

Introduction to the Special Issue on Psychotherapy, the Affordable Care Act, and Mental Health Parity: Obstacles to Implementation

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The articles in this Special Issue of *Psychodynamic Psychiatry* were written by members of The Committee on Psychotherapy of the Group for the Advancement of Psychiatry. Susan Lazar, M.D. is past Chair of The Committee; Frank Yeomans, M.D. is current Chair. The Group for the Advancement of Psychiatry (GAP) was created by the American Psychiatric Association shortly after WWII. It is organized in committees whose function is to publish articles and monographs on issues of contemporary interest.

Psychodynamic Psychiatry is pleased to publish this Special Issue which is of substantial psychiatric and public health relevance. The journal staff commends the GAP Committee on Psychotherapy for calling attention to an area that requires sustained attention and action from the mental health community. Despite progressive legislation serious problems in psychiatric care delivery remain unsolved. These are systematically discussed in this Special Issue of *Psychodynamic Psychiatry*.

America has a crisis in mental health care. Psychological difficulties are common and often reach clinical proportions. For example, in a definitive investigation, a representative sample of 9,282 Americans was interviewed to ascertain the lifetime prevalence and age of onset of *DSM-IV* psychiatric disorders. The investigators found that about 50% of the population met criteria for a psychiatric disorder sometime in their lives. The first onset of the disorder was usually during childhood or adolescence (Kessler, Berglund, Denker et al., 2005). In any given year approximately 57.7 million people suffer from mental disorders. These are severe, chronic, and/or recurrent and often coexist with other mental and physical disorders in about 15% of the population (Green, McLaughlin, Berglund et al., 2010; Kim-Cohen, Caspit, Moffit et al., 2003). Mental disorders are the leading cause of disability

in the U.S. When they co-occur with physical disorders, they increase the cost of medical/surgical care (Lazar, 2014). Psychological problems are often stigmatized leading many people to avoid seeking help from professionals.

As the articles in this issue of *Psychodynamic Psychiatry* make clear, lack of treatment or under-treatment is also the direct result of current health politics and policy. Recent media attention has focused on the violent mentally ill, a small and non-representative percentage of all people with psychiatric difficulties. Although this topic is important, serious problems in delivery of care are even more widespread. Inadequate assessment and treatment of people with psychiatric disorders is the rule, not the exception in the United States, leading to enormous waste of human and financial resources. At present approximately 20% of health care expense is due to administrative costs, much of which occurs because of the practices and policies of insurance companies; a uniquely American phenomenon. Upper level insurance company executives earn considerably more than physicians, even those in surgery, a higher paying specialty than psychiatry (Rosenthal, 2014).

Persistent difficulties in health care delivery were not caused by the Affordable Care Act. The latter however is based on an insurance reimbursement model which will affect more patients and clinicians than previously was the case. The fact that the medical safety net has been greatly expanded must be considered a dramatic example of social justice. Nonetheless since the present insurance reimbursement system leaves much to be desired, true mental illness–physical illness parity can only be achieved when sound reimbursement policies exist and are enforced.

The articles in this issue of *Psychodynamic Psychiatry* indicate that a value conflict between insurance companies and clinicians commonly exists. Far too frequently insurance companies ration mental health care without possessing and/or using knowledge to be able to do so responsibly. Compliance with parity legislation is often avoided and even evaded (Bendat, 2014; Lazar, 2014). Sometimes the goals of insurance companies, patients, and psychiatrists are aligned. Often they are not, however, and the economic goal of the corporation conflicts with the health-oriented goal of the clinician. The image sometimes presented to the general public is that good faith efforts are made to balance treatment with cost. Actually the relationship between clinicians and insurance companies is frequently adversarial. In any struggle about assignment of resources differential power of the adversaries inevitably favors insurance companies. What this means is that therapeutic practice may be determined by an insurance company and not the patient's psychiatrist.

Excessively low reimbursement rates are evidence that psychiatrists have not been effective advocates for themselves or their patients. The reasons for this are puzzling and call out for future exploration and discussion.

One of the issues that comes up again and again in these articles concerns the nature of evidence in psychiatry. It is apparent that psychiatric treatment cannot be based on a “cookbook” algorithm approach to delivery of care. Inferences are frequently based on judgments that are not entirely supported by controlled studies. Since countless treatment situations remain to be adequately studied the circumstance of individual patients must be considered part of the evidence base used to assess appropriateness of treatment. This situation is not unique to psychiatry but often occurs in clinical medicine generally (Roland & Campbell, 2014). In a review of pay for performance policy, the authors listed the “lessons learned” by United Kingdom health policy planners. They commented: “Pay for performance administrators need to recognize that large parts of clinical practice cannot currently be measured. It is better to recognize this than to force poorly designed indicators into a program” (p. 1948). This is eminently sensible.

Psychotherapy may be carried out by professionals with diverse credentials. Many people with psychiatric disorders can be helped by non-physician therapists. Because the patient population is diverse however, there are a number of situations in which it is in the patients’ best interest for psychiatrists to carry out psychotherapy. It is helpful to keep in mind for example that the evidence for therapeutic effect of psychotherapy without medication in the treatment of many types of depression is as good as or better than the therapeutic effect of medication without psychotherapy (Lazar, 2014; Nemeroff, Helm, Thase et al., 2003; Sledge, 2014). Most patients can be best helped through application of a paradigm in which biological-psychological and social influences interact with each other in health and illness. The role of physician psychotherapist must be considered part of integrated treatment particularly of patients with severe, complex, recurrent, or chronic disorders and those with concurrent medical/surgical disorders (Leichsenring & Rabung, 2011; Sandell, Bloomberg, & Lazar, 2000). Hopefully this will be suitably acknowledged by third party payers as parity legislation becomes regularly enforced.

The effort to achieve parity in the treatment of psychiatric disorders is an ambitious but practical public health oriented effort. It is sorely needed and its implementation should lead the way out of a thicket of problems of mental health care delivery that impedes progress in many sectors of American life.

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Preface to Psychotherapy, the Affordable Care Act, and Mental Health Parity: Obstacles to Implementation

Patrick J. Kennedy

With passage of the Mental Health Parity and Addiction Equity Act (MHPAEA) and the Affordable Care Act (ACA), the table has been set for sweeping changes in the way our nation understands, delivers, and pays for mental health care. As an author and co-sponsor of the parity law, I believe it offers vast opportunity to people who have arbitrarily been denied care for their disorders since as far back as we can remember. Because we were able to pass the parity law when we did in 2008, it established a floor for coverage in the Affordable Care Act that came along a year and a half later. Together, MHPAEA and ACA represent the greatest advance in several generations for insurance coverage and treatment of mental health disorders. But if we are realists, we must acknowledge that for the law to make the difference my co-sponsors and I hoped for, it must be implemented with vigilance and unwavering purpose. Writing the law was not enough; compliance with it must be monitored and enforced. And, meanwhile, practitioners, payers, employers, and educators must all examine and change their practices if the law is to fulfill its potential. None of us can wait for someone else to step forward; the responsibility for making parity real rests with each of us.

The articles in this Special Issue outline some of the risks and dangers that remain unaddressed by mere passage of these forward-looking laws as well as some of the pressures that the laws, in fact, create. We see from the outset that complacency is not an option. With insurers inclined to keep their reimbursements low, patients, practitioners, and advocates must develop and follow strategies, including further legislation, to secure the gains promised by parity and health reform.

Patrick J. Kennedy, Author of Mental Health Parity and Addiction Equity Act of 2008; Co-Founder, One Mind; Founder, The Kennedy Forum; Member of Congress (D-RI) from 1995-2011.

In the face of constant skepticism, proponents of psychotherapy must redouble their efforts to produce a strong scientific argument for its effectiveness. Moreover, a research-based approach must be employed to demonstrate the cost-effectiveness of reimbursement for psychotherapy if patients are to have any choice in treatments or therapists are to be reimbursed adequately.

I have long maintained that our nation's concern for adequate treatment of the mental health needs of its military service members and returning warriors will ultimately pave the way for improved mental health care in the general population. Yet, a current survey shows how very far we have to go before we have a handle on the morbidity, mortality, and decreased productivity that today reflect the sorry state of the services and treatments we offer our military and veterans and their families.

Increasingly, we are seeing that not only "serious" mental illnesses have a significant impact on workplace productivity and workers' health. Employers are focusing in on the need to address anxiety, depression, and substance use disorders among their employees. Effective psychotherapeutic approaches can bring substantial improvements in this often overlooked area. Indeed, with improved training and ongoing preparation, psychotherapy and its associated disciplines can flourish in our rapidly changing environment.

This Special Issue elucidates the details of the law, both in how it is being applied and, in too many cases, also being circumvented. In addition, the articles here supply a vast body of research-based information on the epidemiology and actual needs of psychiatric patients and the financial and societal costs of neglecting them. They also provide abundant data on efficacious and cost-effective treatment to which these patients do not yet have full and appropriate access at parity, which is the ultimate goal of MHPAEA and the ACA.

While the articles in this Special Issue highlight serious problems and admonish readers to be focused and active if the improvements promised by MHPAEA and the ACA are to be realized, I believe the message here is ultimately positive. If we take responsibility for securing the gains we can now see are possible, the lives of patients, practitioners, employers, and others around us will be significantly improved. That's what parity and health reform should be all about!

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Biographical Sketch of Guest Editors Susan G. Lazar and Frank Elton Yeomans

Susan G. Lazar, M.D. has been systematically reviewing the medical literature, writing, and speaking on the topic of the cost-effectiveness of all kinds of psychotherapy since 1993 when she served as a consultant to Tipper Gore's Mental Health Work Group of the White House Task Force for National Health Care Reform. She edited and coauthored the 2010 volume *Psychotherapy Is Worth It: A Comprehensive Review of Its Cost-Effectiveness* with The Committee on Psychotherapy of the Group for the Advancement of Psychotherapy, which she served as Chair. Many other publications include coauthoring a 1997 cover article in *The American Journal of Psychiatry*, "The Economic Impact of Psychotherapy: A Review." She also edited and coauthored a special issue of the journal *Psychoanalytic Inquiry* in 1997, "Extended Dynamic Psychotherapy: Making the Case in an Era of Managed Care." Dr. Lazar is Clinical Professor of Psychiatry at Georgetown University School of Medicine, George Washington University School of Medicine, The Uniformed Services University of the Health Sciences, and Supervising and Training Analyst at the Washington Psychoanalytic Institute. She served as the American Psychoanalytic Association's Visiting Woman Scholar in 2010.

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and Psychotherapy for Borderline Personality, coauthored with John Clarkin and Otto Kernberg.

Dr. Yeomans's primary interests are the development, investigation, teaching, and practice of psychotherapy for personality disorders.

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Guest Editors' Introduction

Susan G. Lazar and Frank E. Yeomans

This Special Issue* of *Psychodynamic Psychiatry*, "Psychotherapy, the Affordable Care Act and Mental Health Parity: Obstacles to Implementation," is written to address a moment of both crisis and opportunity with respect to the health of the nation. The ongoing crisis lies in the psychiatric illness that affects one half of the population during some point in their lifetimes; illness which is stigmatized, undiagnosed, and more often than not, treated inadequately if treated at all. Untreated psychiatric patients fill our jails and the ranks of the homeless. Undertreated psychiatric illness leads to enormous losses in the form of increased healthcare costs, disability, morbidity, mortality, diminished productivity, and human suffering.

Opportunity lies in the 2008 Mental Health Parity and Addiction Equity Act (MHPAEA) mandating the provision of mental health care at parity with all other medical care and the fact that the 2010 Affordable Care Act (ACA) mandates mental health care including psychotherapy as one of the 10 Essential Health Benefits. But significant obstacles to this breakthrough legislation remain, particularly in protocols used by insurance companies to rationalize limitations on treatment consistent with immediate cost considerations but not with clinical needs.

In the May 3, 2014 Director's Blog: *The Paradox of Parity* from The National Institute of Mental Health, Director Thomas Insel raises the concern about coverage for efficacious psychosocial treatments and states that "we care deeply that those non-pharmacological treatments that have been shown to be helpful are disseminated and reimbursed broadly . . . It would be a sad irony if in the era of parity only those who could afford to pay out of pocket could get access to effective psychosocial treatments."

We would like to acknowledge our gratitude to Julianne Dorset, Research Assistant to William Sledge, M.D., Department of Psychiatry, Yale School of Medicine, for her meticulous care in editing the majority of the articles in this special issue.

*The articles in this Special Issue were written by The Committee on Psychotherapy of the Group for the Advancement of Psychiatry.

Perhaps the largest group of psychiatric patients at risk of under-treatment is those with chronic, severe, and complex illness, including personality disorders (up to 10% of the population), chronic anxiety and/or depression, and multiple diagnoses. Given proper treatment, often including a more extended and at times also intensive psychotherapy, many, and perhaps most of these patients can improve significantly. In fact, years after treatment ends with extended psychodynamic psychotherapy, these patients, in addition to other diagnostic groups of patients, continue to improve in mental health, productivity, and overall health status with lowered health care expenses. This long-term ongoing consolidation of health improvement, even years after extended psychodynamic psychotherapy, is sometimes referred to as "the sleeper effect" which is noted only with careful long-term follow-up. This effect compares favorably with the fading effects of briefer treatments, including cognitive-behavior treatment. Research suggests that the sleeper effect is correlated with the improvement in interpersonal relationships and self-image that can be traced to psychodynamic approaches. The takeaway is that chronically ill patients need more extensive psychotherapy which yields health gains and is often cost-saving over the long run. Unfortunately, in the current insurance and practice environment, these patients are all too frequently unable to access this care.

This Special Issue includes seven articles relevant to the provision of psychotherapy including the pertinent legal and regulatory issues and current insurance practices that too often severely limit reimbursement. Two articles address the research data on the efficacy and cost-effectiveness of psychotherapy for the major psychiatric diagnoses with particular emphasis on those who are most negatively affected by arbitrary limitations on its provision. Other articles address the enormous challenge of the mental health needs of military service members and veterans, the current practice environment which confronts providers of psychotherapy, the impact on workers' productivity of untreated psychiatric illness, and obstacles to the training of psychotherapy to residents in psychiatry.

"In Name Only? Mental Health Parity or Illusory Reform" by Meiram Bendat, J.D., M.F.T., healthcare attorney and psychotherapist, explains the historic need for mental health parity legislation and analyzes the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) in conjunction with the Affordable Care Act (ACA). Despite the mandates for parity, insurers continue to circumvent the law with intrusive "peer reviews" based on proprietary clinical protocols that are much more stringent than the nuanced and clinically sensitive guidelines adopted by mental health care providers and their professional organizations.

Other parity violations include the use of arbitrary algorithms to flag high-needs patients and ration their care with prospective, predetermined reviews, practices not used in reviewing other medical claims. The author recommends both provider alertness to often subtly rationalized parity violations and also outlines potential legal and legislative remedies.

"The Efficacy of Psychotherapy: Focus on Psychodynamic Psychotherapy as an Example" by Kenneth N. Levy, Ph.D., Johannes C. Ehrenthal, Ph.D., Frank E. Yeomans, M.D., Ph.D., and Eve Caligor, M.D., presents a review of empirical data that support the efficacy of psychotherapy in treating mental illness, with a focus on psychodynamic psychotherapy. This article challenges the common misconception that psychotherapy is an imprecise and ineffective treatment, a misconception that has been associated with the current relative decrease in reimbursement for effective psychotherapy. The increasing body of psychotherapy research supports maintaining psychotherapy as a cornerstone of psychiatric education and practice. The current trend to disregard this literature, which is often the position of insurance companies with regard to reimbursement, puts the public at risk of being deprived access to treatments that can provide long-term improvement of both symptoms and productive engagement in life. This research literature should also have a hand in guiding policy makers in the application of the mental health provisions of the ACA.

"The Cost-Effectiveness of Psychotherapy for the Major Psychiatric Diagnoses" by Susan G. Lazar, M.D., summarizes a nearly 40-year survey of the medical literature relevant to the cost-effectiveness of all kinds of psychotherapy for the major psychiatric illnesses. Most of the studies found in a systematic search reflect cost-effectiveness and at times cost savings ("cost-offset") in overall health care costs, increased productivity, and decreased morbidity and mortality. The group of patients focused on primarily are those most in need of a longer and more intensive psychotherapy, namely the more severe and chronically ill with personality disorders, chronic anxiety and/or depression, and comorbid, complex disorders. Such patients are currently at high risk of inadequate care due to inadequate insurance coverage. Undertreated, they remain vulnerable to residual and recurrent illness with all of its associated sequelae in lowered productivity, dysfunctional relationships, higher overall medical costs, and increased morbidity and mortality.

"The Mental Health Needs of Military Service Members and Veterans" by Susan G. Lazar, M.D., reviews the high prevalence of psychiatric illness in our active duty military and veterans and their urgent need for greater access to effective treatment. Only 23% to 40% of return-

ing military who met strict criteria for any mental health problem in 2004 received psychiatric care after coming home. One fourth of active duty service members have a psychiatric disorder with the prevalence of all disorders, particularly posttraumatic stress disorder, major depressive disorder, bipolar disorder, generalized anxiety, and intermittent explosive disorders increasing with each deployment, especially three or more. Their untreated psychiatric illnesses are associated with increased substance abuse, medical illnesses, decreased employment, family dysfunction, and suicide, currently occurring at a rate of 22 per day among veterans. In addition to the need for increased access to care, Veterans and Department of Defense treatment guidelines need to include recommendations for the research-documented, more extended psychotherapy needed for service members and veterans with chronic, severe, and complex psychiatric disorders to achieve full recovery. We remain far from the goal of providing full mental illness treatment for all military service members and veterans in need.

"Obstacles to Early Career Psychiatrists Practicing Psychotherapy" by Norman A. Clemens, M.D., Eric M. Plakun, M.D., Susan G. Lazar, M.D., and Lisa Mellman, M.D., outlines the difficulties encountered by early career psychiatrists who face a practice environment in which their use of psychotherapy, an essential psychiatric tool, is discouraged by insurance reimbursement practices. In fact, there is a steady decline in the practice of psychotherapy by psychiatrists. The psychiatrist, as a physician, is the only mental health professional capable of providing a differential diagnosis with other medical illness, making fully informed referrals to other physician specialists, prescribing medication, and functioning as a supervisor, consultant, and mental health team leader who can assume full medical responsibility for patient care. The obstacles to coverage of psychiatrist provided psychotherapy pose a serious risk to the opportunities for the physician mental health specialist to consolidate psychotherapeutic skills. Being an expert and experienced psychotherapist serves both as a crucial treatment tool for the psychiatrist physician and also provides vital skills in differential diagnosis and skillful team management, especially with complex treatment situations. This article calls for vigorous advocacy for the enforcement of mental health parity, appropriate payment levels for psychotherapy provided by psychiatrists, and freedom from insurance companies' parity violation of intrusive case management protocols not utilized in their management of other medical care.

"Workplace Effectiveness and Psychotherapy for Mental, Substance Abuse, and Subsyndromal Conditions" by William H. Sledge, M.D. and Susan G. Lazar, M.D., addresses the underappreciated disabling impact of psychiatric illness and subclinical psychiatric illness on workers'

productivity. This article discusses the complex variables from the perspectives of the different stakeholders involved in constructing a policy for the recognition and treatment of these disorders. Important variables include understanding the epidemiology and the negative impact of inadequate care for psychiatrically ill workers, identifying cost-effective treatments, and removing barriers to patients' access to them. While all psychiatric illnesses occur among workers, substance abuse, depression, and especially subsyndromal depression have a profound negative effect on workers' productivity and increased medical care visits and expenses. Studies on the cost-effectiveness of different psychotherapeutic treatments that improve health and productivity are reviewed. Research supports the value of employee assistance programs, specialized cognitive-behavioral treatments, and brief and longer term psychodynamic interventions for different populations of psychiatrically ill workers. Currently employers are insufficiently aware of which evidence-based treatments can mitigate the negative impact on these workers' health and productivity and are most appropriate for which diagnoses. Given the relevant data, employers are in a more informed position to negotiate proper worker benefits with insurance companies which have at times been reluctant to approve them.

"Current State of Psychotherapy Training: Preparing for the Future" by Jerald Kay, M.D. and Michael F. Myers, M.D., provides an overview of what is currently being taught in psychiatry residency programs about psychotherapy in general and discusses the evolution of changes in the field related to mental health parity and the Affordable Care Act (ACA) in particular. These two latter mandates provide the opportunity to redress a relative degree of neglect that has occurred in many training programs with regard to psychotherapy training. While accrediting bodies support the central role of psychotherapy in psychiatric training and practice, there is talk of a "lost generation" of psychotherapy faculty. Timely attention to this vital issue and vigorous advocacy for implementation of true parity are required to remedy the problem. Future psychiatrists must have a firm grasp of not only the principles of psychotherapy but also the development of increasingly effective and evidence-based psychotherapies if they are to be effective health care leaders. The authors conclude with recommendations to residency training programs and to residents themselves regarding what is considered essential in both the curricular and clinical exposure to psychotherapy training. Tomorrow's psychiatrists have a fiduciary responsibility of advocating for their complex and chronically ill patients, including their psychotherapy needs.

This Special Issue surveys current issues impacting the availability of many kinds of psychotherapy for the diverse populations in need. The

legal and regulatory landscape has changed in a promising way that opens the possibility for more access to evidence-based appropriate psychotherapeutic treatments. Obstacles in the practice environment and challenges in training psychiatrists to deliver psychotherapy are outlined. Among the impediments to provision of appropriate psychotherapeutic treatments is a widespread lack of appreciation for the robust research base documenting its efficacy and cost-effectiveness for particular psychiatric diagnoses. Perhaps the most daunting obstacle lies in the opposition of insurance entities which are similarly unaware of the research and driven more by concerns regarding their business models and short-term costs. An important goal lies in expanding the dialogue so that these stakeholders also can become more focused on the health, long-term costs, productivity, morbidity, and mortality experienced by patients, their families, their employers, and their communities when proper care is not supported.

