allowed serious
problems to go unattended under the guise of “kindness and understanding.”

A common misconception about this type of treatment is that the goal is to uncover an original, historical “trauma,” the “why” of a behavior, with the implication that this discovery is curative. It is not. Rather the patient’s experience and understanding of how the past is alive in the present, and the investigation of why the patient wants to keep it that way are the essential factors.

RESULTS OF RESEARCH ON THE EFFECTIVENESS OF PSYCHOTHERAPY

Psychotherapy research has been a field of intense activity and controversy with thousands of published papers. While the effectiveness of different treatment approaches is a central issue in this research, much of it extends toward the question of how treatment works, and to methodologic problems rather than to the measurement of results. This brief overview focuses only on research concerning the effect of psychotherapy.

The recent history of the field dates from a review by H.J. Eysenck in 1952 which concluded that psychotherapy was an ineffective form of treatment. Eysenck concluded that as many patients recover from psychiatric symptoms without treatment as with it. While Eysenck’s methodology has been extensively criticized, it must be acknowledged that the topic is sufficiently complex that it is difficult not to order the data so as to support the previous orientation or theoretical preferences of the investigator. In any event, there is a great deal of research now which supports the notion that psychotherapy works, thanks in part to Eysenck’s early nihilistic challenge. One of the central flaws in Eysenck’s review was his accepting as a measure of “cure” the patient’s subjective statement of symptomatic improvement, neither looking at the nature of the improvement nor re-examining the patient at a later date to assess the durability of the change.

The phenomenon of improvement without treatment is a real and important one if the effect of psychotherapy is to be separated from the mere passage of time. Sifneos and colleagues found that patients who are randomly assigned to a
waiting list report moderate symptomatic relief before treatment starts, but no psychodynamic change in consequence of the passage of time alone. After treatment, the majority of patients show some resolution of emotional conflicts, improved self-understanding, new learning, and the acquisition of problem-solving abilities, whether or not they waited before treatment began.\textsuperscript{8} Investigating the same problem from another point of view, Malan and his associates found that a group of patients who appeared dramatically improved without treatment, when studied more closely, in fact had had a striking therapeutic response to a single interview and actually demonstrated the occasional efficacy of extremely brief psychotherapy.\textsuperscript{9}

The role of psychotherapy in the treatment of hospitalized schizophrenic patients has been another subject of research. May and co-workers first found that psychotherapy was of minimal value,\textsuperscript{10} but Karon and Vandenbros offered evidence that these conclusions were related to the work of inexperienced therapists. They showed that when experienced psychotherapists conduct the treatment, the course of illness is significantly altered. Patients who were treated by experienced psychotherapists not only spent less time in the hospital during the initial period of acute illness, but also spent roughly half as much time back in the hospital during two years of follow-up.\textsuperscript{11}

Karon further reports a review of other psychotherapy research with regard to whether experienced or inexperienced therapists were used in the research project. He concludes: “In every study where psychotherapy has not been helpful, quality control of relevant training, experience, and motivation (of the treating psychotherapist) has not been maintained.”\textsuperscript{12}

The most comprehensive answer to the question of whether psychotherapy works should emerge from the studies of those who review the vast literature on the subject. However, at least one team that has undertaken such a review is extremely cautious in drawing any conclusions. Bergin and Strupp after reviewing over 2,000 papers, summarize their disappointment:

Research in psychotherapy has failed to make a deep impact on practice and technique, presumably, because the results of most investigations have not had substantial practical significance. Reasons for this lack include the relatively short period of time systematic research has been focused on the problems of psychotherapy, deficiencies in techniques available to the researcher, and practical difficulties in designing and carrying out adequately controlled studies. Most researchers have been faced with serious limitations in collecting and analyzing data from representative samples of patients and therapists. Follow-up studies have been difficult to carry out; the crucial requirement of enlisting the full cooperation of therapists, patients, and institutions has been a continual stumbling block; and in general, rigorous designs have been difficult to impose upon the therapeutic phenomena themselves. Researchers who have attacked problems in the area through experimental analogues and similar techniques frequently have been unable to relate their findings to actual therapy situations. These issues have been amply discussed by numerous writers (Bordin, 1965; Edwards and Cronbach, 1952; Ford and Urban, 1967; Frank, 1959; Glover, 1952; Goldstein, Heller, and Sechrest, 1966; Hunt, 1952; Kiesler, 1966; Sargent, 1960, 1961). Two additional problems have limited the practical value of previous studies in psychotherapy, despite the fact that a number of them are of high scientific quality. One is the extreme complexity of the phenomena under study. Because of this factor, individual researchers have by necessity been forced to restrict their efforts to relatively narrow aspects of the larger problem. The other serious problem has been the lack of adequate communication and cooperation among researchers.\textsuperscript{13}

Despite their caution, Bergin and Strupp suggest that the research evidence of the last ten years has shown better
results from psychotherapy. In 1972, they quote Meltzoff, who takes a far less conservative position on the question of the effectiveness of psychotherapy:

In preparing a book on psychotherapy research I have reviewed most of the same literature as Strupp and Bergin, as well as the bulk of the outcome and process research that has been done on all patient types and therapeutic methods. When the evidence from controlled experiments is examined and weighed, the conclusion becomes quite clear that the effectiveness of psychotherapy with a wide variety of patient types, as ordinarily performed by journeymen therapists, has already been amply demonstrated. The research evidence to document this statement obviously cannot be presented here, but it has been steadily accumulating over the last 15 years. It now amounts to over 100 controlled outcome studies, most of which have yielded positive results.  

Another overview is afforded by Bordin who summarized nearly 10 years of psychotherapy research in his recent book. He reviews and discusses 685 publications in the field of psychotherapy and psychotherapy research. He, too, eschews much concern with the question of whether therapy works, in favor of discussing research methodology. However, in his concluding chapter he speaks briefly and definitively on this point:

As I have shown, there is respectable evidence of short or long-term effects of various aspects of the psychotherapeutic situation and of the functional relations among various components of it. True, these items of evidence are still a great distance from fostering a highly advanced level of precision in theoretical propositions and in procedural specifications, but nevertheless contradict the position of the nihilistic skeptic.

A team led by Imber found that outpatients with "minimal contact" brief sessions every other week improved less than patients treated with an hour per week of individual psychotherapy or with group therapy sessions which met for an hour and a half each week. Many patients in all three groups experienced symptomatic relief, but at the end of six months of treatment those in the minimal contact group had improved the least. Follow-up examinations were performed on a large number of the research subjects ten years after the original therapy and it was found once again that those in the minimal contact group were not functioning as effectively as those in either of the other two groups.

A similar study was done by Lorr's research team at a large VA clinic. Outpatients were randomly assigned to be seen either twice a week in psychotherapy, or once a week, or once every other week, and followed for three years after the end of therapy. No differences assignable to treatment frequency were immediately apparent, but at the end of a year, of the patients remaining in contact with the research team (a significant number), those who had been seen in therapy with greater frequency showed differential improvements very similar to those observed by Imber's research team. At three years the gains were maintained and, in some respects, augmented.

In 1964, a clinical research team at the Psychoanalytic Clinic for Training and Research at Columbia University reported that patients with chronic ulcerative colitis who received psychotherapy in addition to the usual medical regimen had a more favorable somatic and psychological response than did a matched control group of patients who received the usual treatment without psychotherapy. It was shown in this study that the longer the duration of treatment, the better the clinical outcome. Follow-up evaluations upon which these judgments were made took place more than five years after termination of therapy.