IN NAME ONLY? MENTAL HEALTH PARITY OR ILLUSORY REFORM

Meiram Bendat

Abstract: The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 and the Affordable Care Act mandate significant insurance and patient protection reforms. Despite these safeguards, lax regulatory enforcement and lack of consumer and provider sophistication have failed to remedy ongoing insurer abuses resulting in deprivation of crucial mental health and substance abuse treatment. Even with persistent and informed advocacy, including strategies outlined herein, any potential parity gains are negated by unreasonably low reimbursement benchmarks already used by insurers in many ACA*-exchange plans. The need for legislative remediation is therefore urgent.

Inadequate access to mental health¹ care has been an enduring blight lurking in the shadows of public awareness. “This situation has been tolerated far too long,” said President John F. Kennedy in 1963. “It has troubled our national conscience—but only as a problem unpleasant to mention, easy to postpone, and despairing of solution.” Since passage of the Community Mental Health Act during President Kennedy’s administration, advances in psychopharmacology have made deinstitutionalization a reality for many. Yet in the absence of robust psychosocial supports to replace locked facilities, the care of many chronically and severely ill patients has been improperly relegated to prisons, charities, and emergency rooms ill equipped to handle their needs.

Compounding inadequate access to community mental health resources has been historic discrimination against mental health coverage by private insurers, managed behavioral healthcare organizations, and employers,² based largely on irrational and disproven fears of rapa-

Dedicated to my dear friend and mentor, Elyn Saks.

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*See Appendix for a list of acronyms used throughout the article.

cious benefits consumption by a patient population culpable of psychic infirmity and pathological dysregulation preyed on, at best, by misguided practitioners with dubious clinical methods. Consequently, in the United States, where an estimated quarter of the population suffers from mental health conditions in any given year (Kessler, Chiu, Demler, & Walters, 2005) and where the lifetime incidence of mental illness is estimated at 50% (Kessler, Berglund, Demler, Jin, Merikangas, & Walters, 2005), insurers have balked at covering mental health conditions by either altogether excluding or greatly limiting treatment.³ Ironically, despite tremendous need for treatment, mental healthcare spending accounted for only 7.3% of total health costs in 2009, dropping from 8.7% in 1990.⁴ Yet the mental health administrative share (including the costs and profits of private insurers) of all healthcare administrative expenditures ballooned from 10% in 1990 to 17.2% in 2009.⁵

Not until passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("Federal Parity Act")⁶ were large group health plans that offered benefits for mental health and/or substance use disorders required, with limited exceptions,⁷ to administer them on par with medical/surgical benefits. In 2011, the General Accounting Office reported on findings "that the implementation of [mental health] parity requirements led to reduced enrollee expenditure" (GAO-12-63, 2011, p. 20). A 2013 report commissioned by the United States Department of Health and Human Services reinforced that "[e]valuations of [Federal Employees Health Benefits Program] parity found no significant increase in total behavioral health spending. Nor did evaluations find an increased probability of any [mental health/substance use disorder] service utilization resulting from parity. In fact, the quantity of [mental health/substance use disorder] services patients received may have decreased slightly after parity was introduced" (Goplerud, 2013, p. 6).

It took full implementation of the Affordable Care Act ("ACA")⁸ in 2014, however, to require insurers to include "essential health benefits," encompassing treatment for mental health, substance abuse, and behavioral disorders, in plans sold on the individual and small group markets.⁹ Notably, while large group plans choosing to offer mental health benefits and individual/small-group plans required to include essential mental health benefits must be parity-compliant, by no means has parity been achieved. Due to the public's unfamiliarity with these intricate laws, stigma and fatigue inhibiting patients, and lax surveillance, it is unsurprising that meaningful mental health treatment remains out of reach for so many insureds.

While one need not scratch hard beneath the surface to find rampant mental health parity violations, reliance on governmental intervention

appears misplaced. Regulatory oversight and public enforcement campaigns have been sporadic and anemic at best. Given the profound, current need for treatment and continued insurer impediments to meaningful care, this article will expound on the ACA and parity laws with an eye toward patient advocacy and empowerment of mental health professionals. Recommendations for reform will follow.

MANDATES FOR REFORM: THE ACA AND FEDERAL PARITY ACT

According to the U.S. Census Bureau's 2011 American Communities Survey, 47.5 million Americans were found to lack health insurance coverage altogether, and 25% of uninsured adults suffer from a mental health condition, substance use disorder, or both (Garfield, Lave, & Donahue, 2010). Responding to these chilling statistics, President Obama's signature piece of legislation, the ACA, forever altered the American health insurance landscape. Among other things, the ACA eliminated insurability barriers like pre-existing conditions and provided for ten categories of "essential health benefits" that insurers must cover in all non-grandfathered individual and small group plans:¹⁰

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

While the ACA requires that "health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life,"¹¹ states regulating insurance marketplaces are nonetheless permitted to establish the scope of essential health benefits based on

Table 1. Variability of “Essential” Mental Health Benefits Across ACA-Exchange Plans

States are free to establish their own scope of:

Inpatient and outpatient services, defining covered conditions

Habilitative and rehabilitative services

benchmark plans¹² from which “substantially equal” and “actuarially equivalent” deviations are permitted (see Table 1).¹³

Though all such plans include in- and outpatient care for mental health, substance abuse, and behavioral disorders, exactly which conditions are covered are inherently subject to deviation. Furthermore, in the absence of state-specific definitions of “habilitative services,” insurers may define such coverage on their own and may substitute greater “rehabilitative” services with lesser “habilitative” services.¹⁴ Thus, even with the ACA’s mandate for inclusion of essential health benefits, plans may not necessarily be required to cover the same mental health conditions or offer a uniform continuum of services across all states.

In 2008, the Federal Parity Act amended the Employee Retirement Income Security Act of 1974 (“ERISA”), regulating private employer-sponsored welfare benefit plans, and the Public Health Service Act, which applies to individual and non-federal governmental health plans regulated by the states. While the Federal Parity Act initially applied only to large group health plans that chose to offer mental health benefits, the ACA further wrapped the Federal Parity Act into all non-grandfathered individual and small group insurance plans required to include essential mental health benefits. Moreover, the Federal Parity Act is intended to work in tandem with state laws applicable to individual and group insurance that may mandate coverage for certain mental health conditions and confer greater protections than provided by the Federal Parity Act.¹⁵ Thus, stakeholders must be attuned to the possibility of concurrent and separate application of the Federal Parity Act and state mental health parity laws (see Table 2).¹⁶ While the Federal Parity Act contains numerous provisions, the most relevant for purposes of this discussion is its unequivocal prohibition of separate treatment limitations applicable only to benefits for mental health or substance use disorders.¹⁷ The Federal Parity Act’s implementing regulations define “treatment limitations” as either “quantitative,” expressed numerically, or “non-quantitative,” expressed as protocols limiting the scope or duration of benefits for treatment. Because non-quantitative treatment limitations (“NQL”) can theoretically take many forms, the implementing regulations identify an “illustrative list”:¹⁸

Table 2. Applicability of Parity Laws to Health Plans

Plan Type	Federal Parity Act	State Parity Laws
<i>Private Employer-Sponsored</i>		
Large group (both grandfathered and non-grandfathered under ACA)		
Self-funded	Generally yes, if MH/SA benefits are offered	No
Fully-insured	Generally yes, if MH/SA benefits are offered	Possibly
Small group (generally < 50 employees but will increase in 2016 to <100)		
Non-grandfathered under ACA		
Self-funded	Yes, with respect to essential mental health benefits	No
Fully-insured	Yes, with respect to essential mental health benefits	Possibly
Grandfathered under ACA		
Fully-insured	No	Possibly
<i>Privately Obtained Individual Coverage</i>		
Non-grandfathered under ACA	Yes, with respect to essential mental health benefits	Possibly
Grandfathered under ACA	No	Possibly

- Medical management standards
- Formulary design for prescription drugs
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design
- Standards for provider admission to participate in a network, including reimbursement rates
- Methods for determining usual, customary, and reasonable charges
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols)
- Exclusions based on failure to complete a course of treatment
- Restrictions based on geographic location, facility type, provider specialty and other criteria that limit the scope or duration of benefits

Additionally, while not enumerated in the “illustrative list,” the regulations cite the following as non-quantitative treatment limitations:¹⁹

- Limitations on inpatient services for situations where the participant is a threat to self or others
- Exclusions for court-ordered and involuntary holds
- Experimental treatment limitations
- Service coding limitations
- Exclusions for services provided by non-psychiatrists
- Network limitations

When applied exclusively to mental health benefits, the above non-quantitative treatment limitations are, without exception, proscribed. Recognizing that non-quantitative treatment limitations may also be employed in the medical/surgical context, however, the regulations further expound that, as written and in operation, non-quantitative treatment limitations may not be imposed on mental health or substance use disorder benefits unless any *processes, strategies, evidentiary standards, or other factors* used in applying them are *comparable* to and *no more stringent than* the processes, strategies, evidentiary standards, or other factors applied to medical/surgical benefits. The regulations operationalize the parity analysis within each of six classifications:²⁰

- In-network, outpatient
- In-network, inpatient
- Out-of-network, outpatient
- Out-of-network, inpatient
- Emergency care
- Prescription drugs

The regulations further emphasize:

The classifications are intended to be comprehensive and cover the complete range of medical/surgical benefits and mental health or substance use disorder benefits offered by health plans and issuers. Medical/surgical benefits and mental health or substance use disorder benefits cannot be categorized as being offered outside of these classifications and therefore not subject to the parity analysis.

Cross-walking or pairing specific mental health or substance use disorder benefits with specific medical/surgical benefits is a static approach that the Departments do not believe is feasible, given the difficulty in determining “equivalency” between specific medical/surgical benefits and specific

mental health and substance use disorder benefits and because of the differences in the types of benefits that may be offered by any particular plan.²¹

In rejecting “that specific mental health or substance use disorder benefits be crosswalked or paired with specific medical/ surgical benefits (e.g., physical rehabilitation with substance use disorder rehabilitation) for purposes of parity analyses,”²² the regulations leave little doubt that the processes, strategies, evidentiary standards, or other factors used in applying non-quantitative treatment limitations for mental health benefits must be the same for *all* medical/surgical benefits within each of the six benefits classifications. For example, concurrent medical necessity reviews applied to outpatient (in- or out-of-network) psychotherapy and only to select outpatient (in- or out-of-network) services (like physical rehabilitation) are impermissible if such concurrent medical necessity reviews are not otherwise applied to *all* outpatient (in- or out-of-network) medical/surgical benefits.

It should come as no surprise that when the Federal Parity Act’s nearly identical interim final regulations were unearthed in 2010, the managed care industry waged war.²³

Cloaking the identities of managed behavioral healthcare organizations opposed to the rules, the “Coalition for Parity, Inc.” sued the secretaries of Health and Human Services, Labor, and Treasury, along with their respective departments. The plaintiffs unsuccessfully challenged the duration of the public comment period, which they had been amply accorded, in an effort to nullify the most substantial provision in the interim final regulations, namely the prohibition against disparate non-quantitative treatment limitations and their implementing processes, strategies, evidentiary standards, or other factors (see Table 3). Without legal sanction to circumvent parity, liability for discriminating against mental health treatment became much more tangible. Or so it appeared.

ENFORCEMENT CHALLENGES

Despite official confirmation that “plans frequently employ NQTLs for behavioral health conditions that are more restrictive than those used for other medical/surgical conditions,”²⁴ to date, not a single parity enforcement action against a health plan, insurer, or managed behavioral healthcare organization has been publicly announced by either the Department of Health and Human Services (“HHS”) or the Department of Labor (“DOL”).²⁵ Moreover, few states with mental health parity laws of their own, including those which have incorporated the Federal Parity Act into state law, have taken robust, public measures

Table 3. Prohibitions on Treatment Limitations Imposed by Federal Parity Act

Treatment Limitation	Rule
Quantitative or Non-Quantitative	
Applied Only to MH/SA benefits within each of six classifications	Strictly prohibited
Non-Quantitative	
Applied to MH/SA and medical benefits within each of six classifications	Prohibited if processes, strategies, evidentiary standards, or other factors are not comparable or more stringent than those applied to medical benefits within each classification

to enforce them (and particularly, their prohibition of disparate non-quantitative treatment limitations).²⁶ In the absence of regulatory scrutiny, one might imagine that private individuals adversely impacted by insurer discrimination would at least have the opportunity to bring their claims to light through the courts. While individuals with employer-sponsored mental health benefits can assert a private right to enforce parity and due process remedies conferred by the Federal Parity Act and ACA under ERISA, beneficiaries of ERISA-exempt plans such as non-federal governmental employees (i.e., first responders, legislators, judges) and privately insured individuals (now including members of Congress) cannot. This is because the Federal Parity Act and ACA apply to their health plans through the Public Health Service Act (“PHSA”), which does not explicitly confer a private right of enforcement.²⁷ Thus, an estimated 30 million Americans covered by non-federal governmental plans currently subject to the Federal Parity Act cannot directly invoke its protections and must assert alternative, indirect, and potentially less effective legal theories to try to enforce their rights.²⁸ As previously uninsured individuals gain coverage through the ACA-exchanges, the number of ERISA-exempt beneficiaries lacking an explicit private right to enforce the Federal Parity Act and ACA will substantially increase.

While insurers obviously take solace from ERISA-exempt beneficiaries lacking an explicit private right of action to enforce their rights (see Table 4), they are also emboldened by ERISA beneficiaries not being able to sue for anything more than owed benefits, injunctive relief, and at best, attorney fees—assuming that individual litigants can even find counsel to represent them in individual benefit cases since, under ERISA, damages for denial of benefits are nonexistent. Thus, even if mental health patients can overcome the stigma and psychic toils of initiating litigation, insurers need not worry much about the potential impact of unlawful claims practices resulting in non-jury damage awards.

Table 4. Explicit Private Rights of Action to Enforce the Federal Parity Act

Plan Type	Private Right of Action	Available Remedy
Private Employer Sponsored (ERISA)	Yes	Award of benefit, Injunction
Non-Federal Governmental (PHSA)	No	Unclear
Individual Coverage (PHSA)	No	Unclear

With little to fear, insurers have brazenly continued to apply proscribed, discriminatory policies toward mental health benefits. These discriminatory practices include adhering to substandard, unjustifiably restrictive (proprietary) medical necessity guidelines that are not recognized by practitioners and medical specialty groups while otherwise adhering to generally recognized medical guidelines for non-mental health conditions. They also include fail-first protocols that require patients to attempt and fail at lower (or no) levels of care before more robust treatments are considered. Rather than approve treatments consistent with assessed needs, insurers demand proof of treatment failures, imminent regression, or risk of requiring even higher levels of care. Perversely, under this schema, failed suicide attempts become the *sine qua non* for intensive or continued care at any level. It is hard to imagine how such inhumane protocol could square with the ACA’s “essential” re/habilitation benefit mandate or be comparably applied and tolerated in the medical context. Equally problematic is the application of involuntary commitment standards (danger to self/others, grave disability) to voluntary levels of care, and the corresponding, self-serving exclusion of involuntary (legally mandated or court-ordered) treatment from coverage.

Capping these abuses is the application of concealed algorithms to restrict higher needs patients from receiving ongoing care. These undisclosed algorithms flag patients whose service needs deviate from industry-determined “norms,”²⁹ often set by “in-house” utilization frequency trends from the pre-parity era when routine access to mental health care was excluded, quantitatively capped, or otherwise financially disincentivized by unequal copays or rates of reimbursement. Circumventing (for now) the Federal Parity Act’s unequivocal prohibition on disparate quantitative treatment limits (such as predetermined visit maximums), undisclosed algorithms do not purport to be an absolute treatment cap. Rather, a wolf in sheep’s clothing, they ostensibly safeguard “quality control” and deter “fraud and abuse” by triggering insurer reviews intended to prospectively ration care under the guise of “medical necessity.”

While these discriminatory protocols apply throughout the continuum of mental health services, they most consistently target psychotherapy and residential treatment, two modalities that are often long-term and intensive in the care of complex or chronic psychopathology.

PRIVATE ENFORCEMENT: “INDEPENDENT” REVIEW ORGANIZATIONS

Theoretically, the ACA has sought to bypass the need for litigation by providing claimants of all non-grandfathered health plans subject to ERISA or PHSA the right to expeditiously challenge insurer denials of mental health claims through independent external reviews. Moreover, regulations implementing the ACA have vested independent review organizations (“IROs”) with the responsibility of verifying plan compliance with the Federal Parity Act’s prohibitions against disparate application of non-quantitative treatment limitations.³⁰ Thus, independent review organizations have been charged with overturning adverse insurer determinations based on unlawful non-quantitative treatment limitations.

Regrettably, the Department of Labor has simultaneously unrolled a federal external review process for self-funded health plans,³¹ providing nearly half of all health benefits in this country, which is laden with conflicts of interest undermining the independence and efficacy of external reviews. Under current Department of Labor rules implementing external reviews, self-funded health plans (primarily through their managed behavioral healthcare organizations) privately contract with “independent” review organizations to adjudicate external appeals. Whereas, in theory, fully insured health plans are subject to oversight by state insurance departments that facilitate external reviews of denied claims through contracts with independent review organizations, independent review organizations contracted with self-funded health plans are self-policing and accountable to no one but their large volume clients, the managed behavioral healthcare organizations. Therefore, not only are independent review organizations implicitly incentivized to not reverse medical necessity denials by the hiring managed behavioral healthcare organizations, they also routinely fail to discharge their fiduciary duties to insureds by overlooking parity and due process violations, even when explicitly alerted to such. The inference is clear—findings of non-compliance with parity laws and procedural safeguards would likely doom any contractual relationships between

managed behavioral healthcare organizations and their cherry-picked external review agents.

All this is not to suggest that state-run external review programs are free of taint. Because many of the independent review organizations contracted with managed behavioral healthcare organizations are also contracted with state insurance departments, their incentive to reverse insurer denials is equally diminished in the fully insured context. Independent review organizations are keenly aware that their decisions in fully insured cases result in direct liability to insurers (rather than employers) and that expensive or frequent reversals will almost certainly be met with retaliation in the form of contractual terminations by insurers (acting as managed behavioral healthcare organizations) in the self-funded context.

Furthermore, while state insurance departments have primary authority to enforce parity compliance in fully insured cases, no state, as a matter of course, routinely scrutinizes mental health claims denials based on parity considerations before assigning external appeals to many of the very same independent review organizations contracted with the managed behavioral healthcare organizations. Some states even immunize independent review organizations from liability except in cases of gross negligence, resulting in complete lack of accountability. And most states as well as all insurers contracted with independent review organizations rely on managed behavioral healthcare organizations to transmit internal case files to external reviewers—often without any advance opportunity for claimants to ensure that all relevant plan, clinical, and insurer files have been forwarded for review. Regrettably, independent review organizations rarely provide claimants with copies of documents received from managed behavioral healthcare organizations prior to adjudication of external appeals, if at all.

Additionally, the external review process for both fully insured and self-funded plans does not require transparency with regard to medical necessity criteria and guidelines used by independent review organizations *before* external appeals are submitted. Thus, it is not infrequent for mental health claimants to challenge adverse medical necessity determinations (based on proprietary managed behavioral healthcare organization guidelines) only to be sandbagged by final rulings from independent review organizations using the same or other proprietary guidelines (i.e., Milliman or InterQual) or unexpected rationales, potentially also in violation of mental health parity laws and the terms of claimants' health plans.

Because self-funded health plan sponsors with the ultimate responsibility to ensure independent review organizations' compliance with the Federal Parity Act and ACA defer to their conflict-riddled managed

behavioral healthcare organizations to safeguard the external appeals process, and because most state-administered external review programs neither adequately insulate patients from insurer–external review agent conflicts of interest nor routinely tackle parity violations, the external appeals process as currently constituted is an inadequate enforcement remedy for mental health claimants.

ENFORCEMENT STRATEGIES: LITIGATION

One strategy, however, carries substantial promise for deterrence of abuse and implementation of reform: impact litigation. In opposing uniform, discriminatory policies through associational challenges and class action suits, providers and beneficiaries can wield substantial leverage. To date, several associational and class action suits invoking mental health parity protections have been filed against insurers and managed behavioral healthcare organizations. These include cases challenging: preauthorization requirements for outpatient psychotherapy; disparate evidentiary burdens imposed by insurer-developed mental health guidelines; fail first protocol applied to all levels of mental health care; and coverage exclusions.³² These cases highlight the fact that while insurers routinely balk at authorizing higher levels of care such as psychiatric hospitalization and residential treatment, they simultaneously try to limit access to the least restrictive levels of care, including outpatient psychotherapy. Furthermore, these cases also unearth procedural abuses such as the failure to respond to appeals, the use of subordinates to review claims denied by their superiors, and the termination of benefits pending adjudication of final appeals.

PROPOSED SOLUTIONS

It is axiomatic that systemic insurer abuses flourish in the absence of enforcement of antidiscrimination and patient protection laws. To make parity a reality, a multi-pronged response is required. First, Congress should extend an explicit private right of action to ERISA-exempt beneficiaries ostensibly protected by the Federal Parity Act and ACA through the Public Health Service Act. Now that members of Congress must purchase insurance through ACA exchanges, their own self-interest may actually prompt such relief. If Congress cannot be convinced to add an explicit private right of action to the Public Health Service Act applicable to these policies, individual states can certainly do so since

the Public Health Service Act sections incorporating the Federal Parity Act and ACA also apply to them. Thus, states can simply pass statutes incorporating the Public Health Service Act provisions related to the Federal Parity Act and ACA while adding explicit private rights of action to enforce these statutes as well as any applicable state parity laws.

Second, the Department of Labor should amend the federal external review process for self-funded plans. By prohibiting self-funded plans and managed behavioral healthcare organizations from directly contracting with independent review organizations, external review agents will have far less to fear in holding insurers and managed behavioral healthcare organizations accountable. In fact, the United States Department of Health and Human Services has adopted such a strategy by specifically designating an independent review organization for appeals of Medicare and federal ACA exchange plans which is not available for hire by self-funded plans or managed behavioral healthcare organizations. Furthermore, by requiring all independent review organizations to publicly post their medical necessity guidelines, redacted rulings, and relevant determination statistics, independent review organizations can be made much more accountable for the fairness of their decisions.

Meanwhile, the Department of Labor, Department of Health and Human Services, and employers sponsoring self-funded plans can be further sensitized to non-quantitative treatment limitations and their implementing processes, strategies, evidentiary standards, or factors improperly impacting mental health and substance abuse benefits. Currently, it appears that the Department of Labor routinely rejects complaints of adverse benefit determinations based on medical necessity without comprehensively analyzing underlying non-quantitative treatment limitations and implementing protocols. To facilitate transparency and the parity analysis, then, the following information should also be required with all adverse benefit determinations as a matter of course:

- A description of any non-quantitative treatment limitations that a health *plan* (or insurance policy) has authorized for MH/SA services within the relevant classification (in- or out-of-network, in- or outpatient) to the claim. This should also include the exact written reference to such within the plan (or insurance policy) documents (as distinguished from a managed behavioral healthcare organization's clinical guidelines implementing the NQTLs);
- A description of any non-quantitative treatment limitations that the *insurer* or *managed behavioral healthcare organization* believes have

been used in any given MH/SA service adverse benefit determination within the relevant classification based on the plan (or insurance policy);

- A description of any non-quantitative treatment limitations implementing processes, strategies, evidentiary standards, or factors that a *plan* (or insurance policy) has authorized for MH/SA services within the relevant classification to the claim. This should also include the exact written reference to such within the plan documents (as distinguished from a managed behavioral healthcare organization's clinical guidelines);
- A description of any non-quantitative treatment implementing processes, strategies, evidentiary standards, or factors that the *insurer* or *managed behavioral healthcare organization* believes have been used in any given MH/SA service adverse benefit determination within the relevant classification;
- A description of the non-quantitative treatment limitations and their implementing processes, strategies, evidentiary standards, or factors that a health *plan* (or insurance policy) has authorized for use with respect to *each and every* medical/surgical service within the same classification as the MH/SA claim. This should also include the exact written reference to such within the plan documents (as distinguished from a managed behavioral healthcare organization's clinical guidelines);
- A description of the non-quantitative treatment limitations and their implementing processes, strategies, evidentiary standards, or factors that the *insurer* or *managed behavioral healthcare organization* believes are used with respect to *each and every* medical/surgical service within the same classification as the MH/SA claim. Because insurers and claims administrators are required to provide all clinical guidelines and rationales in adverse benefit determinations, there is little reason why they cannot be required to post all medical necessity guidelines for medical/surgical procedures broken down by in- and outpatient bases on their websites.
- The frequencies with which the itemized non-quantitative treatment limitations and their implementing processes, strategies, evidentiary standards, or factors are used in both the MH/SA and medical/surgical contexts, by classification.

Effectively, by requiring that adverse benefit determinations explicitly reference the non-quantitative treatment limitations/protocols *authorized* by insurance policies and the non-quantitative treatment limitations/protocols *actually operationalized* by insurers, insurers would be

far more likely to scrutinize their own conduct while policy holders could at least attempt to evaluate the consistency and comprehensiveness of insurer disclosures.

Another important remedy would be for legislators and regulators to prohibit discretionary clauses in health plans. Such clauses effectively require courts to defer to adverse determinations in the absence of insurers' "abuse of discretion," a highly deferential legal standard extremely difficult for patients to surmount. Rather than accord insurers any deference, courts should be required to review health claims denials afresh and in a truly even-handed manner—as they would scrutinize most legal claims. Moreover, rather than claimants being required to justify the medical necessity of healthcare prescribed in good faith, insurers should uniformly bear the burden of disproving medical necessity. Only then will insurers be systematically disincentivized from disregarding potential liability due to deliberate or negligent claims mishandling.

While the above proposals will certainly be met with stiff insurer resistance, there are numerous strategies for clinicians and their patients to employ to facilitate such change. First, establishing and maintaining contacts with federal and state officials is paramount. Important issues too often fail to gain traction due to collective fatigue or worse yet, passivity and submission. If members of Congress and state legislatures are not inundated with concerns that now equally affect them, then they cannot be held as readily accountable for inertia. Since many, if not most clinicians belong to professional associations with potentially far greater resources, leveraging the power of associational standing is an underutilized and highly effective reform tool. While numerous professional associations have actively lobbied for mental health parity, to date only the New York State Psychiatric Association and the American Psychiatric Association have sued to enforce the Federal Parity Act. With more insistent calls for action from impacted members and their patients, however, professional mental health associations can and will do more.

Of course, lobbying for systemic reform is an aspirational (albeit critical) task. Insisting on immediate recourse for patients is an entirely different matter.

A WORD OF CAUTION

Ethical, contractual, and legal principles compel advocacy of patient access to mental health treatment. Clearly, the greater custody and control clinicians and facilities exercise over patients, the greater the

imperative to avoid abandonment through effective advocacy.³³ This imperative increases commensurate with the degree of patients' mental impairments. Moreover, network contracts, often ignored by clinicians and facilities upon being signed, may also require providers to submit clinical appeals on behalf of patients. While clinicians are not expected to employ attorney skills in contesting denials, they should be readily familiar with the following due process rights, which are now standard across ERISA and non-grandfathered health plans and which must generally be "exhausted" (a term of art for "fully undertaken and completed") as a prerequisite to filing external appeals with independent review organizations or to commencing legal actions.

When possible, appeals should be written to preserve the integrity of the clinical record, to articulate the precise issues being challenged, and to invite a meaningful exchange with insurers. With limited exceptions, the time frame for internally appealing denied claims is no less than 180 days from the date of a benefits denial, though some plans provide for subsequent levels of internal appeals that must be pursued within even shorter timeframes, typically 60 days after an initial appeal denial. In urgent cases, insurers must respond to any claims and appeals within 72 hours and must treat any claims or appeals as "urgent" if designated as such by treating clinicians—at least in theory.

Since insurers, managed behavioral healthcare organizations, independent review organizations, and regulators are not usually available to process urgent mental health appeals on evenings, weekends, and holidays, and while their unavailability obviously obstructs access to urgent care and defeats the purpose of expedited reviews, clinicians and patients must hold these entities accountable to their legal obligations. Thus, clinicians and patients should not delay submitting (urgent) appeals through tracked means, placing the onus on regulators and insurers to justify non-compliance with mandated processing timeframes.

Moreover, while patients and their designated representatives are entitled to obtain copies of their claims files from insurers and managed behavioral health organizations prior to submitting their appeals, it is rarely the case that these records are made available, let alone on expedited bases. Because such records can be extremely helpful in proving parity violations and demonstrating procedural irregularities, insurers and managed behavioral healthcare organizations make it difficult to obtain this information by, at best, providing fax numbers for requests that are routinely ignored or delayed. Nonetheless, in non-urgent cases, patients or their authorized representatives (i.e., parents of minors, guardians, conservators) should directly request their case files from insurers while, in urgent cases, providers are legally deemed "autho-

rized representatives" and should likewise attempt to review insurer case management records prior to appealing.

APPEALING

While no particular format is prescribed for appealing denied claims, appeals of mental health claims should ideally strike an appropriate balance between maintaining patient privacy and facilitating necessary disclosure. Because the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") grants providers (and not insurers) the discretion to decide what constitutes a "minimally necessary disclosure," patients and providers submitting claims and appealing denials should not succumb to insurer coercion for gratuitous detail. By identifying the bases for a claim or appeal in advance, providers and patients can set limits on what will be revealed. For example, while insurers may deny care as "not medically necessary," all too frequently such denials occur in the context of prospective reviews that violate parity laws. Thus, while medical necessity may be relevant to an appeal, challenging adverse determinations may more suitably center on the disparate application of medical management techniques. In other words, challenging insurers' oracular forecasts of long-term needs in the outpatient mental health context (when such is not the case in the outpatient medical/surgical context) may suffice without further clinical disclosures.

That said, standards do matter and comprehensive appeals should often (though not always) refute adverse determinations of medical necessity based on clinical rationales that do not comport with case facts or prevailing national standards (i.e., published guidelines or research). Thus, it matters little which clinical rationales insurers offer if they are selectively tailored or not congruent with prevailing clinical standards. Moreover, insurers cannot rely on clinical definitions of "medical necessity" that conflict with contractual language in health plans. Therefore, in addition to procuring insurer case files for purposes of identifying proscribed denial rationales, procedural irregularities (i.e., appeals decisions made by subordinates of initial claims reviewers), or more thoroughly dissecting flawed conclusions, the most vigilant appellants should compare definitions of medical necessity in policy documents with clinical protocols employed by insurers. Hypothetically, then, insurer denials predicated exclusively on internally developed clinical guidelines that ignore health plan definitions of "medically necessary" as "services recognized by peer-reviewed literature" might be particularly susceptible to legal challenge. It is hoped that the succeeding articles in this installment will lay out a comprehensive base of research

from which support for psychotherapy can be reliably cited in "medical necessity" appeals.

Apart from providing a brief clinical history, the reasons for current treatment, and diagnostic information, appeals should carefully weigh how to respond to insurers' insistence on "progress." While inefficacious mental health treatment, including psychotherapy, should not be offered (let alone reimbursed), the idea that "progress" rather than "prevention" should serve as the benchmark for treatment is a red herring. Obviously, in the case of severe mental illness, psychotherapy is frequently necessary to prevent further deterioration or to sustain any gains. Given that many chronic medical disorders only result in death and that insurers would be hard-pressed to ration their outpatient care in the interim, parity would mandate similar treatment. Thus, while expounding on progress may be warranted in some circumstances, appeals should at least emphasize the role of treatment in maintaining patient functioning that would erode in its reduction.

Of course, no appeal is complete without adequate confirmation of its receipt. Since insurers often fail to dispose of appeals within proper timeframes, if at all, verification of their receipt is critical when other remedies must be sought (i.e., external appeals or lawsuits). Some courts punish belated, incomplete, or non-responses by insurers by not according any deference to their prior determinations, thereby increasing the likelihood of successful legal challenges.

CLINICAL CONSIDERATIONS

While most outpatient medical claims are never reviewed beyond coding, it has become all too common a practice for insurers to demand ongoing reviews of even the most basic level of mental healthcare, outpatient psychotherapy. Often, these reviews are prospective (rather than retrospective) such that their very use offends the parity laws. They also consume enormous clinical resources on the part of providers and dramatically unsettle patients.

Thus, it is unsurprising that attending providers would reflexively balk at being critiqued by "peer reviewers" of materially different professional backgrounds (and often of far less experience or stature) who have never even encountered the same clinical situations or diagnostic groups of patients. Since most, if not all providers are loathe to pleading their patients' cases to outside parties intent on rationing care and lecturing them on appropriate treatment standards, providers must be mindful of their understandable hostility before engaging in clinical reviews affecting their patients. Likewise, providers must be careful to

resist defending against their hostility by allowing peer reviewers to use a "collegial" approach masquerading as a false alliance by means of which more than "minimally necessary" disclosures are elicited and then used to substantiate the denial of care.

To further contain their indignation and manage incursions into the therapeutic milieu, providers should plan a strategy for managing insurer reviews before they occur. By addressing the implications for privacy and the burden of insurance reviews with patients at the onset of treatment, providers can attempt to establish protective parameters in advance. Thus, how much time providers can be reasonably expected to devote to claims without charging their patients and what to charge for administrative work can be negotiated in advance. In the out-of-network context, where no contractual relationship exists between providers and insurers, it may also be reasonable for providers to bill insurers for their professional time allotted to "peer reviews." While insurers may refuse to reimburse these charges, their accounting certainly may prove valuable in litigation, when insurers might be ordered to compensate providers for their trouble, especially if brought on by unlawful claims review procedures.

Last, it is worth mentioning that providers must remain attuned to the particular patient fantasy of providers as "hero-rescuers" when insurance is at stake. While reasonable expectations must be set for clinical roles, expectations of omnipotence, benevolence, or futility of insurance negotiations are worthy of clinical exploration as they may all color patient dynamics and contribute to the psychotherapeutic task at hand.

CONCLUSION

Even with the promise of mental health parity and "essential health benefits," access to care is meaningless in the absence of reasonable reimbursement benchmarks. While the ACA has mandated a reduction in healthcare costs, including administrative fees, the ACA does not set uniform reimbursement benchmarks for any size plan, whether fully insured or self-funded. Instead, insurers are required to simply establish actuarial values based on total premium amounts that must be used to reimburse clinical services. With little more than self-interest in mind, many insurers have set the reimbursement bar so low that some leading facilities and providers have refused their compensation terms.

Perhaps nowhere is this problem more acutely demonstrated than in the nation's most populous state, California, where the absence of state law establishing reasonable reimbursement benchmarks has en-

couraged insurers to apply Medicaid reimbursement rates to ACA-exchange plans. In turn, ACA-exchange provider networks in California are a fraction of large-group provider networks, which often establish far more favorable reimbursement benchmarks (based on either Medicare or the Fair Database). Access to leading facilities and healthcare providers is therefore severely restricted (Terhune, 2013), even when insureds opt for out-of-network benefits made equally illusory by the same Medicaid caps. Ironically, then, while we may finally have the tools to end insidious insurer discrimination in the mental health context, any parity advances are negated by strangulation of reasonable reimbursement for all “essential health benefits” in many, if not most, ACA-exchange plans. Without Congress and the states acting swiftly to establish minimum reimbursement benchmarks, private insurance will be nothing more than an extension of Medicaid—with meaningful care effectively out of reach for premium-paying patients lured into the ACA exchanges by the promise of access, affordability, and quality.

ENDNOTES

1. For convenience, “mental health” shall encompass “substance abuse” in this article.
2. For convenience, these entities shall be collectively referred to as “insurers” in this article. Technically, insurers underwrite and generally administer health plans. Managed behavioral healthcare organizations are generally owned by insurers, and while they may not underwrite plans, they are responsible for most, if not all aspects of plan administration, including development and implementation of clinical protocols. Employers, as group sponsors of health plans, either purchase coverage from insurers or contract with managed care organizations to administer health plan benefits.
3. Until 2014, about one-third of insureds in the individual market had no coverage for substance use disorder services and nearly twenty percent had no coverage for mental health services, including outpatient therapy visits and inpatient crisis intervention and stabilization. (See ASPE Issue Brief, 2011.)
4. Specifically, in 2009, the mental health and substance abuse shares of all health expenditures were 6.3% and 1.0%, respectively. In 1990, they were 6.9% and 1.8%, respectively (Substance Abuse and Mental Health Services Administration, 2013, p. 255).
5. Substance Abuse and Mental Health Services Administration, 2013, p. 261.
6. Pub. L. No. 110-343, Div. C, Tit. V, Sub. B, §§ 511-512, 122 Stat. 3765, 3881-3893 (Oct. 3, 2008) passed as part of the Emergency Economic Stabilization Act of 2008, expands the parity requirements established by the Mental Health Parity Act of 1996 (Pub. L. No. 104-204, Tit. VII, §§ 701-702, 100 Stat. 2874, 2944-2950 (Sept. 26, 1996)), the first federal mental health parity law, which required parity in annual and aggregate lifetime dollar limits.
7. Large group plans demonstrating that the Federal Parity Act’s requirements have increased health care costs by 2% in the first year that the Federal Parity Act applies to the plan, or by at least 1% in subsequent years, may seek exemption for the following year. Self-insured non-federal government employee plans can opt out of compliance with the federal parity law but few have done so. Church-based plans, TriCare, Medicare, and traditional Medicaid are subject to different regulatory schema forming the basis for separate discussion.

8. Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010), (codified in scattered sections of 29 U.S.C. & 42 U.S.C.).

9. Employer-sponsored large-group plans and “grandfathered” individual and small group plans are not currently required to include “essential health benefits.” Grandfathered plans are those created before March 23, 2010. See 45 CFR § 147.140.

10. 42 U.S.C. § 18022(b)(1).

11. 42 U.S.C. § 18022(b)(4)(D).

12. Benchmark plans are based on a plan from: (1) Any of the largest three plans in the state’s small group insurance market (by enrollment); (2) Any of the largest three state employee health benefit plans (by enrollment); (3) Any of the largest three national federal employee health plans (by enrollment); (4) The largest commercial non-Medicaid Health Maintenance Organization (HMO) operating in the state.

13. 42 U.S.C. § 18022(b)(1) and 45 C.F.R. § 156.115.

14. *Id.*

15. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68252 (Nov. 13, 2013).

16. Since it is beyond the scope of this article to address state mental health parity laws, data maintained at www.ncsl.org/research/health/mental-health-benefits-state-mandates.aspx by the National Conference of State Legislatures may prove useful.

17. The Federal Parity Act permits large group plans to exclude all or any mental health conditions from coverage and does not consider this to be a “treatment limitation.” Any mental health or substance use disorder conditions that are covered by large group plans, however, must be covered on par with medical/surgical conditions. The Federal Parity Act does not allow plans to exclude specific non-experimental/investigational treatments for covered conditions. Furthermore, fully-insured large group plans are still subject to state mental health parity laws, which may require coverage for certain conditions that must then be administered according to the Federal Parity Act and any applicable state laws.

18. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68272 (Nov. 13, 2013).

19. *Id.* at 68246.

20. The regulations permit splitting the outpatient classification into two subclassifications: (1) office visits and (2) all other outpatient items and services. See *id.* at 68242.

21. *Id.* at 68243.

22. *Id.* at 68243.

23. See *Coalition for Parity v. Sebelius*, 709 F.Supp.2d 10 (LEXIS 2010).

24. See Gopelrud, 2013, p. x [“Analyses of large employer benefits in 2010 found numerous examples of NQTLs that were stricter for MH/SUD than for medical/surgical services. Some of the most common NQTLs include MH/SUD precertification requirements that were more stringent than medical/surgical requirements (28% of tested plans), medical necessity criteria that were applied to MH/SUD benefits but not to medical/surgical benefits (8% of tested plans), the use of routine retrospective reviews for MH/SUD services, and not for medical/surgical services, and reimbursement rates that were based on lower percentages of UCR rates for MH/SUD services than those provided for medical/surgical services.”] Also see p. xiii, “Although we were able to identify areas where the application of NQTLs appeared to be inconsistent with the IFR, it is likely that our reliance on these limited sources of information drawn primarily from large employers’ health plans resulted in a significant under-identification of problematic NQTLs.”

25. The DOL has, however, expressed support for allowing private plaintiffs to sue a managed behavioral healthcare organization for various parity violations in an amicus brief submitted to the United States Court of Appeals for the Second Circuit. See *New York State Psychiatric Association, Inc. et al v. UnitedHealthGroup, Inc. et al.*, April 22, 2014.

26. Most notably, in 2014 the New York State Attorney General publically announced several high-profile settlements with insurers Emblem Health, Cigna Health and Life Insurance Company and MVP Health Care (operating contractually with Value Options) for parity violations, including disparate treatment caps for nutritional counseling, disproportionately high (40% more) denials of coverage in behavioral health cases than in medical cases, and exclusions of residential treatment for behavioral health conditions when subacute medical care was otherwise covered.

27. See August 17, 2012 Technical Guidance for Non-Federal Governmental Plans by the United States Department of Health & Human Services: "The ERISA private right of action under section 502(a) is not available to participants or beneficiaries of non-federal governmental plans...HHS will not enforce the requirement that non-federal governmental plans provide notice of the ERISA private right of action."

28. See estimates cited in Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, 78 Fed. Reg. 68240, 68257 (Nov. 13, 2013).

29. See, for example, *C.M. v. Fletcher Allen Healthcare*, 2013 U.S. Dist. LEXIS 120469, 3. (Cigna Health Insurance Company informed the patient, "[M]ost Cigna customers complete routine outpatient treatment in 8 sessions. Should claims exceed 25 sessions for this customer [C.M.], a case review based on medical necessity and the benefit plan design will be necessary. In addition, at that point, claim payment for this customer will be pulled from the automatic process and require prior authorization for additional sessions.")

30. See 76 Fed. Reg. 37208, 37216 (June 4, 2011) ("Additional examples of situations in which a claim is considered to involve medical judgment include adverse benefit determinations based on:...Whether a plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act and its implementing regulations, which generally require, among other things, parity in the application of medical management techniques.")

31. See United States Department of Labor August 23, 2010 Technical Release 2010-01, Interim Procedures for Federal External Review Relating to Internal Claims and Appeals and External Review Under the Patient Protection and Affordable Care Act.

32. See *New York State Psychiatric Association, Inc. et al v. UnitedHealth Group et al.*, March 11, 2013 (complaint filed). Also see *K.M. et al v. Regence BlueShield et al.*, July 11, 2013 (complaint filed). Also see *A. F. ex rel. Legaard v. Providence Health Plan* (decided on Aug. 8, 2014).

33. See *Wickline v. California*, 192 Cal. App. 3d 1630 (1986).

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APPENDIX. Acronyms

ABD	Adverse Benefit Determination
ACA	Affordable Care Act
DOL	United States Department of Labor
ERISA	Employee Retirement Income Security Act of 1974
FEHBP	Federal Employees Health Benefits Program
HHS	United States Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
IFR	Interim Final Regulation
IRO	Independent Review Organization
MH/SA (SUD)	Mental Health / Substance Abuse
MBHO	Managed Behavioral Healthcare Organization
MHPAEA	Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008
NQTL	Non-Quantitative Treatment Limitation
PHSA	Public Health Service Act
UCR	Usual, Customary, and Reasonable

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The Efficacy of Psychotherapy: Focus on Psychodynamic Psychotherapy as an Example

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Abstract: The growing number of individuals seeking treatment for mental disorders calls for intelligent and responsible decisions in health care politics. However, the current relative decrease in reimbursement of effective psychotherapy approaches occurring in the context of an increase in prescription of psychotropic medication lacks a scientific base. Using psychodynamic psychotherapy as an example, we review the literature on meta-analyses and recent outcome studies of effective treatment approaches. Psychodynamic psychotherapy is an effective treatment for a wide variety of mental disorders. Adding to the known effectiveness of other shorter treatments, the results indicate lasting change in many cases, especially for complex and difficult to treat patients, ultimately reducing health-care utilization. Research-informed health care decisions that take into account the solid evidence for the effectiveness of psychotherapy, including psychodynamic psychotherapy, have the potential to promote choice, increase mental health, and reduce society's burden of disease in the long run.