One additional study will be cited which points to the difficulties of early assessment of response to treatment. In 1968, a study was begun at two clinics involving 150 moderately depressed women between the ages of 25 and 60, from
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working and lower-middle-class backgrounds. All patients were treated with antidepressant medication, and after an initial treatment phase, half of the patients were assigned on a random basis to once-to-twice weekly psychotherapy, and the other half to brief monthly interviews which were not deliberately psychotherapeutic but were for assessment and prescribing. One hundred and six patients remained on medication and completed an eight-month course of treatment. On social adjustment scales the patients who received psychotherapy improved 44 percent as contrasted with 28 percent improvement in the low-contact group. The authors conclude:

The social adjustment of recovering depressed women, treated initially with antidepressant medication, is enhanced by the addition of weekly supportive psychotherapy. These beneficial effects, however, take some time to develop. They are not apparent after two to four months of treatment, but are after six to eight months, indicating that psychotherapy should not be short-term. The effects are seen in the improved work performance, reduced interpersonal friction, freer communication, reduced anxiety, and in overall adjustment. Maintenance medication, either alone or with psychotherapy, does not afford these advantages.22

Finally, we would cite several preliminary studies of the effect of psychotherapy upon patterns of utilization of general medical services. In two of these there was a clear-cut decrease in the demand for and utilization of medical services. Such findings raise important and, as yet, unanswered questions about measures of cost-benefit effectiveness of psychotherapy, and they point to the need to consider that the effect of treatment must be examined across a broad range of response systems.23, 24, 25, 26

It is rare that any review of psychotherapy research closes without recommendations for additional research, and this report shall not break with that tradition. It is evident that continued efforts in research are essential to the scientific and therapeutic advance of medical psychology. Computers and the centralization of medical information on large numbers of people over a period of time open the possibility of a whole new era in psychiatric research. The problem of locating and following the treatment outcome on a large number of psychiatric patients is close to solution, and requires only that necessary resources be allocated to the research with, of course, vigorous attention to methods assuring confidentiality. We urge that attention be paid to these critical questions and that the questions not be limited to psychological variables. The outcome of most medical treatment is measured by responses within the organ system in which symptoms occurred. Psychotherapy is unique in its ability to affect a wide range of psychological, social, and biological functions. However, unless policy decisions are made to afford priority to these questions, they will remain unanswered.
Public attitudes

The perception of psychiatrists, particularly in their role as psychotherapists, as practicing in mysterious ways is in part based on the public's desire to avoid confronting the existence of unconscious attitudes in themselves, i.e., the "dark side" of their own natures. To the extent that psychiatrists enjoy this exalted status as "keepers of secrets," they must pay the inevitable price of social depreciation, as exemplified in jokes about psychiatrists.

To a considerable extent, the rest of the medical profession expresses the same attitudes albeit in a more tangential fashion. There is a tendency for physicians to misdiagnose psychiatric conditions because of the doctor's discomfort in acknowledging the psychological factors in illness. Thus, many patients who suffer chronic depression or anxiety neurosis manifested in the form of physical complaints, are offered incomplete treatment by being denied proper psychiatric attention.

Psychiatrists are faced with the task of helping the public (including the rest of medicine) understand that they are neither pied pipers of permissiveness who encourage social disruption by encouraging patients to attack the societal roots of authority and promulgate sexual license without self-responsibility, nor are they proponents of "adjustment" to an oppressive society, but rather medical specialists treating illnesses that have a larger than usual psychological component to their causes or manifestations. There is a widespread myth that long-term intensive psychotherapy and psychoanalysis are selectively indicated for and preferred by affluent individuals to the exclusion of the economically disadvantaged. The facts are that when these modalities are made available, they are used by all socio-economic groups.

Cost control

The economics of insurance coverage for long-term intensive psychotherapy are carefully reviewed in a recent article.

There is no definitive evidence available for either side of this controversy [between proponents and opponents of comprehensive mental health coverage]. There is, however, an increasing flow of data in support of the contention that comprehensive mental health coverage does not radically change existing utilization patterns of mental health care.