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With the advent of the Affordable Care Act and the focus on parity in the provision of mental health care, it is more important than ever to understand the evidence base for mental health treatments for the various types of psychological and psychiatric difficulties from which many Americans suffer. We suggest that it is incumbent for all stakeholders—government agencies that fund and supplement the provision treatment; public and private insurance companies that fund and reimburse treatments; patients and families that consume and pay for mental health services, and clinicians that provide such services—to be familiar with the evidence base supporting the efficacy of a full range of mental health interventions. In this article we review the extensive evidence for the usefulness of psychotherapy as a central and important treatment modality for a range of mental health problems and disorders.

In the United States, 31% of the population is affected by mental health problems every year; however, 67% do not receive treatment (Kessler et al., 2005). This discrepancy between those in need of mental health services and those who receive them is known as the “service gap” or “treatment gap.” Although mental health treatment utilization has increased over recent years, this increase has been accounted for by increased rates of patients receiving pharmacotherapy (Olfson & Marcus, 2009, 2010). At the same time, there is much evidence that the use of psychotherapy is on the decline. For example, although the percentage of people in the United States receiving outpatient psychotherapy has remained relatively steady over the years (3.37% in 1998, 3.18% in 2007), the use of psychotherapy as a sole intervention (15.9% to 10.5%) and psychotherapy prescribed in conjunction with medication (40% to 32.1%) have steadily decreased while the rate of medication prescribed alone (44.1% to 57.4%) has steadily increased (Olfson & Marcus, 2010; Olfson, Marcus, Druss, & Pincus, 2002). The average number of psychotherapy visits also has decreased over time, and fewer psychiatrists are delivering psychotherapy (Akincigil et al., 2011; Mojtabai & Olfson, 2008a). This decrease in the number of outpatients receiving psychotherapy and the increase in the number of outpatients receiving medication is in direct opposition to studies that report clear preference for psychotherapy over medications for many patients and families. For example, studies consistently show that patients, particularly depressed ones, prefer psychotherapy to medication (McHugh, Whitton, Peckham, Welge, & Otto, 2013; Prins et al., 2008; van Schaik et al., 2004).

Patient and family preferences aside, decisions about treatment interventions should be driven by the best evidence available. Thus it is surprising that this increase in the use of medications and decrease in the provision of psychotherapy is inconsistent and in direct contrast

with the evidence base and often leads to questionable practice. For example, antidepressants are often prescribed for subthreshold or lower levels of depression when effect sizes are lower for the use of medication alone in such depressions and psychotherapy is the preferable first-line treatment (Antonuccio, Danton, & DeNelsky, 1995; Persons, Thase, & Crits-Christoph, 1996; Wexler & Cicchetti, 1992).¹

While the decline in psychotherapy utilization no doubt reflects many factors (e.g., increasing medicalization, direct-to-consumer advertising of psychotropic drugs, increasing emphasis on short-term vs. long-term outcomes), restrictions in insurance reimbursements for psychotherapy have played an important role in psychotherapy delivery in the U.S. Insurance reimbursement practices frequently provide financial disincentives for providing psychotherapy as compared to the incentives for providing psychotropic medications (Mojtabai & Olfson, 2008a). For example, psychotherapy reimbursement rates have decreased over recent decades (Frank, Goldman, & McGuire, 2009; Rupert & Baird, 2004) while psychiatrists can bill three or four patients for 15-minute medication checks within the same time frame as the typical hour needed for a psychotherapy session. As a result rates of depression treatment by, for example, psychologists have decreased (Rupert & Baird, 2004), and fewer and fewer psychiatrists are providing psychotherapy (Druss, 2010; Mojtabai & Olfson, 2008a). At the same time treatment of psychological conditions by primary care physicians has increased (Mojtabai & Olfson, 2008b; Olfson et al., 2002). Primary care physicians, despite best intentions to help their patients, receive only 6 weeks of psychiatry training during medical school, generally do not receive training in psychosocial interventions, and thus rarely offer such options to their patients despite the evidence of the efficacy and cost-effectiveness of such treatments (Antonuccio et al., 1995; Heuzenroeder et al., 2004; Spielmans, Berman, & Usitalo, 2011; Vos et al., 2005). In contrast, in the United Kingdom and many other European countries treatment guidelines such as the U.K.'s National Institute for Health and Clinical Excellence (www.nice.org.uk) place greater value

1. At the same time, psychotropic medication is increasingly prescribed by primary care physicians instead of psychiatrists, further increasing the noted disparity as the former cannot provide psychotherapy (Mojtabai & Olfson, 2010). This is even more relevant when taking into account that psychopharmacological interventions have to be monitored carefully due to their potential of somatic side effects (e.g., De Hert, Detraux, van Winkel, Yu, & Correll, 2011). In everyday practice there is a growing trend for polypharmacy with poor risk-benefit ratios, off-label use of antipsychotic medication, for example for the treatment of anxiety syndromes (Comer, Mojtabai, & Olfson, 2011), and the widespread dissemination of medication whose long-term effects have not been adequately understood, for example concerning amphetamine-based stimulants for children with a diagnosis of ADHD.

on the provision of psychosocial treatments as first line treatments for many psychological and psychiatric conditions (Clark, 2011; Richards & Borglin, 2011).

Following the emphasis on psychosocial treatments in the U.K. and Europe, the underutilization of psychotherapy has been recognized, leading to government-based intervention to improve access. For example, the U.K. government initiated a program called Improving Access to Psychological Therapies (IAPT) for depression and anxiety. This program was aimed at training 6,000 therapists over a six-year period beginning in 2008 in order to increase access for one million people. The Swedish government also embarked on an equally ambitious shift in order to remedy the underprovision in psychotherapy for treating psychological problems (Holmqvist, Ström, & Foldemo, 2014). Efforts of this kind have been sorely lacking in the U.S. healthcare system

The declining utilization of psychotherapy in the U.S. is unfortunate from the perspective of our patients, who could benefit from the many evidence-based psychotherapeutic interventions available, but also from the perspective of long-term expenditures, especially in relation to chronic complex mental disorders such as personality disorders, which profit preferentially from psychotherapeutic intervention—often in conjunction with medication management. Declining utilization of psychotherapy in the U.S. is not at all warranted by the data on outcome. Despite common misconceptions, there is a vast evidence base for the efficacy of different forms of psychotherapy for a wide spectrum of disorders with effects that are as strong as or stronger than those of medication and without the serious side effects often found with medication use.

In this article we provide an overview of some of these outcome data. We focus on outcome of psychodynamic interventions, where negative bias in the field is most pronounced (Levy & Anderson, 2013). Many clinicians and academicians in psychiatry and psychology believe that psychodynamic treatments have either (1) not been tested or (2) that they have been found to be less effective than other treatment approaches. Although it is true that psychoanalytic and psychodynamic psychotherapies possess a smaller research base than some other approaches such as cognitive behavioral (CBT), there currently exists a strong literature on the efficacy of psychodynamic therapies (PDT) for a variety of acute and chronic mental disorders. We also focus on PDT as a case study of the misconception that psychotherapies do not have an evidence base. The reader keeps in mind that there is an equally strong or larger database for cognitive behavioral treatments and interpersonal psychotherapy (considered by some a PDT treatment; Crits-Cristoph, 1992) and emotion-focused treatments. Additionally, there

is a growing evidence base for humanistic and existential based treatments. Similarities and differences between these various treatment approaches will be briefly described in the next section.

WHAT IS PSYCHOTHERAPY?

“What is therapy?”; “What is the evidence for its efficacy?”; and “How should practitioners across all professions be trained?” These questions are essential with regard to this core clinical activity of psychiatrists, psychologists, social workers, and other mental health care professionals (Weissman et al., 2006). “Psychotherapy” can perhaps best be thought of as a plural noun given the many types and various levels of intervention by which it can be defined. For our purposes, we broadly define psychotherapy as a series of interrelated techniques or interventions designed to ameliorate mental health, emotional, behavioral, psychological, and/or psychiatric disorders based primarily on the verbal and/or nonverbal communication with an identified therapist or practitioner with an identified patient.²

The most well-known individual psychotherapies include cognitive behavioral therapy (CBT), behavioral therapy (BT), psychodynamic therapy (PDT), the latter including expressive, supportive, and depth PDTs, psychoanalysis (PSA), interpersonal therapy (IPT), Gestalt, Humanistic/Existential, experiential, client-centered (CCT), and derivative therapies such as emotion focused therapy. Within each of these modalities therapy can be conceptualized as long-term (e.g., one or more years with sessions; one or more times a week), or short-term (e.g., 6, 12, 16, or 24 sessions, usually once per week). BTs are based on the application of learning principles, the influence of reinforcement, and behavioral patterns and tend to avoid focusing on cognition, be it conscious or unconscious, although in recent years there has been more focus among BT therapists on integrating these types of processes (see Levy & Anderson, 2013). CBT techniques utilize learning principles, but in the context of conscious thought processes, particularly those that may be distorted (e.g., “I have to be excellent at everything I do or I am a failure”), and may lead to feelings of depression, anxiety, or

2. The words *client*, *patient*, and *consumer* are used differentially by various professional groups that provide treatment to refer those individuals who receive psychotherapy. In this article, we use the convention of *patient*. All three terms infer a relationship with another: a client is under the protection or receiving professional advice from an advisor; a patient is suffering from an illness and receives care from a doctor; a consumer buys services from his or her insurance plan and a managed care provider.

both. CBT treatments tend to teach patients skills and the use of homework assignments, like in BT, tends to take a more didactic stance. In contrast, humanistic/existential/CCT and PDT treatments are usually more conversational, focusing on fears, emotion, and unconscious influences. BT and CBT therapies tend to be brief (e.g., 6 to 16 weeks), although there is some evidence that many BT and CBT therapies are practiced long term in the community (Gillespie, Duffy, Hackmann, & Clark, 2002; McKay, Nudelman, McCadam, & Gonzales, 1996; Thompson-Brenner & Westen, 2005; Westen & Morrison, 2001) and that BT and CBT treatments for more severely disturbed patients such as personality disordered ones are typically conceptualized as long term (Beck, Freeman, Davis, & Associates, 2004; Linehan, 1993). In contrast PDTs tend to be longer term, although there are now a number of short-term or brief PDTs available (Abbass, Sheldon, Gyra, & Kalpin, 2008; Barber, Muran, McCarthy, & Keefe, 2013; Milrod, Leon, Barber, Markowitz, & Graf, 2007).

THE NATURE OF EVIDENCE

In order to assess and understand whether or not psychotherapy is effective and of value, we must examine the nature of evidence. There should be no disagreement regarding the need for empirical support for our interventions. There is, however, great disagreement about the nature and scope of what constitutes evidence. Some have suggested that randomized controlled trials (RCT), which involve randomizing patients to two or more treatments, including a placebo condition that controls for attention and credibility, are the gold standard of evidence. In fact, some have gone so far as to suggest that RCT is not only the gold standard, but the lone standard, the only evidence that deserves consideration. This attitude leads to an implicit but erroneous assumption that the absence of a certain type of evidence proves the lack of merit in approaches that do not have that level of evidence. At the other extreme, there are those who point to a number of important critiques of the RCT design as significant threats to both internal and external validity. These critics have noted that the controls provided by the RCT design are confounded by such factors as the use of selected samples (e.g., those willing to participate in RCTs and the use of limiting inclusion and exclusion criteria; Westen, Novotny, & Thompson-Brenner, 2004), non-random dropout (that can invalidate the randomization process; Miranda & Borkovec, 1999), lack of treatment fidelity (Ablon & Jones, 1999), and common factors, therapist factors, and investigator allegiance effects (Berman & Reich, 2010; Luborsky, Diguier, Seligman, Rosenthal, Krause, Johnson et al., 1999; Robinson, Berman, & Neimeyer,

1990) as well as other lack of controls (e.g., experiences outside the consultation room). These investigators often prefer naturalistic studies that lack randomization as an alternative (Blatt & Zuroff, 2005; Silberschatz's statement in Persons & Silberschatz, 1998; Stiles, Barkham, Mellor-Clark, & Connell, 2008). Beutler, Forrester, Gallagher-Thompson, Thompson, and Tomlins (2012) further criticize the standard RCT model by noting that the use of inclusion and exclusion criteria to create a homogenous group of patients, the focus on treatment fidelity and expert adherent therapists results in a lack of variability, that in turn reduces variance and the capacity to examine patient, therapist, and treatment characteristics as moderators of outcome.

Rather than privileging RCTs or naturalistic designs, Levy (Levy, 2012; Levy & Scott, 2007) has argued for a pluralistic approach toward levels of evidence. RCTs are very valuable, in some ways clearly a gold standard, but in some ways confounded, as such they are in no way the lone standard. Rather Levy argued that the juxtaposition and convergence of multiple types and levels of evidence constitute *the platinum standard*. The rationale is that each type of evidence speaks to different issues.³ Given the different nature of evidence provided by these different types of studies, there is a need for a diversified portfolio of evidence in which a variety of methods are juxtaposed against one another in order to protect against the introduction of non-random error. A convergence of evidence provides reliability and validity of inferences. Thus, to the degree results from experimental/RCT studies are consistent with data from naturalistic studies, process studies, and ultimately meta-analyses, we can be confident of reliable and valid findings. Furthermore, clinical interventions should be consistent with and related to what is known about developmental psychopathology and putative mechanisms of change. The true value of evidence is therefore derived from the convergence between different approaches, which, when interpreted isolated from other sources, can be problematic (for a more detailed discussion see Levy & Scott, 2007).

Additionally, important information for clinical practice can be derived from psychopathology, assessment, and epidemiological research literatures. For example, epidemiological studies have found that personality disorders are not only prevalent in their own right but are highly comorbid with other disorders such as mood disorders, anxiety disorders, and substance use disorders (Zanarini et al., 1998). Additionally, this comorbidity negatively affects the course and treatment

3. So while the RCT has excellent internal validity it suffers in terms of external validity and while naturalistic studies have excellent external validity, they suffer in terms of internal validity.

outcome for these disorders (Newton-Howes, Tyrer, & Johnson, 2006). Thus, an empirically supported principle is that clinicians should evaluate for personality disorders anytime they determine that a patient is suffering from one of these common comorbid conditions given their effects on treatment outcome. Second, when interpreting outcome data it is important to remember that there may be significant but still unidentified moderators that can influence outcome and would change our assessment of an intervention and/or provide prescriptive knowledge. For example, in June 2005 the FDA withdrew approval for the use of Gefitinib due to lack of evidence of its efficacy, however, secondary moderator analyses found that the medication was more effective for women and particularly those of Asian descent (Soo et al., 2011). Thus a medication that appeared inefficacious was highly efficacious for a subset on individuals. It is quite possible that the same kinds of moderating effects may exist with regard to psychotherapy interventions.

Findings across studies can vary quite a bit. Sometimes this variance represents random error or variance, while other times it may result from differences in study design such as sampling, treatment fidelity, or outcome measurement. For this reason reviews of groups of studies are important for understanding the broader clinical implications, and deriving evidence-based principles for clinical decision making. Some even consider systematic reviews to be the highest level of the evidence pyramid (Spring & Neville, 2010). One particularly useful method for systematically reviewing and combining findings across multiple studies is the use of meta-analysis. For each study the size of the effect or effect size (ES) is calculated and converted into a common metric to ultimately be combined. While in meta-analysis the main focus is on the direction and magnitude of the effects (ES) across studies, differences in ES between subgroups of studies can be examined too. As described in the next section, meta-analysis was developed specifically to answer questions about psychotherapy outcome but has been utilized to serve all of science. A major strength of the meta-analytic approach is that it controls for outlier findings among individual studies that may run counter to the larger body of literature.

Nonetheless meta-analysis is not without controversy, and individual meta-analyses as well as the technique itself have been criticized. There are four basic problems that need to be addressed in a meta-analysis: (1) study heterogeneity or "comparing apples with oranges"; (2) study quality, or "garbage in, garbage out"; (3) inclusion and exclusion criteria, where small conceptual differences between meta-analyses can result in vastly different answers; and (4) dissemination bias. The latter, called the "file drawer problem," is when studies with negative results or results that counter the bias of the investigators are less likely to

be published and appear in meta-analyses. Based on these critiques a number of guidelines for conducting and reporting meta-analyses have been developed (AMSTAR; Shea et al., 2009; MARS; APA, 2008; PRISMA; Moher, Liberati, Tetzlaff, & Altman, 2009). Nevertheless, consumers of meta-analytic findings, similar to consumers of findings from individual studies, need to be aware of how these methodological issues raised have been addressed in interpreting the findings.

DOES PSYCHOTHERAPY WORK?

Controversy about the effectiveness of psychotherapy began in 1952 when the British experimental psychologist, Hans Eysenck, caused a furor when he proclaimed that psychotherapy was no more beneficial than the absence of treatment. In his report, Eysenck (1952) summarized the results of 24 reports of psychoanalytic and eclectic psychotherapies with more than 7,000 neurotic clients treated in naturalistic settings compared with two control groups. Eysenck found that the more intensive the therapy, the worse the results. In fact, Eysenck's interpretation suggested that clients in psychoanalytic treatment had significantly worse cure rates than clients who received no treatment.

It has been more than 60 years since Eysenck rocked the psychotherapy community with these claims. Despite the use of what is now considered seriously flawed research methodology (e.g., inconsistent methods, selection bias, inappropriate control groups) and a polemic tone that some feel indicated a pre-existing bias, Eysenck's article was extremely important to the field and challenged therapists to pay more systematic attention to the results of their efforts and has spurred a great deal of empirical research. Thanks in large part to researchers' response to Eysenck's charge, we now know, generally speaking, that psychotherapy does indeed help people get better (Smith, Glass, & Miller, 1980; Wampold, 2001). Numerous studies and subsequent meta-analyses have demonstrated that any number of specific psychotherapeutic approaches, either alone, or, in some cases, in combination with pharmacological approaches, are more effective than credible alternative psychological interventions containing nonspecific factors (e.g., the provision of hope, support, empathy, or interventions provided by experts) serving as "psychological placebos" (Barlow, 1996).

Early on, there were a number of critiques of Eysenck's review. The most notable were by Christie (1956), Bergin (1971), Lambert (1976), Luborsky, Singer, and Luborsky (1975), Rosensweig (1954), and Strupp (1963). However, one critique in particular revolutionized not only the field of psychotherapy and psychotherapy research but all of science.

In response to Eysenck's use of a tally method for his comprehensive review, Gene Glass (Smith & Glass, 1977) developed meta-analysis as a method for generating a common metric that could be used aggregate or combine findings across studies. As mentioned above, meta-analysis is now used in every science, applied or basic, to summarize findings across studies, and because of this capacity is considered to be able to provide the highest level of evidence available to scientists and practitioners (for a discussion from a medical perspective, see for example, Rawlins, 2008, 2011).

In the late 1970s and early 1980s, Glass and colleagues (Smith & Glass, 1977; Smith, Glass, & Miller, 1980) published a large review paper and book of their initial meta-analysis in which they summarized the findings of 375 psychotherapy outcome studies completed at that time. Based on these findings, Glass and colleagues concluded that psychotherapy did indeed convincingly lead to significant improvements in treated patients: On average, the typical therapy patient is better off than 75% of untreated individuals. Few reliable differences were found between different types of psychotherapy. Since Glass and colleagues' original meta-analysis there have been numerous meta-analytic reviews of psychotherapy in general with mixed clients, psychotherapy of specific psychotherapy orientations such as CBT (Butler, Chapman, Forman, & Beck, 2006; Hofmann, Asnaani, Vonk, Sawyer, & Fang, 2012) or PDT (Barber et al., 2013; Driessen et al., 2010; Leichsenring & Rabung, 2008, 2011), psychotherapies for specific disorders such as depression (Cuijpers, van Straten, van Oppen, & Andersson, 2008; Driessen et al., 2010), anxiety disorders (Keefe, McCarthy, Dinger, Zilcha-Mano, & Barber, 2014), personality disorders (Leichsenring & Leibling, 2003), and other disorders such as schizophrenia (Gottdiener & Haslam, 2003). The overwhelming consensus across these meta-analyses is that a number of different psychotherapies are effective, and particularly so when compared to no treatment wait-list controls or placebos. Consistent with these findings, the American Psychological Association's Division 12 Task Force on empirically supported psychotherapies now lists 13 separate psychotherapy treatments for depression, five treatments for various anxiety disorders, and four treatments for borderline personality disorder (APA, Division 12, 2013). Supporting the early findings of Smith and Glass (1977), and despite the differences in the number of studies conducted as a function of psychotherapy orientation, there are few reliable differences between orientations across meta-analytic studies. This finding in and of itself suggests that there are a number of useful and effective psychotherapy treatments available to the practicing clinician for treating patients.

As contemporary researchers increasingly agree that psychotherapy works, psychotherapy research is, nevertheless, at a critical period. A confluence of pressures both inside (e.g., evidence-supported treatment movement, practice guidelines) and outside the profession (e.g., managed care, legislation, National Alliance for the Mentally Ill) make it incumbent upon therapists to become better informed about the usefulness of psychotherapy and the evidence for it. There has been a shift toward focusing research efforts on more precise questions, including those such as: Given a patient's diagnosis, which treatment is recommended? What treatments have shown efficacy in empirical trials? Does the therapy produce results beyond simply symptom change? Do the changes achieved during the course of treatment endure with time? How does length of treatment affect the nature of long-term outcome? Which treatments that show efficacy in clinical trials have demonstrated similar effectiveness in community treatment settings?

In the following section we will examine the evidence for the use of psychodynamic psychotherapy with a range of specific psychological and psychiatric disorders. We will examine findings from (1) meta-analytic studies; (2) RCTs; (3) naturalistic studies, and (4) process-outcome studies.

EFFECTIVENESS AND EFFICACY OF PSYCHOTHERAPY FOR SPECIFIC DISORDERS

Overall, the effect sizes from meta-analytic studies suggest that psychodynamic psychotherapy is more effective than placebo, as effective as much-studied CBT, and possibly more effective than antidepressants. We will review specific studies that will illustrate particularly important findings. These relate for example to good long-term outcomes, to evidence for what has been termed a "sleeper effect" of continued improvement after treatment termination, to positive effects especially in the area of personality disorders and interpersonal difficulties, going beyond mere symptom reduction, and some evidence for possibly specific mechanisms of change.