Sharfstein and Magnas draw extensively from the experiences with the Blue Cross/Blue Shield plan operating under the Federal Employees Health Benefit Program (FEHBP) because that plan is by far the largest one with accurate utilization data over a period of time. Four and a half million enrollees in this plan carry the so-called "high option plan," which has, since 1967, covered 100 percent of inpatient mental health care costs as well as 80 percent of outpatient psychotherapeutic services in excess of the first $100 in charges. During a three-year period (1971, 1972, 1973) in which there was free access in and out of the program, Sharfstein and Magnas conclude that the availability of unlimited intensive psychotherapy with co-payment coverage did not seem to cause any appreciable increase in the number of people utilizing this form of treatment.
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The majority of patients, in fact, tend to limit themselves to short-term treatments... In each of the three years for which data are presented at least 78 percent of people in psychotherapy limited their treatment to 25 visits a year; 90 percent restricted themselves, on a yearly basis, to one visit or less a week.  In discussing this same plan in his Introduction to Coverage and Utilization of Care for Mental Conditions Under Health Insurance Sabshin states:
The upward trend in utilization of benefits for mental disorders that had characterized the high option of the Blue Cross/Blue Shield Plan for Federal Employees since its beginning in 1960 appears to have ended. Utilization leveled off in 1973 and 1974. Thus in 1972 benefits for mental disorders constituted 7.3 percent of benefits for all conditions; in 1973 they constituted 7.4 percent; and in 1974 they were back down to 7.3 percent.

Similar findings come from another source. The Joint Information Service publication, Psychiatrists and Their Patients is a summary of information on the private practice of psychiatry gathered from questionnaires returned by 440 randomly selected psychiatrists. In examining this data to see the effect of insurance coverage upon the duration and frequency of treatment, one finds that the utilization of psychiatric services for insured and uninsured patients is roughly the same, indicating that the degree of utilization in terms of numbers of visits is not significantly affected by the presence of insurance coverage for this group.
There is evidence that undiagnosed emotional illness, possibly because inadequately or inappropriately treated, is a major burden on the health care system and consumes a significant share of the health care dollar. It is generally acknowledged that a large proportion (estimated up to 75 percent) of patients consulting non-psychiatric specialists and family practitioners, have no demonstrable organic problems. It is also conventional wisdom that the greatest proportion of medication prescribed by nonpsychiatric physicians is non-specific or frankly psychotropic. Over-medication and misuse of medication in these situations is common. Studies in this country and in West Germany have demonstrated that psychotherapy not only helps such patients solve the problems that brought them to treatment, but also reduces their tendency to seek inappropriate medical treatment, to receive unneeded diagnostic tests, and to experience unnecessary hospitalization. The West German study specifically demonstrated the cost effectiveness of long-term intensive psychotherapy, including psychoanalysis, administered by competent therapists. As a result of these findings, the West German National Health Insurance System now includes a significant amount of coverage for long-term intensive psychotherapy, including psychoanalysis, effectively monitored by a peer review process.
Recent findings show that claims for outpatient mental health care outside the Federal Employees Plan also seem to be leveling off. (See p. 36 above). There are also indications that adequate outpatient care, either long-term intensive psychotherapy or psychoanalysis may forestall psychiatric hospitalization. This same study confirmed that usage of other health benefits including medical or surgical hospitalization remained low following the completion of psychotherapy.
Plans for collaboration are underway among the American Psychoanalytic Association, the National Institute for Mental Health and the National Association of Blue Shield Plans. When carried out, this collaboration will attempt to replicate in the United States the West German study that found that long-term intensive psychotherapy or analysis reduced the usage of other health insurance benefits after treatment was over in comparison with a control group of
similarly insured people who had not had such psychotherapy or analysis.

The question of inclusion of mental health benefits under a possible National Health Insurance scheme in this country is being debated actively. Some insurance companies are fearful of including psychotherapy coverage believing that the indications for undertaking psychotherapy are unclear as are the indications for terminating it. They believe it is thus unpredictable in expense, likely to be overused, difficult to monitor and its quality hard to assure. The findings noted above demonstrate that such fears are probably greatly exaggerated.

QUALITY CONTROL

The public has an overriding interest in reducing the cost-benefit ratio of health care. Unfortunately, the emphasis is usually on reducing costs, with less attention to enhancing the quality of benefits. In fact, the ratio may actually get worse if cost control reduces benefits; conversely, higher costs which result in higher benefits may lead to an improved system. The focus on costs, of course, reflects the relative ease of their precise measurement; benefits are difficult to quantify.