REVIEWING STUDIES ON MAJOR DIAGNOSTIC CATEGORIES

Personality Disorders

Personality Disorders are considered a major treatment challenge in and of themselves, and they also complicate the treatment of other

disorders. For example, there are now a number of independent large-scale outcome and longitudinal studies that show that comorbid personality disorders (PD), particularly borderline personality disorder (BPD), not only affects treatment outcome of major depressive disorder (MDD) adversely (Fournier et al., 2008; Shea, Widiger, & Klein, 1992), but also lead to lower rates of remission, longer times to remission, and increased relapse rates (Grilo et al., 2010; Gunderson et al., 2004; Links, Heslegrave, Mitton, van Reekum, & Patrick, 1995; Newton-Howes et al., 2006; Skodol et al., 2011; Zanarini, Frankenburg, Hennen, & Silk, 2006). Fournier and colleagues (2008) in a comparative study of CBT with paroxetine found that treatment was less effective for those MDD patients with a comorbid PD and that almost all MDD patients with a comorbid PD relapsed upon discontinuation of medication. Although the response rate for CBT was negatively affected by the presence of a PD, in contrast to the medication condition, those that did respond to CBT tended not to relapse. Grilo et al. (2010), in a six-year prospective longitudinal study, found that a comorbid PD predicted longer time to remission in MDD and faster time to relapse compared with MDD patients without a PD. Skodol et al. (2011), in a nationally representative sample of over 5000 individuals, found that MDD patients with comorbid BPD represented approximately half of the patients who did not remit as of a three-year period. Surprisingly, there are now findings from four independent longitudinal studies (Gunderson et al., 2004; Links et al., 1995; Skodol et al., 2011; Zanarini et al., 2006) that have found the negative effects of BPD on MDD seem to work in one direction. That is, MDD does not seem to have the same negative effect on outcome in BPD. For instance, the rate of remission of BPD is not affected by whether or not patients had co-occurring MDD, or whether MDD responded to medication. For instance, Gunderson et al. (2004) in a sample of 675 found that improvements in MDD were not followed by improvements in BPD, whereas improvements in BPD were often followed by improvements in MDD. Similar findings were reported with regard to the relationship between PDs (especially BPD) with bipolar disorder (Bieling, Green, & Macqueen, 2007; Colom et al., 2000; George, Miklowitz, Richards, Simoneau, & Taylor, 2003; Gunderson et al., 2006; Kay, Altshuler, Ventura, & Mintz, 2002) and anxiety disorders (Ansell et al., 2011). Thus, personality disorders, especially BPD, given their prevalence, comorbidity, and consequences are a major health concern that clinicians need to be prepared to address.

Before reviewing the research on specific models of therapy for specific personality disorders, we point to several meta-analyses of psychotherapy for combined personality disorders that provide encouraging findings (Budge et al., 2013; Leichsenring & Leibing, 2003; Perry,

Banon, & Ianni, 1999). Perry and colleagues (1999) identified 15 studies, including six RCTs, and found pre-post effect sizes ranging from 1.1 to 1.3. In a second meta-analysis, Leichsenring and Leibing (2003) examined the efficacy of both PDT (14 studies) and CBT (11 studies) in the treatment of patients with personality disorders; 11 of the studies were RCTs. The authors reported pre-treatment to post-treatment effect sizes using the longest term follow-up data reported in the studies. For psychodynamic psychotherapy (mean length of treatment was 37 weeks), the mean follow-up period was 1.5 years after treatment end and the pre-treatment to post-treatment effect size was 1.46, indicating that psychodynamic treatment benefits endure over time. For CBT (mean length of treatment was 16 weeks), the mean follow-up period was 13 weeks, and the pre-treatment to post-treatment effect size was 1.0. The authors concluded that both PDT and CBT demonstrated effectiveness for patients with personality disorders, but that current evidence for long-term effectiveness is stronger for psychodynamic psychotherapy. In the most recent and comprehensive meta-analysis on PDs, Budge and colleagues (2013) analyzed 30 studies that compared an active psychotherapeutic treatment with treatment as usual. They found that active psychotherapeutic treatments were more efficient than treatment as usual comparisons, with medium effect size ($d = .40$). In addition, the effectiveness of PDT for individuals with personality disorders is supported by two more recent meta-analytic studies for short-term PDT (Town, Abbass, & Hardy, 2011) and for the treatment of depression with comorbid personality disorders (Abbass, Town, & Driessen, 2011).

To summarize, based on limited data, psychodynamic and CBT treatments appear to be equally effective for personality disorders, yet longer term treatments might yield better outcomes, and psychodynamic treatments may have longer lasting effects. However, findings from these meta-analyses of personality disorders are difficult to interpret due to the mixing samples that can vary quite a bit in terms of severity. Thus research on specific personality disorders is informative.

Borderline Personality Disorder (BPD)

BPD patients have traditionally taken up high levels of treatment resources (Bender, Dolan, & Skodol, 2001) and have been considered a difficult population to treat effectively. Four psychodynamic treatments for borderline personality have empirical support: Russell Meares's Interpersonal-Self Psychological approach also known as the Conversational Approach, Bateman and Fonagy's Mentalization Based Therapy

(MBT; Bateman & Fonagy, 2004), Kernberg et al.'s Transference Focused Psychotherapy (TFP; Clarkin, Yeomans, & Kernberg, 2006), and Robert Gregory's Deconstructive Dynamic Psychotherapy (DDP; Gregory & Remen, 2008). The latter three have been shown to be efficacious in RCTs.

Interpersonal-Self Psychological Approach. Meares developed an interpersonal self-psychological approach for the treatment of BPD guided by the conversational model of Hobson (1985), the main aim of which is to foster the emergence of reflective consciousness that William James called *self-consciousness* (James, 1890). A basic tenet of this approach is that self-consciousness is achieved through a particular form of conversation and reflects a deeper sense of relatedness. A pre-post study that evaluated the effects of this approach for patients with BPD found that patients at the end of treatment showed an increase in time employed and decreases in number of medical visits, number of self-harm episodes, and number and length of hospitalizations (Stevenson & Meares, 1992). Although the inferences that can be drawn from this study are limited by the lack of a control group, these findings supported the further development and study of psychodynamic treatments for BPD. In a later quasi-experimental study (Meares, Stevenson, & Comerford, 1999), researchers compared BPD patients treated twice weekly for one year with those in a treatment-as-usual (TAU) waitlist control group (all waitlisted patients received their usual treatments, which consisted of supportive psychotherapy, crisis intervention only, cognitive therapy, and pharmacotherapy). Thirty percent of patients with interpersonal-psychodynamic psychotherapy no longer met criteria for a *DSM-III* (American Psychiatric Association, 1980) BPD diagnosis at the end of the treatment year, whereas all of the TAU patients still met criteria for the diagnosis. These results demonstrated that psychotherapy based on psychodynamic principles is generally beneficial to patients with BPD in a naturalistic setting, having strong ecological validity in a real world setting. A five-year follow-up found the improvements were maintained (Stevenson, Meares, & D'Angelo, 2005). A second quasi-experimental study (Korner, Gerull, Meares, & Stevenson, 2006) replicated these findings.

Mentalization Based Therapy. Bateman and Fonagy (2004, 2006) developed Mentalization Based Therapy (MBT) that integrates philosophy (theory of mind) and elements of psychoanalytic traditions (ego psychology, Kleinian theory, and attachment theory). They posit that the mechanism of change in all effective treatments for BPD involves the capacity for mentalization—the capacity to think about mental states in oneself and in others in terms of wishes, desires, and intentions. Men-

talizing involves both (1) implicit or *unconscious* mental processes that are activated along with the attachment system in interpersonal situations and (2) coherent integrated representations of mental states of self and others that influence thinking, emotional states, and behavior. The concept of mentalization has been operationalized in the Reflective Function (RF) scale (Fonagy, Steele, Steele, & Holder, 1997).

In an RCT (Bateman & Fonagy, 1999), the effectiveness of 18 months of an MBT day hospitalization program was compared with routine general psychiatric care for patients with BPD. Patients randomly assigned to the day hospital program showed statistically significant improvement in depressive symptoms and better social and interpersonal functioning, and significant decreases in suicidal and parasuicidal behavior and number of inpatient days. Patients were reassessed every three months for up to 18 months post-discharge (Bateman & Fonagy, 2001). Short-term follow-up results indicated that patients who completed the MBT not only maintained their substantial gains, but also showed continued steady and significant improvement on most measures, suggesting that BPD patients can continue to demonstrate gains in functioning long after treatment has ended. At 18-month post-discharge follow-up, 59.1% of patients treated with MBT were below the BPD diagnostic threshold, compared to only 12.5% of those treated in routine general psychiatric care. In a second follow-up, eight years post randomization and five years post the end of treatment, even more impressive findings were obtained: those treated with MBT showed not only statistical superiority in reduced suicidality, service utilization, medication use, and increases in global and vocational functioning, but an impressive level of clinical change (only 13% met criteria for BPD compared to 87% of those in the TAU group; Bateman & Fonagy, 2008). A recent RCT found MBT to be as effective as supportive psychotherapy in most of the outcome measures, but slightly more effective in improvement of global functioning (Jørgensen et al., 2013).

In summary, findings on the long-term significance of MBT are particularly important given the entrenched and chronic nature of BPD. Follow-up studies of CBT treatments for BPD have typically examined relatively short time frames (between 6 and 18 months), leaving the long-term efficacy of these treatments unclear. Additionally, outcomes for these studies have generally been mixed.

Transference Focused Psychotherapy (TFP). TFP is a modification of psychodynamic therapy based on object relations theory to address the needs of patients with BPD. TFP aims to reduce the patient's use of primitive defenses that deny the patient access to important parts of his emotional experience and to increase the patient's coherent sense of

self as a means to reduce suicidality and self-injurious behaviors, and to facilitate better behavioral control, increased affect regulation, more gratifying relationships, and the ability to pursue life goals (Clarkin, Yeomans, & Kernberg, 2006; Kernberg, Yeomans, Clarkin, & Levy, 2008). Using *clarifications*, *confrontations*, and *interpretations*, the therapist helps the patient integrate cognitions and affects that were previously split off and disorganized. The tactful *interpretation* of the dominant themes that the patient experiences in the here and now of the *transference* shed light on the reasons that internal representations of self and other remain fragmented and thus facilitate the development of a coherent sense of self and others.

There is accumulating evidence for the effectiveness and efficacy of TFP. An initial study (Clarkin et al., 2001) with a pre-post design showed that patients with BPD who were treated with TFP had marked reductions in the severity of parasuicidal behaviors, fewer emergency room visits, hospitalizations, days hospitalized, and reliable increases in global functioning. The effect sizes were large and equal to those demonstrated by other BPD treatments (Bateman & Fonagy, 1999; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991). The one-year drop-out rate was 19.1%, and no patient committed suicide. These results compared well with other treatments for BPD.

A second quasi-experimental study (Levy, Clarkin, Foelsch, & Kernberg, 2007) provided further support for the effectiveness of TFP in treating BPD. Twenty-six women diagnosed with BPD and treated with TFP were compared to 17 patients in a TAU group. There were no significant pre-treatment differences between the treatment group and the comparison group in terms of demographic or diagnostic variables, severity of BPD symptomatology, baseline emergency room visits, hospitalizations, days hospitalized, or global functioning scores. The one-year drop-out rate was 19%. Patients treated with TFP, compared to those treated with TAU, showed significant decreases in suicide attempts, hospitalizations, and number of days hospitalized, as well as reliable increases in global functioning. All of the within-subjects and between-subject effect sizes for the TFP-treated participants indicated favorable change. The within-subject effect sizes ranged from 0.73 to 3.06 for the TFP-treated participants, with an average effect size of 1.19—well above what is considered a “large” effect (Cohen, 1988).

In an RCT (Clarkin et al., 2007; Levy et al., 2006), 90 clinically referred patients were randomized to one of the three treatments: TFP, DBT, and a psychodynamic supportive psychotherapy (SPT; Appelbaum, 2005). Results of individual growth-curve analysis indicated that both the TFP and DBT-treated groups, but not the SPT group, showed signifi-

cant decrease in suicidality. Both TFP and supportive treatment were associated with improvement in anger and with improvement in facets of impulsivity. Only the TFP-treated group demonstrated significant improvements in irritability, verbal assault, and direct assault.

In an earlier report on this sample, Levy and colleagues (Levy et al., 2006) examined changes in attachment organization and reflective function as putative mechanisms of change, using the Adult Attachment Interview (AAI; George, Kaplan, & Main, 1985) and the Reflective Function coding scale (RF; Fonagy, Steele, Steele, & Target, 1997). After 12 months of treatment there was a significant increase in the number of patients classified as secure with respect to attachment state of mind for TFP, but not the other two treatments. Significant changes in narrative coherence and RF were found as a function of treatment, with TFP showing increases in both constructs during the course of treatment. These findings are important as they show that TFP is not only an efficacious treatment for BPD, but works in a theoretically predicted way and thus has implications for conceptualizing the mechanism by which patients with BPD may change. The fact that patients in TFP did better on these putative mechanisms (e.g., reflective function) than those in DBT and SPT is initial evidence that this form of psychodynamic therapy is associated not only with symptom change but also with underlying psychological processes that mediate the patient's adjustment to the world. This is significant in the context of the literature showing that many treatments do not show specific effects on specific, theory-driven mechanisms (Ablon & Jones, 1998; Ablon, Levy, & Katzenstein, 2006; Castonguay, Goldfried, Wiser, Raue, & Hayes, 1996; DeRubeis et al., 1990; DeRubeis & Feeley, 1990; Iardi & Craighead, 1994; Jones & Pulos, 1993; Shaw et al., 1999; Trepka, Rees, Shapiro, Hardy, & Barkham, 2004).

TFP was also examined as a control condition in a study in Amsterdam by Arntz and colleagues (Giesen-Bloo et al., 2006). The authors compared TFP with Schema Focused Therapy (SFT; Young, 1994), an integrative approach based on cognitive-behavioral or skills-based techniques along with object relations and gestalt approaches. Their study is unique in examining two active treatments over three years, however it lacked a control (Grenyer, 2007). While patients benefited from both treatments, SFT appeared more efficacious. However, a number of serious limitations including failure in the randomization process (Levy, Meehan, & Yeomans, 2012) and non-adherent therapists (Yeomans, 2006) argue against this conclusion. Additionally, a later independent study (Doering et al., 2010) also found TFP to be efficacious, and a recent meta-analysis of treatments for BPD failed to find any differences in treatment effects between specific treatments (Levy et al., 2012).

Mixed and Other Personality Disorders

Other studies have examined psychodynamic psychotherapy for personality disorders (Abbass, Sheldon, Gyra, & Kalpin, 2006; Winston, Laiken, Pollack, Samstag, McCullough, & Muran, 1994; Winston, Pollack, McCullough, Flegenheimer, Kestenbaum, & Trujullo, 1991). Winston and colleagues compared a short-term psychodynamic psychotherapy based on the work of Malan (1976) and Davanloo (1992) and a short-term psychodynamic psychotherapy called Brief Adaptive Psychotherapy (BAP) with a waitlist control in a group of patients predominately diagnosed with cluster C personality disorders. Both STPP treatments address defensive behavior and elicit affect in interpersonal contexts, although the BAP treatment is less confrontational. The authors found that both treatment groups showed significant change on the global severity index of the SCL-90 (approximately 1 standard deviation) and some changes on the social adjustment scale. At 18 months, post-treatment follow-up indicated the maintenance of treatment gains (Winston et al., 1994). Abbass et al. (2006) examined STPP for outpatients with a range of personality disorders. The authors found significant improvement in interpersonal problems, significantly more hours worked, and better employment outcomes relative to controls.

In another study using an RCT-design to examine outpatients with cluster C personality disorders (avoidant, dependent, obsessive-compulsive; Svartberg, Stiles, & Seltzer, 2004), the authors examined a 40-week STPP compared with cognitive therapy (CT) and found no statistically significant difference between the short-term psychotherapy group and CT groups on any measure for any time period. At two-year follow-up, 54% of the short-term dynamic psychotherapy patients and 42% of the CT patients had recovered symptomatically.

Depression

Although the data base is not as large for psychodynamic treatments of depression as it is for CBT, there is enough data to suggest that PDT is equally effective, and thus should be available to patients, and that further research is warranted on psychodynamic approaches. This conclusion is based on three sets of findings reviewed below: (1) meta-analytic studies; (2) RCTs; and (3) process-outcome studies.

Before turning to studies on depression, it is important to call attention to the emerging literature indicating a high rate of treatment failure

or treatment resistance in depressed patients, and a growing interest in management of what is commonly referred to as "treatment resistant depression." Treatment resistance is of particular relevance to this review, as one of the reasons for resistance seems to be comorbidity. In the large STAR*D study of depression, 78% of the sample had comorbidity or other problems like suicidality that would have excluded subjects from RCTs, but that made them similar to the majority of patients that clinicians see. STAR*D found that the comorbid group was more intolerant of antidepressant medications, had lower rates of treatment response (39% versus 52%), and lower rates of remission from depressive symptoms (25% versus 34%) when compared with patients who did not have comorbidity (Wisniewski et al., 2009). There is also evidence that personality disorders in particular adversely affect the outcome of major depressive disorders, cause persistent functional impairment, extensive treatment utilization, and are associated with a significant suicide risk (Bender et al., 2006; Skodol et al., 2005). Personality disorders, especially BPD "robustly predicted the persistence" of major depressive disorder (Skodol et al., 2011), leading Skodol and his colleagues to suggest that assessment and treatment of personality disorders is essential in patients with major depressive disorder. Given the apparent association of comorbidity, especially personality disorder comorbidity, with treatment resistance in depression (and other disorders), research into the treatment of complex comorbid patients is indicated.

Meta-Analytic Studies on Therapy for Depression. The psychotherapy treatment of depression is probably the most studied of any psychological disorder. In the last three decades alone, there have been 40 meta-analytic reviews of the outcomes for patients with depression alone (Cuijpers & Dekker, 2005; Lambert, 2013). A number of meta-analyses have focused specifically on the psychodynamic treatment of depressive disorders (Crits-Christoph, 1992). There are several meta-analytic studies that examine the efficacy of psychodynamic psychotherapy as compared with other active treatments, mostly CBT (Churchill, Hunot, Corney, Knapp, McGuire, Tylee et al., 2002; Crits-Christoph, 1992; Driessen et al., 2010; Gloaguen, Cottraux, Cucheret, & Blackburn, 1998; Leichenring, 2001; Svartberg & Stiles, 1991). Each of these meta-analyses suggests good evidence for the efficacy of psychodynamic psychotherapy and CBT (Crits-Christoph, 1992; Leichenring, 2001). A number of these studies compared effect sizes in PDT with that of CBT (Churchill et al., 2002; Gloaguen et al., 1998; Svartberg & Stiles, 1991). In the Churchill et al. review, the authors found no significant differences between groups post-treatment with regard to symptoms, symptom reduction, or dropout. Further, there were no differences between groups

at 3 months and 1-year follow-up. For the Gloaguen and colleague's meta-analysis, Wampold and colleagues (Wampold, Minami, Baskin, & Callen Tierney, 2002) showed that there were no demonstrable differences between PDT and CBT in studies in which CBT was compared with bona-fide PDT (i.e., PDT defined as a clearly articulated model of treatment). Leichsenring (2001) found no significant differences between CBT and PDT modalities in terms of depressive symptoms, general psychiatric symptoms, or social functioning. The most recent meta-analysis by Driessen et al. (2010) found short-term psychodynamic psychotherapy (STPP) to be a viable option for the treatment of depression. STPP was more effective than nonspecific TAU, and during follow-up as effective as other specific psychotherapeutic treatments, mostly CBT.

Effect sizes for psychodynamic psychotherapy are quite large (between 0.90 and 2.80) with the average depressed patient treated in psychodynamic psychotherapy better off than 82% to 100% of depressed patients before therapy. As a point of comparison, the effect sizes for antidepressant medications range between .24 for citalopram (Celexa) and .31 for escitalopram (Lexapro; Turner, Matthews, Linardatos, Tell, & Rosenthal, 2008), and effect sizes for medications decrease when antidepressants are compared to active placebos (e.g., non-inert placebo that mimics the side effects of an antidepressant drug but do not have antidepressant components).

Randomized Controlled Trials on Therapy for Depression. Initially, brief dynamic therapy was used as a comparison from which to assess the validity of other treatments (Hersen, Himmelhoch, Thase, & Bellack, 1984). In these studies, PDT was not a bona fide treatment, meaning it was not a clearly defined therapy but rather a "grab bag" term as little attention was paid to a clearly articulated model of treatment, the appropriateness of the therapists, or the fidelity of the treatment. More recent studies have paid better attention to these issues and tend to show that psychodynamic treatment is as effective as other modalities (Barber, Barrett, Gallop, Rynn, & Rickels, 2012a; Barkham, Shapiro, Hardy, & Rees, 1999; Cooper, Murray, Wilson, & Romaniuk, 2003; Driessen et al., 2013; Gallagher-Thompson & Steffen, 1994; Shapiro et al., 1994; Shapiro, Rees, Barkham, & Hardy, 1995). For example, Gallagher-Thompson and Steffen (1994) found in an RCT that 20 sessions of brief psychodynamic psychotherapy were as effective as 20 sessions of CBT in reducing depression in caregivers of elderly family members. Shapiro et al. (1994, 1995) randomized patients to 8 or 16 weeks of psychodynamic-interpersonal psychotherapy or CBT. They found that both treatments were equally effective for the 8-week and 16-week conditions,

and that there were no group differences at one-year follow-up. In both therapy conditions, severe depressions responded better to 16 weeks of intervention, speaking to the length of treatment issue that we will discuss later in the article. Thus, similar effect sizes were found when PDT was compared with CBT and these effects were comparable to those reported in other studies of CBT and IPT. Two recent RCTs add to the evidence. In a randomized-controlled study in a sample of patients with low socioeconomic status, high psychiatric comorbidity, and a long illness duration, STPP was as effective as psychotropic medication with SSRI/SNRIs (Barber et al., 2012). In the largest RCT for depression to date, 341 patients were randomized to either 16 sessions of manualized STPP or 16 sessions of manualized CBT accompanied with optional antidepressant medication for severe cases. Results indicated that both treatments are equally effective in symptom reduction (Driessen et al., 2013). What is particularly important about this study is that with the large sample size, it was sufficiently powered to test for equivalence on a number of measures, which was found. This led Thase (2013) in his editorial in the *American Journal of Psychiatry* to declare that “. . . psychodynamic psychotherapy is indeed an effective treatment option for outpatients with major depressive disorder” (p. 954).

Process-Outcome Studies. A different approach to studying psychotherapy outcome focuses on the relationship between specific aspects of therapy process—the techniques that are observed in the course of the session—and treatment outcome. There are a number of process studies that suggest the value of a psychodynamic approach for depression. Jones and Pulus (1993) found that although patients in both CBT and PDT improved, improvement in both therapies was dependent on the use of psychodynamic techniques embedded in the sessions in each treatment. Indirect evidence for the importance of psychodynamic process also comes from the findings of Castonguay, Goldfried, Wisner, Raue, and Hayes (1996). In examining mechanisms of change in CBT for depression, they found that focusing on distorted cognitions was inversely related to successful treatment outcome. However, a focus on feelings about the self, while elaborating and integrating emotional experience to develop an in-depth self-understanding, predicted positive treatment outcome. These findings suggest that cognitive behavioral therapists use psychodynamic strategies at times, and that these are associated with positive treatment outcome for patients of both psychodynamic and cognitive-behavioral therapists.

Anxiety Disorders

The effectiveness of CBT for the treatment of anxiety disorders is well established (Hofmann & Smits, 2008). In fact, during the 1980s and 1990s there were many RCTs examining CBT for a range of anxiety disorders. By the later 1990s and early 2000s the literature in support of the effectiveness of CBT was large enough to raise doubts about the value or ethics of non-exposure based/CBT methods for treating a range of anxiety disorders (Eagle, 2005). On the other hand, the outcome for CBT was far from complete. Many patients relapsed and sought out continued psychotherapy (Westen & Morrisson, 2001). Additionally, the notion of CBT as a superior treatment was for the most part not based on direct comparisons with bona fide treatments (e.g., PDT) but rather comparisons to placebos and waitlist controls. Despite mounting pressure from the academic community and insurance companies to limit treatment for anxiety exclusively to CBT treatments, some clinical researchers persisted with humanistic/existential and psychodynamic approaches, resulting in several RCTs of PDT in the treatment of anxiety disorders (Alström et al., 1984a, 1984b; Beutel et al., 2013; Bögels, Wijts, Oort, & Sallaerts, 2014; Bressi, Porcellana, Marinaccio, Nocito, & Magri, 2010; Brom, Kleber, & Defares, 1989; Crits-Christoph, Wilson, & Hollon, 2005; Durham et al., 1994; Leichsenring et al., 2013; Milrod et al., 2007; Pierloot & Vinck, 1978; Wiborg & Dahl, 1996). Overall, the evidence is positive for the effectiveness of PDT for a range of anxiety disorders as indicated from findings from a recent meta-analysis including 14 RCTs with 1073 patients (Keefe et al., 2014). The within-group effect size for PDT was large ($g = 1.06$). Psychodynamic treatment was always superior to waitlist control or minimal care interventions in five RCTs. PDT was equally effective when compared with other active treatments, with all but three comparison treatments being CBT or BT spectrum treatments. For example, two smaller RCTs compared psychodynamic psychotherapy with CBT (Bögels et al., 2014; Durham et al., 1994); one found the treatments equally effective (Bögels et al., 2014) and the other found that PDT provided significant improvement but to a lesser degree than CBT (Durham et al., 1994). However, in the latter study, in contrast to the CBT treatment, PDT was not manualized, there was no specific training of therapists, and there were neither adherence checks nor treatment fidelity monitoring for the dynamic therapists.

A particularly important RCT was conducted by Milrod and colleagues (2007) who manualized a psychodynamic treatment for panic

based on theory and case reports that focused on symptom reduction through exploring *unconscious* determinants, such as unacknowledged anger and conflicts regarding autonomy and dependence. Panic Focused Psychodynamic Psychotherapy (PFPP) is aimed at helping patients understand the underlying emotional meaning of their panic allowing patients to acknowledge previously unacceptable feelings and ideas that have led to panic. This contrasts with CBT, which relies on exposure to panic triggers (i.e., bodily sensations such as breathlessness, tightness in the chest, heart palpitations), and a highly structured set of exercises aimed at easing attacks. In an RCT, Milrod and colleagues compared PFPP over 12 weeks to Applied Relaxation Therapy (ART), a standard and structured relaxation-focused approach that has often been used in trials aimed at assessing the effectiveness of other treatment approaches. Results showed not only efficacy for PDT but found similar effect sizes to those seen in studies of CBT, and a lower drop-out rate than typical in CBT. The 26 patients in the PFPP group had a greater reduction in their symptoms compared to the 23 patients in the ART group, with 73% of PFPP patients meeting criteria for "response," compared to just 39% of those in the ART cohort. Even more important, moderator analyses (Milrod, Leon, Barber et al., 2007) revealed that PFPP was particularly useful for panic patients who had a comorbid personality disorder. This is important given that a host of reviews suggest that anxiety patients with comorbid personality disorders do not benefit as much in standard CBT as those without the comorbidity (Brooks, Baltazar, & Munjack, 1989; Massion, Dyck, Shea, Phillops, Warshaw, & Keller, 2002; Noyes et al., 1990; Pollack, Otto, Rosenbaum, & Sacks, 1992; Reich & Green, 1991; Yonkers, Dyck, Warshaw, & Keller, 2000; see review by Mennin & Heimberg, 2000). If replicated, these results would make Panic Focused Psychodynamic Psychotherapy the treatment of choice for patients with panic disorder and personality disorder.

A second RCT for panic disorder (Beutel et al., 2013) compared PFPP with CBT and found no differences in remission rates or difference in symptom change scores between PFPP and CBT when taking patient baseline level of emotional processing into account. Taken together, PFPP has proved its effectiveness in two independent RCTs, both against a fair TAU group as well as against a strong CBT comparator.

For generalized anxiety disorder, Leichsenring and colleagues (2009; Salzer, Winkelbach, Leweke, Leibing, & Leichsenring, 2011) found no differences between STPP and CBT with regard to expert-rated symptom reduction in a small RCT. Regarding social phobia, a large multicenter RCT comparing STPP with CBT found both treatments to be equally effective with regard to response rates and more effective than

a waitlist control group (Leichsenring et al., 2013). In the short term, the CBT group had higher remission rates, but these differences disappeared in the two-year follow-up assessment (Leichsenring, 2013). Finally, one RCT found that psychodynamic treatment combined with pharmacotherapy was more effective in preventing relapse for panic disorder than pharmacotherapy alone (Bressi et al., 2010).

Somatic Symptoms

There are a growing number of studies showing evidence for the effectiveness of PDT in treating psychosomatic symptoms. In one RCT, 16 sessions of STPP added to the medical treatment as usual (TAU) were more effective than the medical treatment alone in patients with functional dyspepsia (Faramazi et al., 2013). Another RCT on women with breast cancer and comorbid depression found psychodynamic group psychotherapy to be more effective with regard to depression, quality of life, and other variables than TAU (Beutel et al., 2013). While some studies failed to find a superiority of PDT over specialized enhanced primary care (see for example Scheidt et al., 2013), two recent meta-analyses on the impact of STPP on somatic symptoms (Abbass, Kisely, & Kroenke, 2009) and general psychotherapeutic approaches on severe somatoform disorder (Koelen et al., 2014) present compelling evidence on the effectiveness of psychotherapeutic interventions in this difficult to treat patient group. Koelen and colleagues found a slight superiority of psychodynamic over CBT approaches on the improvement of patient functioning, though not on symptom change. Especially relevant for GPs are findings that additional, psychodynamically informed group therapy reduced symptom distress and GP visits in an RCT with difficult to treat patients with medically unexplained symptoms (Schaefer et al., 2013).

Eating Disorders

Several randomized control trials have examined psychodynamic treatment for eating disorders (Bachar, Latzer, Kreitler, & Berry, 1999; Crisp et al., 1991; Dare, Eisler, Russell, Treasure, & Dodge, 2001; Fairburn, Kirk, O'Connor, & Cooper, 1986; Garner et al., 1993; Gowers, Norton, Halek, & Crisp, 1994; Hall & Crisp, 1987; Russell, Szmukler, Dare, & Eisler, 1987). The general finding was that for anorexia nervosa, psychodynamic treatment is as effective as other treatments, including

behavioral and strategic family therapy (Crisp et al., 1991; Dare et al., 2001; Gowers et al., 1994; Hall & Crisp, 1987; Russell et al., 1987). Gowers et al. found significant improvements in weight and body mass index as compared to a TAU control condition. Dare and colleagues found that both psychodynamic psychotherapy and family therapy were significantly superior to routine treatment in terms of weight gain. With regard to bulimia nervosa, Fairburn et al. (1986) and Garner et al. (1993) found that psychodynamic and CBT treatments resulted in comparable improvements in bulimic episodes and self-induced vomiting although CBT was superior on other measures of general psychopathology. At follow-up both were equally effective and superior to pure behavior therapy (Fairburn et al., 1995) suggesting that both CBT and psychodynamic treatment are preferred choices over behavior therapy. On the other hand, a very recent study on the treatment of bulimia nervosa compared a non-directive psychodynamic therapy with a shorter but highly specific CBT intervention. Both led to significant symptom improvement, but the CBT intervention was more effective (Poulsen et al., 2014). More research is needed on the effectiveness of PDT in bulimia.

In the Anorexia Nervosa Treatment of Outpatients (ANTOP; Zipfel et al., 2014) trial, the largest study to date on the treatment of anorexia nervosa, 242 women were randomized to either 40 hours of focal STPP, enhanced CBT, or optimized treatment as usual by experienced community therapists. All three treatments were effective with regard to weight gain. However, there were more dropouts in the treatment by community TAU experts than in both manualized intervention groups. While STPP was equally effective as CBT at the end point of treatment, only psychodynamic therapy was more effective than TAU by community experts at 12-months follow-up.

Marital Therapy

In a controlled outcome study, Snyder, Wills, and Grady-Fletcher (1991) followed up 59 couples four years after receiving either behavioral or insight-oriented marital therapy. There were no group differences between the two treatment conditions at either termination or six-month follow-up. However, at four-year follow-up couples who received the insight-oriented therapy were more likely to be happily married (79% vs. 50%), whereas the couples who received the behavioral therapy were more likely to be divorced (38% vs. 3%).

Schizophrenia

There is clear evidence for the limited efficacy of CBT in the treatment of schizophrenia. In this context, a recent review conducted by the rigorous standards of the Cochrane Collaboration found other “active” psychological interventions equally effective (Jones, Hacker, Cormac, Meaden, & Irving, 2012). Furthermore, results from new trials on alternate approaches yield promising results, allowing patients to have a wider variety of treatment options. For example, in a controlled study, a manual-based supportive psychodynamic psychotherapy showed large effects in general as well as in specific treatment domains in patients with a first episode of psychosis after two years of treatment (Rosenbaum et al., 2012). In addition, it was more effective in the improvement of overall symptoms and functioning than TAU, with small to medium effects. These results are in line with an earlier study by Rosenbaum and colleagues (2006), where one weekly session of supportive psychodynamic psychotherapy was more effective than TAU, and as effective as a time-intensive, multimodal treatment after one year.

SUMMARY OF EMPIRICAL FINDINGS WITH PSYCHODYNAMIC PSYCHOTHERAPY

In summary, psychodynamic psychotherapy appears to be as effective as other treatments: effect sizes from meta-analyses suggest that it is equally, and sometimes even more effective than other psychotherapy, as effective as CBT, and often more effective than antidepressants. Although controversial, there are also a number of reasons to suggest the value of longer-term psychodynamic treatments for depression and anxiety. First, the long-term outcome and relapse rates from studies of depression strongly suggest the need for more intensive treatment. Despite reasonable short-term efficacy, the long-term efficacy of short-term versions of CBT, IPT, and PDT, as well as for medication treatment is poor. Second, there is an established literature showing that short-term treatments tend to ameliorate demoralization and symptoms but do not lead to more established rehabilitative changes in personality and functioning (Howard, Lueger, Maling, & Martinovich, 1993). These two sets of findings taken together suggest the need for longer and more intensive interventions. Third, there are findings from meta-anal-

yses, particularly of within-group effects that have found large effects for longer-term treatments (de Maat, de Jonghe, Schoevers, & Dekker, 2009; Leichsenring & Rabung, 2008, 2011). Finally, there are a number of quasi-experimental as well as experimental studies (i.e., RCTs) that have found superiority for longer-term PDT as compared to short-term (Knekt et al., 2008; Knekt, Lindfors, Laaksonen et al., 2011; Knekt, Lindfors, Renlund et al., 2011). Across individual studies, both experimental studies such as RCTs and more naturalistic studies, as well as multiple meta-analyses, and across a number of disorders, the findings are quite consistent in suggesting the value of psychodynamic psychotherapy in reducing the burden of mental illness. Empirical support for the usefulness of PDT exists for the treatment of depression, anxiety disorders, eating disorders, personality disorders, substance abuse, somatic symptoms, and marital discord. Emerging evidence also points toward the effectiveness of PDT for schizophrenia.

COMMON MISCONCEPTIONS ABOUT PSYCHOTHERAPY AND MEDICATION

There are a variety of commonly held misconceptions among clinicians as well as patients with regard to psychotherapy outcome as compared with medication management. Medications are often prescribed as a first-line intervention for the treatment of depressive and anxiety disorders (Otto, Smits, & Resee, 2005). However, the evidence that these disorders often respond more reliably to psychotherapeutic intervention (often with fewer untoward effects) is frequently neglected.

Results of both individual RCTs and meta-analytic reviews suggest that for a range of disorders such as borderline personality disorder, depressive disorders, and many anxiety disorders, psychotherapy should be the first line and/or primary treatment (DeRubeis, Siegle, & Hollon, 2008; Fournier et al., 2010; Hollon et al., 2005; Wexler & Cicchetti, 1992). For borderline personality disorders, medications can be an important augmentation, by taking the edge off certain symptoms, although their use can also result in iatrogenic problems (Frankenburg & Zanarini, 2006, 2011). For depression, medications may be indicated when depression is severe and includes neurovegetative signs or there is a worsening clinical picture. Some have noted that in these cases medications can help the patient be more available for psychotherapy (Roose & Johannet, 1998)—while this might be true, especially in the case of neurovegetative signs, such an understanding is very different from medications serving as the only treatment provided, as is increasingly the case.

Similar findings exist for anxiety disorders (Otto, McHugh, & Katak, 2010) where the combination of medications and psychotherapy do not yield greater improvements relative to either treatment alone. While medications might be useful for brief periods to help control anxiety, it is important to note that their use often undermines the effectiveness of psychotherapy, particularly CBT and BT approaches that rely on exposure and new learning or extinction (Hart, Panayi, Harris, & Westbrook, 2014; Otto, McHugh, & Katak, 2010).

With regard to the treatment of depression, Wexler and Cicchetti (1992) published a meta-analysis examining treatment success rates, treatment failure rates, and treatment dropout rates. Findings indicated that although psychotherapy and medications were both effective, psychotherapy produced a higher success rate (47%) than medication (29%) and that the combination of the two did not provide any additional benefit over that of psychotherapy alone (47%); however, adding psychotherapy to medication did provide some benefit over medication alone (47% for the combined psychotherapy and medication). Moreover, the use of medication, either alone or in combination with psychotherapy resulted in increased risk of dropout from treatment and other negative side effects. Thus they concluded with the very reasonable recommendation that the first-line treatment for depression should be a course of individual psychotherapy rather than exposing patients to unnecessary costs and side effects associated with combined treatment or medication alone. Only if there is no improvement in four months of treatment, or if there is a worsening of symptoms, should medication be introduced. Shortly after this publication, a letter to the editor chastised Wexler and Cicchetti's conclusion that psychotherapy be considered the initial treatment of choice by noting that it was difficult to imagine insurance companies adhering to their recommendation. Wexler and Cicchetti responded that if that was true it would be a shame because they would be ignoring the data. Since that meta-analysis, there have been many additional studies and meta-analyses examining psychotherapy, medication, and their combined effects in the treatment for depression (Huhn et al., 2014). The general effect sizes from meta-analyses for psychotherapy tend to be considerably larger than the effect sizes found in meta-analyses examining medication (effect size estimates = 0.31 for medications vs. effect size estimates ranging from .85 to 1.48 for psychotherapy; see Shedler, 2010); however, the few studies that directly compare psychotherapy and medication tend not to reveal consistent differences between the two treatments. In contrast to the findings of Wexler and Cicchetti, a few meta-analytic studies do find the combination of psychotherapy and medication to be superior to either alone with regard to outcome (Cuijpers et al., 2014). However,

psychotherapy consistently has lower rates of dropout and obviously fewer medication-rated side effects and the introduction of medication raises dropout for psychotherapy, although when in combination with psychotherapy, medication dropout is reduced. Further, much of this effect for antidepressants is only with those patients who exhibit neurovegetative signs; for those patients who do not exhibit neurovegetative signs, the effect size for antidepressant treatment is often around zero.

While the data are unclear whether or not augmenting psychotherapy with medications is useful or counterindicated, there is strong evidence that the addition of psychotherapy is a useful augment in the medication treatment of a range of disorders including ADHD, bipolar disorder (Miklowitz, 2008), and even schizophrenia (Brus, Novakovic, & Friedberg, 2012; Dixon et al., 2010; Gottdiener, 2006), and moreover, having good psychotherapeutic skill aids in the prescribing of medications and increases its effects (Blatt, Sanislow, Zuroff, & Pilkonis, 1996).

CONCLUSION

The under-provision and declining utilization of psychotherapy in the U.S. is not warranted in light of the strong evidence base for psychotherapy as evidenced in our broad review focused on psychodynamic psychotherapy as an exemplar. This situation represents a significant problem for the implementation of the Affordable Care Act. We would suggest that to the degree that decreasing reimbursement for psychotherapy relative to medication fuels declining utilization, the shift away from psychotherapeutic treatment relative to medication is "penny wise and pound foolish." This may be especially pronounced in relation to the costs incurred, by both patients and society at large, in the management of complex mental disorders.

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The Cost-Effectiveness of Psychotherapy for the Major Psychiatric Diagnoses

Susan G. Lazar

Abstract: Psychotherapy is an effective and often highly cost-effective medical intervention for many serious psychiatric conditions. Psychotherapy can also lead to savings in other medical and societal costs. It is at times the first-line and most important treatment and at other times augments the efficacy of psychotropic medication. Many patients are in need of more prolonged and intensive psychotherapy, including those with personality disorders and those with chronic complex psychiatric conditions often with severe anxiety and depression. Many patients with serious and complex psychiatric illness have experienced severe early life trauma in an atmosphere in which family members or caretakers themselves have serious psychiatric disorders. Children and adolescents with learning disabilities and those with severe psychiatric disorders can also require more than brief treatment. Other diagnostic groups for whom psychotherapy is effective and cost-effective include patients with schizophrenia, anxiety disorders (including posttraumatic stress disorder), depression, and substance abuse. In addition, psychotherapy for the medically ill with concomitant psychiatric illness often lowers medical costs, improves recovery from medical illness, and at times even prolongs life compared to similar patients not given psychotherapy.

While “cost-effective” treatments can yield savings in healthcare costs, disability claims, and other societal costs, “cost-effective” by no means translates to “cheap” but instead describes treatments that are clinically effective and provided at a cost that is considered reasonable given the benefit they provide, even if the treatments increase direct expenses.

In the current insurance climate in which Mental Health Parity is the law, insurers nonetheless often use their own non-research and non-clinically based medical necessity guidelines to subvert it and limit access to appropriate psychotherapeutic treatments. Many patients, especially those who need extended and intensive psychotherapy, are at risk of receiving substandard care due to

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inadequate insurance reimbursement. These patients remain vulnerable to residual illness and the concomitant sequelae in lost productivity, dysfunctional interpersonal and family relationships, comorbidity including increased medical and surgical services, and increased mortality.

This article is a comprehensive review of the medical literature from 1984–2012 that is relevant to the cost-effectiveness of psychotherapy. With the passage of the Mental Health Parity and Addiction Equity Act (MHPAEA), insurance companies are required to provide coverage for psychiatric care at parity with other medical care. Many insurance companies unfortunately have found ways to evade the mandate, which is currently not being adequately enforced. In order to understand the basic issues in the struggle for coverage of appropriate treatment, some background information is necessary.

Clearly any statement claiming that a treatment should be covered under insurance must provide evidence for its effectiveness and ideally, its cost-effectiveness. “Cost-effectiveness” is not synonymous with “effectiveness” or “efficacy”—it refers to the financial cost of a treatment and relates it to specific outcome measures of effectiveness (Cellini & Kee, 2010). In essence, it signifies the impact per dollar spent. A systematic cost-effectiveness analysis, for example, can be calculated by comparing the incremental cost-effectiveness ratios—a ratio of incremental cost to incremental effect—of two different interventions. While many psychiatric patients improve with relatively brief courses of treatment, there are also important groups that are very costly to society if inadequately treated. Studies show that these patients often require more intensive and/or extended psychotherapy than most insurance companies are willing to support, despite the research that suggests the need for more care for these patients to achieve recovery as well as savings that often result from decreased medical expenses and improved productivity. However, insurance companies tend to focus on controlling short-term immediate costs and not long-term planning and thorough treatment that might lead to better health outcomes and savings in the budgets of other parties.