Quality control is a major concern of any profession, and medical and psychiatric efforts reflect their professional ethic. The development of educational programs to train new members of the profession, continuing education for practitioners, and certification and recertification procedures to monitor the effects of these educational programs are all aspects of quality control. Retrospective audits of clinical practice can be used to evaluate quality, and to enhance these educational pursuits. These methods of quality control tend to focus on the competence and quality of the practitioner.

Another form of quality control focuses on the review of episodes of treatment. When this review is performed by or under the supervision of professional peers, it is a component of “peer review.” It may involve the comparison of selected aspects of treatment with previously selected standards, the examination of case records, or the direct study of the treatment process. Peer review has become a subject of increased interest, since the 1972 amendments to the Social Security Law mandated it for services rendered to inpatients who are beneficiaries of federal health programs.

Psychiatry has a long history of peer review, most prominent in psychiatric education. Individual supervision of therapists conducting treatment is more common in the teaching of psychotherapy than in any other area of medical education. However, psychiatry faces a special problem in implementing the type of peer review procedures being developed by other specialities in response to the federal mandate. Most medical peer review processes are developed with the assumption that patients’ records can be reviewed against previously determined criteria by non-physician reviewers. The clinical data basic to psychotherapy, and the process of treatment, are difficult to translate into such simple terms. As a result, peer review by uninformed individuals may constitute a danger to adequate prescription and conduct of appropriate modalities of psychotherapy—and thus interfere with appropriate patient care.

In an effort to respond to this danger and also to achieve the goals of quality control and cost containment, the American Psychiatric Association, the American Psychoanalytic Association and the American Academy of Child Psychiatry have developed criteria and procedures for peer review of psychotherapy and psychoanalysis for all age groups. The general principles for the appointment of local peer review committees include the recommendation that
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its members should be chosen to represent subspecialities and all significant points of view in order that all groups may have a voice on the committee. Members should be appointed from private practice, clinic or mental health center practice, medical schools, etc.45

It is now clear that the quality of all psychotherapy can be reviewed, monitored, and enhanced by peer review in much the same way as the quality of other medical procedures. There is even some early evidence that costs can be controlled, inappropriate utilization reduced,46 and the cost-benefit ratio improved. As a result, in 1977, the Office of Civilian Health and Medical Program of the Uniformed Services (OCHAMPUS) contracted with the American Psychiatric Association to establish and operate a nationwide, retrospective peer review system for psychiatric CHAMPUS claims, using local peer review panels composed of psychiatrists.

It should be noted that there are some problems inherent in the peer review process, and that by itself it is not sufficient as a means of professional quality control. Peer review tends to identify and reduce incompetent or unacceptable professional behavior, but it does not necessarily improve average or above average professional behavior. In fact, the time and effort required for an effective review process may actually interfere with the functioning of superior practitioners. Peer review that is designed only to control costs and to monitor the lower levels of practice, and that is not linked to educational and research programs aimed at enhancing the quality of all practice, is likely to lead to a deterioration of practice to a lowest common denominator.

A profession is a social organization, and each professional has an obligation not only to provide quality care to his own patient, but to assure the general public that they can place their trust in any member of that profession. Peer review is an essential mechanism in responding to that obligation.

Psychotherapy, including-long term intensive psychotherapy, is an essential method of treatment in psychiatry. Although it has important differences from many other types of medical treatment, it shares their most essential characteristics. A growing body of scientific data supports the view of experienced physicians that, when properly prescribed and administered, it is effective and appropriate therapy. There are public and professional attitudes that interfere with its general acceptance, but data now demonstrate that its costs can be controlled, (including the costs of long-term intensive psychotherapy), its quality monitored, and that for a great many patients it is the treatment of choice. Decisions concerning its role in health delivery or health financing systems should be made on the basis of the information available about it as a medical treatment.

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