In fact, the increased medical expenses of the psychiatrically ill, compared to medical patients without a psychiatric illness, are a hidden multiplier of medical budgets. Melek and Norris (2008) found that when they studied an insured group, patients with psychological disorders had increased medical costs that represented 21.1% of total health-care costs of the whole group. In this same study, 40% or more of high utilizers of healthcare had depression, anxiety, or dysthymia, but only 20% of their increased medical costs were attributable to their psychiat-

ric care (Melek & Norris, 2008). Luber et al. (2000) reviewed the records of 15,186 outpatients at an internal medicine clinic at Weill Medical College of Cornell and found that patients diagnosed with depression had more primary care visits, higher total outpatient charges, greater resource utilization of all types, and longer hospital stays even after controlling for the higher burden of comorbid illness associated with their depression. In one study at a Veterans Administration facility, patients with posttraumatic stress disorder (PTSD), either alone or in combination with depression, also exhibited higher use and accrued higher costs of non-psychiatric medical care (Deykin et al., 2001). It was found that the higher use and costs were related significantly to the patient's increased number of medical conditions, highlighting for these authors the fundamental linkage between mental and physical health. A high percentage of the psychiatrically ill are never even diagnosed; for those who are, a majority receive inadequate treatment (Wang, 2005a, 2005b). Simply put, patients with chronic, complex, and/or recurrent psychiatric illness have more medical conditions and higher medical costs. These patients can often be treated with psychotherapy that yields better mental health and overall health outcomes. Yet these facts are unfortunately ignored by many insurance companies intent on minimizing reimbursement and evading the mandate for mental health parity.

Among other evidence-based psychiatric treatments, psychotherapy is a vital, cost-effective, and often cost saving component of care for certain patient populations (Lazar, 2010). Unfortunately, there is a serious lack of awareness of the research and clinical experience validating it—a deliberate and nuanced evasion of the MHPAEA of 2008 by insurers, and a refusal to reimburse appropriately for psychotherapy and other clinically indicated psychiatric services. Reimbursement denials are often based on the non-research and non-clinically established medical necessity guidelines of insurance companies, their behavioral managed care components, and independent review organizations (see Bendat, 2014, this issue).

By short-changing those who need an appropriate course and type of psychotherapy, we ignore the fact that we are being “penny (and profit) wise” in the short run for an individual company and very much “pound foolish” in the long run for the broader community. Inadequate psychiatric care often yields increased medical costs, debility, and decreased worker productivity impacting businesses and the economy, all in addition to the disability, morbidity, and mortality suffered by patients and their families. Studies focusing on the patient groups who require an extended course of psychotherapy to improve and who are

most at risk for insufficient insurance reimbursement will be emphasized in this article and discussed first.*

PATIENTS WHO REQUIRE INTENSIVE AND EXTENDED PSYCHOTHERAPY: PERSONALITY DISORDERS, CHRONIC COMPLEX DISORDERS, CHRONIC UNIPOLAR DEPRESSION, COMORBID CHRONIC DEPRESSION, AND PERSONALITY DISORDERS

Patients who need intensive (more than once weekly) and extended (generally more than 20 sessions) psychotherapy treatment are those with chronic, debilitating personality disorders and those with chronic, complex disorders such as severe longstanding depression and anxiety, as well as patients with multiple chronic psychiatric disorders. These patients are among the most seriously ill and are frequently not adequately treated with psychotherapy, due to arbitrary limits on reimbursement for psychotherapy by insurance companies (Bendat, 2014, this issue).

Patients with *personality disorders* have deeply ingrained, maladaptive, and inflexible ways of thinking and behaving that generally lead to impaired relationships with others. Such patients are enormously costly to society, are among the most chronically impaired groups in psychiatric populations, are unemployed for longer periods, and have more drug problems, suicide attempts, interpersonal difficulties (Gabbard, 2000; Linehan & Heard, 1999; Pilkonis, Neighbors, & Corbit, 1999; Reich, Yates, & Nduaguba, 1989), criminal behavior, divorce, child abuse, and heavy use of mental and general health care (Skodol, Gunderson, et al., 2005). The lifetime prevalence of personality disorders is between 10% and 13.5% (Casey & Tyrer, 1986; Lenzenweger, 2008; Maier, Lichtermann, Klingler, Heun, & Hallmayer, 1992; Reich, Nduaguba, & Yates, 1988; Zimmerman & Coryell, 1990), affecting at least 30 million Americans of all social classes, races, and ethnicities.

Hadjipavlou and Ogrodniczuk (2010) reviewed a number of randomized clinical trials (RCTs) of different psychotherapy treatment ap-

*Much of the following material was also referenced in a systematically searched, comprehensive review of 23 years [1984–2007] of the medical literature relevant to the cost-effectiveness of all varieties of psychotherapy published in *Psychotherapy Is Worth It: A Comprehensive Review of Its Cost-Effectiveness* [Lazar, 2010]. In addition, more recent studies [2007–2012] have been included for this article using the search terms: cost + [specific diagnosis] + psychotherapy; cost-effectiveness + [specific diagnosis] + psychotherapy; long-term psychotherapy + cost; extended psychotherapy + cost.

proaches for personality disorders that demonstrated the effectiveness of both cognitive behavioral therapy (CBT) and psychodynamic specialized treatments. Effectiveness was measured by reduced symptomatology, improved social and interpersonal functioning, and decreased hospitalization. Equivalent effects among the interventions they compared were common. The authors referenced the British Health Service National Institute for Health and Care Excellence (NICE) clinical guideline (2009), which cautions against the use of brief psychological interventions especially for borderline personality disorder (BPD) stating, “. . . there is perhaps an even stronger signal that longer treatments with higher doses are of greater benefit. In several studies, significant improvement was only observed after 12 months of active treatment” (p. 207). In an editorial review of a number of studies, Anthony Bateman (2012) has also reiterated the point that a number of carefully designed psychotherapies for borderline personality disorder appear to be effective including transference-focused psychotherapy (TFP), dialectical behavior therapy (DBT), supportive psychotherapy, and structured clinical management (Bateman & Fonagy, 2009; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991; McMMain, Guimond, Streiner, Cardish, & Links, 2012).

Psychotherapy is also effective and cost-effective for patients with severe personality disorders including antisocial, narcissistic, and borderline personality disorders (Soeteman et al., 2010).

Patients with personality disorders or chronic, complex disorders (including serious longstanding anxiety and depression) tend to have disturbed interpersonal relationships. While psychotherapy of different approaches improves symptoms, a number of studies imply that psychodynamic treatments are significantly superior in improving maladaptive interpersonal relationships (Huber, Zimmerman, Henrich, & Klug, 2012; Leichsenring & Rabung, 2008; Levy et al., 2006; Shedler, 2010), a highly significant risk factor for increased mortality exceeding smoking, alcoholism, obesity, and hypertension (Holt-Lunstad, Smith, & Layton, 2010). For those who require an extended course of psychotherapy due to their mental illness, both longer duration and higher frequency of psychotherapy have independent positive effects. Together, these factors are associated with the most positive treatment outcomes (Grande et al., 2006; Rudolf, Manz, & Ori, 1994; Sandell et al., 2000). Leichsenring and Rabung (2008) found that long-term psychodynamic psychotherapy is significantly more effective and provides greater improvements in symptoms and personality functioning as compared to briefer treatments for such patients. In an update, Leichsenring and Rabung (2011) performed another meta-analysis of ten prospective studies. The authors examined controlled trials of long-term psycho-

dynamic psychotherapy (LTPP) that had patients in LTPP for at least a year or at least 50 sessions, and used reliable outcome measures, totaling 971 patients with chronic complex disorders. They found that LTPP was superior to less intensive forms of psychotherapy and that outcome and duration of psychotherapy were positively correlated. Shedler (2010) showed that when compared to patients treated with other psychotherapies, patients treated with psychodynamic psychotherapy better maintain therapeutic gains and continue to improve after treatment ends. The factors that contribute to the cost-effectiveness of extended intensive psychotherapy for these patients include savings from decreased sick leave, and decreased medical costs and decreased hospital costs (Bateman & Fonagy, 1999; Bateman & Fonagy, 2003; Bateman & Fonagy, 2008; Clarkin et al., 2001; Clarkin, Levy, Lenzenweger, & Kernberg, 2007; Dossmann, Kutter, Heinzl, & Wurmser, 1997; Duehrssen, 1962; Duehrssen & Jorswiek, 1965; Hall, Caleo, Stevenson, & Meares, 2001; Heinzl, Breyer, & Klein, 1996; Keller, Westhoff, Dilg, Rohner, & Studt, 1998; Levy et al., 2006; Meares, Stevenson, & Comerford, 1999; Stevenson & Meares, 1992; Stevenson & Meares, 1999; Teufel & Volk, 1988; van Asselt, Dirksen, Arntz et al., 2008).

With regard to BPD, Gregory, DeLucia-Deranja, and Mogle (2010), found that treating alcoholic BPD patients with a 12-month dynamic psychotherapy program resulted in a large, sustained improvement in core BPD symptoms and substance abuse symptoms, 18 months after treatment. In a study of 12 months of DBT (van den Bosch, Verheul, Schippers, & van den Brink, 2002), a similar improvement was achieved for borderline patients with substance abuse. These patients however, did not retain their improvement and returned to pre-treatment levels of heavy drinking and drug use at six-month follow-up. These authors state that there is no empirical support that the core pathology of patients with BPD (unstable relationships, primitive defenses, identity disorder, and boredom) is affected by one year of DBT. They also suggest that intrapsychic elements of this pathology may be more positively affected by psychodynamic psychotherapy. Levy et al. (2006) and Clarkin et al. (2007) also found that dynamic psychotherapy leads to broader personality changes than supportive or DBT for borderline personality disorder.

Many other studies indicate that borderline patients take significantly longer to improve than patients with less severe anxiety and depressive disorders and need longer-term treatment (Fonagy, 2002; Høglend, 1993; Howard, Kopta, Krause, & Orlinsky, 1986; Kopta, Howard, Lowry, & Beutler, 1994; Levy, Meehan, & Yeomans, 2010; Seligman, 1995). In the Borderline Personality Disorder Study of Cognitive Therapy (BOSCOT) trial, patients received either 30 sessions of individual CBT-

PD (CBT for personality disorders) over one year, or treatment as usual. Six years later the CBT-PD did provide therapeutic gains but was not more cost-effective and quality of life and affective regulation remained poor. Of note, these authors also referenced the NICE guidelines to the effect that twice-weekly psychotherapy sessions may be considered for these patients and brief psychotherapeutic interventions (of less than three months' duration) are not to be used (NICE, 2009; Palmer, Davidson, Tyrer et al., 2006).

In a prospective study of 100 patients with unipolar depression, Huber et al. (2012) investigated the effectiveness of long-term cognitive behavior, psychoanalytic and psychodynamic therapies, measuring outcomes pre-treatment, post-treatment, and at three-year follow-up. All three therapies yielded a similar improvement in patients' depressive symptoms immediately after treatment. The CBT and psychodynamic therapy groups were not significantly different in depressive symptoms at three-year follow-up, while the psychoanalytically treated group was significantly improved in depressive symptoms at the three-year point. Both the psychoanalytically treated and psychodynamic therapy groups had fewer interpersonal problems than the CBT group at both post-treatment measurement points. The improvement in interpersonal problems was the only detectable superiority of psychodynamic therapy over CBT, while the psychoanalytically treated group had significantly greater improvement in general distress and interpersonal problems immediately after treatment, and in depressive symptoms, general distress, interpersonal problems, and self-schema than the CBT group at three-year follow-up.

Blatt, Quinlan, Pilkonis, and Shea (1995) re-examined data from the National Institute of Mental Health Treatment of Depression Collaborative Research Program and found that perfectionistic patients did especially poorly in all brief treatments. An earlier publication (Blatt, 1992) indicated that perfectionistic patients fare better in more intensive, extended psychoanalytic treatment than in less intensive long-term therapy. Fava, Ruini, and Belaise (2007) reviewed the literature on the unsatisfactory degree of remission that current therapies yield for unipolar depression. They point out that seemingly successful treatment is often accompanied by residual symptoms which have a strong prognostic value that can progress to become prodromal symptoms of recurrence, and are likely the most consistent predictors of relapse. Dysfunctional social and interpersonal patterns are positively correlated with persistent depression and relapse and are correlated with poor long-term outcome. The authors conclude that the fact that a patient no longer meets syndromal criteria is insufficient to designate full recovery despite the fact that the number and quality of sub-syndromal

symptoms is often not specified in treatments judged to be successful. Accordingly, treatments are needed that address ongoing characterological traits that put patients at risk for recurring illness. A number of studies point to psychodynamic treatments as having greater efficacy with these traits (Clarkin et al., 2007; Huber et al., 2012; Leichsenrung & Rabung, 2008; Levy et al., 2006; Shedler, 2010). And demonstrating the impact of LTPP on the brain, Buchheim et al. (2012) published the first study documenting treatment-specific changes in the limbic system and regulatory regions in the prefrontal cortex associated with improvement in depression after LTPP.

Additional studies specifically link personality disorders with treatment resistant, persistent, and recurrent depression. Skodol, Grilo, et al. (2005) concluded that patients with major depressive disorder and co-occurring personality disorder had significantly more role limitations due to emotional problems, impaired social functioning, and general health perceptions than patients with major depressive disorder alone. Markowitz et al. (2007) found that poor psychosocial functioning can compound the impairments of major depressive disorder, and affect the course of the illness. Furthermore, subjects whose personality disorders remitted showed improvement in social functioning and were more likely to achieve remittance of their depression than those with major depression and persisting personality disorders—the group that functioned poorest. These authors concluded that both personality and mood disorders need to be treated in comorbid patients, since the course of personality psychopathology influences depressive outcome as well as psychosocial functioning.

Grilo et al. (2010) also found that patients with major depressive disorder (MDD) and personality disorders at baseline had significantly longer time to remission than patients with major depression without personality disorders. In particular, they found borderline and obsessive-compulsive personality disorders at baseline to be robust predictors of accelerated relapse after remission from an episode of major depressive disorder, even when controlling for other negative prognostic predictors. Similarly, in a study of a nationally representative sample of adults, Skodol et al. (2011) found personality disorders to be negative prognostic indicators for the course of major depressive disorder. Borderline personality disorder emerged as a particularly robust independent predictor of chronicity (accounting for approximately 57% of persistent cases) and also as the strongest predictor of persistence of major depressive disorder, followed by schizoid and schizotypal personality disorder, any anxiety disorder (the strongest Axis I predictor) and dysthymic disorder. Taking the long view from a cost-effective perspective, it would seem clear that patients with major depression and

a comorbid personality disorder need both illnesses treated to avoid recurrent and persistent depressive illness even when the treatment of the personality disorder may require a longer and more intensive treatment.

In a study of outpatients with a mixture of diagnoses, De Maat, Philipszoon, Schoevers, Dekker, and De Jonghe (2007) examined a total of 861 patients who were either in LTPP, receiving an average of 139 sessions, or in psychoanalytic treatment, receiving an average of 413 sessions. The patients had common Axis I and II disorders, excluding those with disorders generally treated in institutions. Patients treated with LTPP had substantially reduced healthcare use and sick leave. The effects endured after termination and counterbalanced the cost of treatment in about three years after treatment. In a subsequent publication, De Maat, de Jonghe, Schoevers, and Dekker (2009) reviewed 27 studies ($n = 5063$) to examine the overall effectiveness of long-term psychoanalytic therapy and psychoanalysis and their impact on symptom reduction and personality change at treatment termination and at follow-up. Both long-term psychotherapy and psychoanalysis yielded large effect sizes for improvements in moderate and severe pathology at termination and follow-up. Costs and efficacy of psychoanalysis versus psychoanalytic therapy are reported by Berghout, Zevalink, and Hakkaart-van Roijen (2010a, 2010b) in two publications. Berghout and colleagues report that psychoanalysis, with its greater frequency, is more costly but more effective from a health-related quality perspective, and that long-term psychoanalytic treatment leads to decreased consumption of medical care, higher work productivity, and economic benefits in the long run (Berghout et al., 2010a, 2010b). Beutel, Rasting, Stuhr, Ruger, and Leuzinger-Bohleber (2004) also reported significantly reduced work absenteeism and lowered hospitalization in a seven-year follow-up after psychoanalysis and long-term psychoanalytic therapies.

In addition, studies indicate that intensive psychotherapy is effective for cocaine dependency (Crits-Christoph et al., 1999; Crits-Christoph et al., 2001) and that extended psychotherapy is an effective treatment for eating disorders (Bachar, Latzer, Kreitler, & Berry, 1999) and pain disorders (Monsen & Monsen, 2000).

ANXIETY DISORDERS

Anxiety disorders are the most common American mental health problem affecting 18.1% of adults yearly (Kessler, Chiu, Demler, & Walters, 2005) and in 1990, accounted for an annual cost of \$42.3 billion in medical, psychiatric, medication, mortality, and lost productivity costs

(Greenberg et al., 1999). In a review of economic evaluations and quality of life in patients with generalized anxiety disorder (GAD), Bereza, Machado, and Einarson (2009) concluded that GAD leads to substantial economic cost and morbidity. Patients with GAD are higher users of primary care services than patients with any other psychiatric disorder (Marciniak et al., 2005). GAD is as disabling as mood disorders and more disabling than other anxiety or personality disorders (Kessler, DuPont, Berglund, & Wittchen, 1999).

Posttraumatic Stress Disorder is a debilitating and very costly illness that occurs in at least 14% of Iraq and Afghanistan war veterans (Tanielian & Jaycox, 2008) and in up to 31% of Vietnam War veterans. Veteran with PTSD are five times as likely to be unemployed, two to six times more likely to be substance abusers, and four times more likely to have chronic medical conditions (Kulka et al., 1990). Other patients with PTSD, which has a lifetime prevalence in the U.S. of 6.8% (Kessler, Berglund, et al., 2005), occurs in 23% of those exposed to trauma (Breslau, Davis, Andreski, & Peterson, 1991), leading to high rates of substance abuse and disability. Psychotherapy for PTSD includes a number of effective specialized approaches including psychodynamic, cognitive, and desensitization treatments (Brom, Kleber, & Defares, 1989; Foa, 1997; Foa, Rothbaum, Riggs, & Murdock, 1991; Frueh, Turner, Beidel, Mirabella, & Jones, 1996; Goenjian et al., 1997; Lubin, Loris, Burt, & Johnson, 1998; March, Amaya-Jackson, Murray, & Schulte, 1998). These can lead to significant savings in subsequent medical costs (Dunn et al., 2007).

Other anxiety disorders, including panic, phobic, obsessive-compulsive, and generalized anxiety disorders, can be effectively treated with cognitive-behavioral, supportive, and psychodynamic psychotherapies (Butler, Cullington, Hibbert, Klimes, & Gelder, 1987; Gava et al., 2007; Gilliam, Diefenbach, Whiting, & Tolin, 2010; Joesch et al., 2012; Landon & Barlow, 2004; Marchand, Roberge, Primiano, & Germain, 2009; McHugh, Smits, & Otto, 2009; Milrod et al., 2007; Roberge, Marchand, Reinhartz, & Savard, 2008; Tolin, Diefenbach, & Gilliam, 2011; Wiborg & Dahl, 1996). Psychotherapy also enhances the cost-effectiveness of anxiolytic medication (Jenike, 1993). While any effective treatment for this costly illness can be assumed to be cost saving, certain studies have specifically documented these savings (Katon, Roy-Byrne, Russo, & Cowley, 2002; Katon et al., 2006; Salvador-Carulla, Segui, Fernández-Cano, & Canet, 1995). In a review of over 300 randomized controlled trials of CBT for panic disorder, both CBT and pharmacotherapy were found to be effective, individually and in combination. Pharmacotherapy alone proved to be more cost-effective at the end of treatment

while CBT proved to be more cost-effective at the long-term follow-up (Freedman & Adessky, 2009).

DEPRESSION

Depression has a lifetime prevalence in the U.S. of 19.3% with major depression being a common diagnosis affecting 16.6% of adults (Kessler, Berglund et al., 2005). Major Depression occurs in one of every 10 to 20 primary care patients (Halaris, 2011), and in 2001 cost the U.S. \$83.1 billion in medical costs and mortality costs from suicide and lost productivity (Greenberg et al., 2003). Suicide accounts for 1,000 deaths a day worldwide representing 0.9% of all deaths. Two thirds of these suicides are committed by people with depressive disorders (Sartorius, 2001). Psychotherapy has been shown to be both effective and cost-effective for depression by decreasing disability (Kamlet, Wade, Kupfer, & Frank, 1992; Mynors-Wallis, 1996; Rost, Smith, & Dickinson, 2004; Schoenbaum, Sherbourne, & Wells, 2005; Smit et al., 2006), decreasing days in the hospital (Huxley, Parikh, & Baldessarini, 2000; Retzer, Simon, Weber, Stierlin, & Schmidt, 1991; Rosset & Andreoli, 1995; Verbosky, Franco, & Zrull, 1993), and in some studies leading to reductions in total healthcare costs (Browne et al., 2002; Dunn et al., 2007; Edgell, Hylan, Draugalis, & Coons, 2000; Hengeveld, Ancion, & Rooijmans, 1988).

For the treatment of major depressive disorder, behavioral activation and cognitive therapy are more expensive than medication but lead to better recovery with fewer relapses (Dobson et al., 2008). A study by Sava, Yates, Lupu, Szentagotai, and David (2009) showed CBT to be more cost-effective than medication (fluoxetine) alone. In another study (Prukkanone, Vos, Bertram, & Lim, 2012), maintenance CBT yielded the highest cost-effectiveness of all treatments and the lowest cost—amounting to one-third of the cost of maintenance antidepressant medication for major depressive disorder. However, in the six-year Sequenced Treatment Alternatives to Relieve Depression (Star*D), the largest trial of treatment for major depressive disorder, there was no difference in effectiveness between pharmacotherapy and cognitive therapy at any treatment level (Sinyor, Schaffer, & Levitt, 2010).

In a striking study, Nemeroff et al. (2003) found that for patients with major depression and childhood trauma (in contrast to patients with major depression without childhood trauma), the combination of psychotherapy and medication was only marginally superior to psychotherapy alone. For these patients, psychotherapy alone is superior to

antidepressant treatment alone and psychotherapy appears to be an essential element in their treatment. The psychotherapy used in this research was a structured, time-limited treatment with a combination of elements from traditional cognitive-behavioral and interpersonal therapies.

For moderate to severely depressed patients, CBT in combination with pharmacotherapy is more costly but also more cost-effective if the patients' increased work productivity is factored in (Sado et al., 2009). For women patients, brief problem-focused couple's therapy is effective and cost-effective (Cohen, O'Leary, & Foran, 2010), as is psychotherapy for postnatal depression (Morrell et al., 2009).

For bipolar patients, a number of different psychotherapies enhance the effectiveness of medication (Scott & Etain, 2011; Soares-Weiser et al., 2007), increase compliance with medication, and are cost-effective by decreasing relapse and hospitalization (Sachs, 2008; Scott et al., 2009). In inpatient settings, CBT has been shown to decrease readmissions for schizophrenic and bipolar patients but not for major depressive or personality disordered patients (Veltro et al., 2008).

In a brief four-month follow-up of the British Adolescent Depression Antidepressant and Psychotherapy Trial (ADAPT), the addition of CBT to fluoxetine was not cost-effective (Goodyer et al., 2008), and in the Treatment for Adolescent Depression Study (TADS), CBT was not more cost effective than fluoxetine at 12 weeks, but was equally cost-effective by 36 weeks (Domino et al., 2008). In a later publication, Domino et al. (2009) concluded that the combination of fluoxetine and CBT was more cost-effective than fluoxetine alone. This is one of a number of studies that show psychotherapies to be more cost-effective if examined with a longer follow-up period. In another study of depressed adolescents (Weisz et al., 2009), the comparison of CBT versus the usual care of other psychotherapies showed that all led to similarly effective outcomes, but CBT was briefer, cheaper, and more cost-effective in lower-utilizing patients.

The authors of a review of the cost-effectiveness of psychotherapy (Bosmans et al., 2008) were unable to make a firm conclusion on the cost-effectiveness of psychotherapy. The literature review by Wolf and Hopko (2008), found two dynamic psychotherapies and antidepressant medication for primary care patients with major depression to be equally efficacious and cognitive-behavioral and cognitive therapy to be possibly efficacious. Holman, Serfaty, Leurent, and King (2011) found that 12 sessions of CBT for depressed elders in primary care was a more effective treatment than the treatment as usual, but added additional costs. Asarnow et al. (2009) found that very brief CBT for depressed teenagers in primary care decreased the likelihood of the development

of severe depression at six months and had a favorable impact on the course of illness at 18 months.

SCHIZOPHRENIA

According to a study by Saha, Chant, Welham, and McGrath, (2005), schizophrenia has a worldwide prevalence of 4 per 1,000 people, as opposed to the more commonly cited 1% of the entire population (Regier et al., 1993). It is an extremely costly illness due to its severity, chronicity, and associated healthcare and rehabilitation costs for patients, as well as resulting in high losses of productivity for both patients and their caregivers. In 2002 the total U.S. excess societal cost associated with schizophrenia was \$62.7 billion including \$22.7 billion in excess direct healthcare costs (McEvoy, 2007; Wyatt, Henter, Leary, & Taylor, 1995).

For the treatment of schizophrenia, several forms of psychotherapy, including family psychotherapy, social skills training, psychoeducation, personal psychotherapy, and CBT, have been demonstrated to be both effective and cost-effective by restoring functioning and decreasing relapse and medical costs (Bertelson et al., 2008; Dickerson & Lehman, 2006; Falloon, McGill, Boyd, & Pederson, 1987; Girón et al., 2010; Glick, Clarkin, Haas, & Spencer, 1993; Glick et al., 1990; Haas et al., 1988; Heinssen, Liberman, & Kopelowicz, 2000; Hogarty et al., 1986; Hogarty et al., 1991; Karow et al., 2012; Leff et al., 1989; Leff et al., 1990; Lewis et al., 2002; Liberman, Cardin, McGill, & Falloon, 1987; Liberman, Mueser, & Wallace, 1986; Mausbach, Cardenas, McKibbin, Jeste, & Patterson, 2008; Montero et al., 2001; Patel et al., 2010; Rummel-Kluge & Kissling, 2008; Rund et al., 1994; Schmidt-Kraepelin, Janssen, & Gaebel, 2009; Spiegel & Wissler, 1987; Tarrier, Barrowclough, Porceddu, & Fitzpatrick, 1994; Turkington et al., 2008; van der Gaag, Stant, Wolters, Buskens, & Wiersma, 2011; Zhang, Wang, Li, & Phillips, 1994). Adding psychotherapy to psychotropic medication yields significant health gains and is more cost-effective than medication alone (Chisholm, 2005; Chisholm et al., 2008; Gutierrez-Recacha, Chisholm, Haro, Salvador-Carulla, & Ayuso-Mateos, 2006).

SUBSTANCE ABUSE

The U.S. has the highest incidence of substance abuse among the Western democracies (Anthony, Warner, & Kessler, 1994) with astro-

nomical associated costs. From 2000–2004, deaths from tobacco use totaled 443,000 per year while annual losses in productivity amounted to \$96.8 billion (Centers for Disease Control and Prevention [CDC], 2009) and from 1995 to 1999 accounted for \$157 billion annually in health-related costs (Office of National Drug Control Policy, June 2011). In 1987, the prevalence of alcohol abuse was 8.6% to 11.9% of the population (Anthony, Warner, & Kessler, 1994) at a cost of \$99 billion (Rice, Kelman, Miller, & Dunmeyer, 1990). In 2010 half of Americans aged 12 or older used alcohol, amounting to 131.3 million people (Substance Abuse and Mental Health Services Administration, 2011). The medical and indirect costs of street drugs were \$67 billion 20 years ago even before the HIV and crack epidemics (Regier et al., 1993) and cost the U.S. economy more than \$193 billion in 2007, according to a new study by the National Drug Intelligence Center (NDIC, 2011).

Group therapy has some beneficial effects on smoking cessation (Stead & Lancaster, 2005). In one review of behavioral interventions, ranging from minimal to intensive, Murthy and Subodh (2010) found that most of the reviewed studies showed moderate success in smoking cessation in participants at six months. Similarly, Mottillo and colleagues (2009) performed a meta-analysis of 50 RCTs that examined the efficacy of behavioral interventions on smoking cessation. The authors concluded that intensive interventions resulted in substantial increases in smoking abstinence as compared to controls.

For the treatment of alcohol abuse, brief psychological interventions, family therapy, and group therapy are cost-effective, yielding lower alcohol use, decreased emergency room visits, and hospitalizations (Babor et al., 2007; French et al., 2008).

Methadone treatment for opiate users is more effective in combination with more intensive (compared to minimal) psychotherapy (Kraft, Rothbard, Hadley, McLellan, & Asch, 1997).

Cannabis is the most commonly used illicit substance worldwide (United Nations Office on Drug and Crime, 2011). Specialized psychotherapies, such as motivational enhancement, cognitive behavioral, contingency management, and family therapy, are effective and cost-effective interventions for marijuana abusers (Danovitch & Gorelick, 2012; Dennis et al., 2004; Olmstead, Sindelar, Easton, & Carroll, 2007).

In a study of 887 drug and alcohol abusing male veterans (Humphreys & Moos, 2007), 12-step-based self-help groups were more effective and cost-effective than CBT programs at two-year follow-up. In a meta-analysis of 34 well-controlled studies of psychosocial interventions for substance use disorders, effect sizes for the interventions ranged from low to medium for polysubstance use, small to medium for opiate use, medium to large for cocaine use, and moderate to high

for cannabis use (Dutra et al., 2008). Treatment approaches included combined CBT and contingency management, which had the highest effect sizes, and contingency management alone, which had the second highest effect size. CBT alone and relapse prevention alone were among the treatment approaches that lead to low to moderate effect sizes.

THE MEDICALLY ILL WITH COMORBID PSYCHIATRIC ILLNESS

In investigating the costs of comorbid psychiatric illness in medical patients, Levenson, Hamer, and Rossiter (1990) found that 28% of 455 medical inpatients were “very depressed” and another 28% (very anxious) and that those with significant psychopathology had a 40% longer median length of hospital stay, 35% greater mean hospital costs, and more procedures performed than inpatients without psychopathology. Verbosky et al. (1993) found that depressed medical/surgical inpatients had twice as long a hospital stay as those who were not depressed. Browne, Arpin, Corey, Fitch, and Gafni (1990) found that poorly adjusted, chronically ill medical patients had overall medical expenses that were two and a half times greater than those of chronically ill patients who were more well adjusted. Druss, Rosenheck, and Sledge (2000) also found higher rates of work absenteeism and higher medical costs in patients with ongoing mental disorders. In another study, a CBT-based intervention successfully lead to reduced work absenteeism caused by pain-related illness (Ektor-Ankersen, Ingvarsson, Kullendorff, & Ørbæk, 2008).

Psychotherapy for medical patients with cardiovascular disease, diabetes, severe irritable bowel syndrome, rheumatoid arthritis, and for elderly patients with hip fractures is both effective and cost-effective in savings in total healthcare costs (Creed et al., 2008; Davidson, Gidron, Mostofsky, & Trudeau, 2007; Hay, Katon, Ell, Lee, & Guterman, 2012; Katon et al., 2008; Kenardy, Mensch, Bowen, Green, & Walton, 2002; Sharpe, Allard, & Sensky, 2008; Simon et al., 2007; Snoek et al., 2008; Strain et al., 1991). Psychotherapy for cardiac surgery patients can lead to improved mental health and briefer hospital stays (Furze et al., 2009; Lewin, Coulton, Frizelle, Kaye, & Cox, 2009; Dao et al., 2011). Group psychotherapy for patients with hypochondriasis can yield a reduction in medical expenses and overall clinical improvements (Hedman et al., 2010). Proactive psychiatric consultation for medical patients greatly reduces inpatient hospital days and costs (Desan, Zimborean, Weinstein, Bozzo, & Sledge, 2011). Luborsky et al. (2004) also found that patients

have improved general health and lower health care costs after a period of psychotherapy.

With respect to mind-body interactions, psychotherapy has an impact on the brain and has been shown to create similar changes in metabolism as psychotropic medication (Baxter et al., 1992), at times unique positive changes (Karlsson, 2011), and normalizing neurotransmitter metabolism changes (Viinamäki, Kuikka, Tiihonen, & Lehtonen, 1998). Buchheim et al. (2012) published the first study documenting treatment-specific changes in the limbic system and regulatory regions in the prefrontal cortex associated with improvement in depression after long-term psychodynamic psychotherapy.

Psychotherapy has been shown to improve quality of life and at times survival in patients with breast cancer, and malignant melanoma (Caplette-Gingras & Savard, 2008; Fawzy et al., 1990; Fawzy et al., 1993; Spiegel, Kraemer, Bloom, & Gottheil, 1989). Kuchler, Bestmann, Rappat, Henne-Bruns, and Wood-Dauphinee (2007) found better survival rates in patients with gastrointestinal cancers that were given an average of six sessions of mostly supportive psychotherapy. Of those with localized disease, 57% of those who received psychotherapy were alive ten years later compared to 21% not treated. For those with regional involvement, 13% of those given psychotherapy survived compared to 2% of those who did not. Receiving psychotherapeutic support was an independent prognostic factor for survival at ten years.

PSYCHOTHERAPY FOR CHILD AND ADOLESCENT PATIENTS

Since children are not wage earners, data for this population demonstrating savings from lowered disability subsequent to psychotherapy are unattainable. One can, however, arrive at the conclusion, from data that we do have, that efficacious psychotherapy for children and adolescents leads to both reduced medical visits (Finney, Riley, & Cataldo, 1991), better control of chronic illness (Moran, Fonagy, Kurtz, Bolton, & Brook, 1991), and reductions in arrests, institutionalizations, and social service support for patients with ADHD—all of which incur significant societal costs (Satterfield, Satterfield, & Schell, 1987; Weiss & Hechtman, 1986). Four meta-analyses of more than 200 separate studies of psychotherapy for children and adolescents demonstrate the effectiveness of a variety of psychotherapeutic interventions in which the treated patients improved more than three-fourths of the untreated group (Casey & Berman, 1985; Kazdin, Bass, Ayers, & Rodgers, 1990; Weisz & Weiss, 1993; Weisz, Weiss, Alicke, & Klotz, 1987).

Psychotherapy increases the effectiveness of psychotropic medication for children with ADHD (Jensen et al., 2005) and for adolescents with depression (March et al., 2007). Heinicke and Ramsey-Klee (1986) found that for 7- to 10-year-old children with learning disorders, greater improvement was provided by four times per week psychodynamic psychotherapy than one time per week, and furthermore, that the improvement was sustained at one-year follow-up. Intensive psychoanalytic psychotherapy is also helpful for children and adolescents in regulating brittle diabetes (Moran et al., 1991).

In a large study at the Anna Freud Center in London (Fonagy & Target, 1994; Target & Fonagy, 1994a, 1994b) the charts of 763 children were reviewed to investigate the impact of intensive versus non-intensive psychotherapy for children with different disorders, including children with disruptive disorders. Severely impaired children did better with intensive treatment (three to five sessions per week) and did not respond well to less frequent psychotherapy. Increased intensity of treatment was significantly related to improvement in children under age 12, and while those older than 12 did equally well with intensive or non-intensive treatment, a longer duration of treatment was positively related to better outcome for this age group.

CONCLUSION

In summary, while the efficacy of psychotherapy has been amply demonstrated by many research publications (Levy, Ehrenthan, Yeomans, & Caligor, 2014, this issue) cost considerations are increasingly dominant in all areas of medical care. Policy is increasingly driven by financial considerations including measures of cost-effectiveness and cost-offset, possibly in no area of medicine more than in the provision of treatment for psychiatric patients. Cost-effectiveness signifies the value society is willing to place on a treatment proven to be effective. The costs and effects of an intervention can be expressed as a ratio of its incremental cost to its incremental effect for comparison with the incremental cost/effectiveness ratios of other interventions. Many of the studies summarized here demonstrate cost-effectiveness for the conditions studied. Cost-offset, signifying savings in other medical costs and other budgets, as a result of an effective treatment, can often also be demonstrated by the provision of psychotherapy for a number of conditions. However, the standard of cost-offset as a requirement for provision of an effective and cost-effective treatment is clearly a double standard not employed in the rest of medical care. In other words, one can hardly imagine withholding other effective and urgently required

medical or surgical care only if savings can be demonstrated in overall healthcare or other budgets by virtue of providing it.

Despite passage of the MHPAEA, insurers have continued to apply discriminatory protocols to avoid reimbursement at parity for mental health care. These practices include the use of their own substandard, overly restrictive medical necessity guidelines not recognized by mental health providers or their specialty organizations while otherwise adhering to accepted medical guidelines for other health care services. In addition, insurers of mental health benefits often demand “fail-first” protocols requiring attempts at lower levels of care than clinical situations demand, proof of treatment failures with lower levels of care, and frequent, ongoing evidence of imminent danger of serious regression and threat to life as requirements for continuing insurance coverage. In addition, insurers frequently employ algorithms that illegally impose quantitative limits on mental health services in a manner not employed with other health services. It is hard to imagine how such inhumane protocols are consistent with the ACA’s “essential” benefit mandate which requires the provision of mental health services or would be comparably applied and tolerated in the context of other medical care. While these discriminatory protocols apply throughout the continuum of mental health services, they most consistently target psychotherapy and residential treatment—modalities that are often long term and intensive in the care of complex or chronic psychopathology (Bendat, 2014, this issue).

This review of the psychotherapy research literature yields support for many different kinds of psychotherapy of varying lengths and intensity for the major psychiatric diagnoses. For those who need more to achieve recovery, research indicates that a policy of arbitrarily limiting psychotherapeutic services results in increased costs in medical services, disability, morbidity, and mortality. Nonetheless, the current insurance establishment has reacted with disregard for the cost-effectiveness of providing greater access to and reimbursement for psychotherapy, particularly for psychiatric patients with chronic and complex illnesses who often need a more intensive and extended benefit than insurers are willing to support. In addition to patients with chronic and severe anxiety, depression, and comorbid conditions with more than one chronic mental condition, this group of patients includes those with personality disorders, constituting 10% of the population, or 30 million Americans.

We face the serious danger, now often a reality, of underserving the population most in need because of the influence of economic special interests in shaping policies.

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The Mental Health Needs of Military Service Members and Veterans

Susan G. Lazar

Abstract: The prevalence in active duty military service members of 30-day *DSM-IV* psychiatric disorders, including posttraumatic stress disorders and major depressive disorder, is greater than among sociodemographically-matched civilians. Only 23–40% of returning military who met strict criteria for any mental health problem in 2004 had received professional help in the past year. One-fourth of Regular Army soldiers meet criteria for a 30-day *DSM-IV* mental disorder, two-thirds of whom report a pre-enlistment age of onset. Both pre- and post-enlistment age of onset are predictors of severe role impairment which was reported by 12.8% of respondents. In addition, three-fifths of those with severe role impairment had at least one psychiatric diagnosis. The number of deployments, especially three or more, is positively correlated with all disorders, especially major depressive disorder, bipolar disorder, generalized anxiety disorder, posttraumatic stress disorder, and intermittent explosive disorder. Patients with posttraumatic stress disorder and major depressive disorder frequently have comorbidity with other psychiatric diagnoses and an increased death rate from homicide, injury, and cardiovascular disease, and are at increased risk of medical illness, smoking and substance abuse, decreased employment and work productivity, marital and family dysfunction and homelessness. Active duty suicides have increased from a rate lower than among civilians to one exceeding that in civilians in 2008. Suicides among veterans climbed to 22 per day in 2010 with male veterans having twice the risk of dying from suicide as their civilian counterparts. Associated extremely high costs of psychiatric illness in decreased productivity and increased morbidity and mortality can be ameliorated with appropriate treatment which is not yet fully available to veterans in need. In addition, Veterans Administration/Department of Defense treatment guidelines to date do not recognize the need for intensive and extended psychotherapies for chronic complex psychiatric conditions including personality disorders and chronic anxiety and depressive disorders. It has been suggested that treatment should be available for all military service member mental illness regardless of whether or not it predates military service, a goal which remains distant.

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Especially in the last decade, members and veterans of the uniformed services have been exposed to years of war, multiple deployments, and high levels of psychiatric illness. Within the Veterans Health Administration there is a backlog (claims pending for more than 125 days) in providing medical care and disability benefits in which post-9/11 (Iraq and Afghanistan conflicts) claims make up 23% of the total inventory and 24% of the backlog (“Characteristics of Claims,” U.S. Dept. of Veterans Affairs, 2014). Soldiers are returning home with posttraumatic stress disorder (PTSD), depression, substance abuse, other psychiatric illnesses, and an increased rate of comorbidity with a panoply of medical illnesses. In addition to delays for treatment within the Veterans Health Administration, veterans who seek treatment in the private sector face severe limitation especially in the provision of mental health services because of obstacles to their coverage by insurance companies despite the incorporation of the mandate for mental health parity within the Affordable Care Act (Bendat, 2014, this issue). The high costs from increased medical care, decreased work productivity, and increased morbidity and mortality from veterans’ inadequately treated psychiatric illness is a national crisis that reflects poorly on our commitment to members of our currently all-volunteer armed services.

EPIDEMIOLOGY OF *DSM-IV* MENTAL DISORDERS AND CONSEQUENCES OF POSTTRAUMATIC STRESS DISORDER (PTSD) AND DEPRESSION

In the RAND Corporation’s publication, *The Invisible Wounds of War*, Eibner, Ringel, Kilmer, Pacula, and Diaz (2008) reported that surveys of returning service members and veterans found 13.8% of all previously deployed troops met screening criteria for PTSD, 13.7% met screening criteria for major depression, compared to prevalence of 3.5% and 6.7% respectively in the U.S. civilian population (Kessler, Chiu, Demler, & Walters, 2005), and that only 23% to 40% of those who met strict criteria for a mental health problem in 2004 reported receiving professional help in the past year (Hoge et al., 2004). This rate is similar to the low rates of adequate treatment in the civilian population as reported by Wang et al. (2005).

A more recent report examined data on 5,428 non-deployed Regular Army soldiers in 2011 and found that one-fourth of Regular Army soldiers met criteria for any 30-day *DSM-IV* mental disorder, two-thirds of whom reported pre-enlistment age of onset of at least one 30-day disorder (Kessler et al., 2014). Both pre- and post-enlistment age of onset were predictors of severe role impairment which was reported by

12.8% of respondents, with pre-enlistment age of onset being a more powerful predictor. Of all those with severe role impairment, 61.5% had at least one 30-day *DSM-IV* disorder. Mental disorders are leading causes of U.S. military morbidity, with healthcare appointments and lost work days exceeded only by those caused by injuries. The most prevalent disorders were intermittent explosive disorder (IED; 11.2%), PTSD (8.6%), and attention deficit hyperactivity disorder (7.0%). Other disorders in this report were much less common (3.3%–5.7%). For example, the prevalence of major depressive disorder (MDD) in active duty troops was 4.8% (compared to 0.9% in the civilian population). Defining “internalizing disorders” as those with symptoms of anxiety, depression, and somatic concerns, and “externalizing disorders” as those with symptoms of hyperactivity and aggression, all prevalence estimates for the military (15.0% for any internalizing, 18.4% for any externalizing, and 25.1% for any disorder) were higher than those for the civilian population (5.3% any internalizing, 7.3% any externalizing, and 11.6% any disorder). The number of deployments, especially three or more, was positively correlated with all disorders and especially so with MDD, bipolar disorder, generalized anxiety disorder (GAD), PTSD, and IED. The finding of higher levels of pre-enlistment onset for externalizing disorders in the soldiers surveyed compared to the general population suggests that these disorders are higher in recruits and associated with joining the Army. Soldiers with internalizing disorders, however, had a pre-enlistment onset with prevalence comparable to the civilian population, suggesting that the higher rates of first-onset post-deployment internalizing disorders, including depression, anxiety, and somatic symptoms, are secondary to a higher risk after enlistment. In other words, serving in the military, especially the experience of deployment and increasingly with the number of deployments, leads to increasing anxiety, depressive and somatizing psychiatric illnesses in military service members. In addition never-married soldiers had a lower prevalence than married soldiers of *DSM-IV* disorders, suggesting unique stressors on military marriages.

In the general population 88% of men and 79% of women with PTSD also experience one other disorder in their lifetime. Roughly half of these individuals have three or more comorbid diagnoses (Kessler, Sonnega, Bromet, Hughes, & Nelson, 1995). Additionally, the number of comorbid disorders is positively correlated with PTSD severity (Marshall et al., 2001). Two-thirds of those with PTSD have major depression (Karney, Ramchand, Osilla, Caldarone, & Burns, 2008), which comorbidity has more negative impact than either diagnosis alone, including more suicidal ideation and mental and primary healthcare visits (Campbell et al., 2007). For all patients with PTSD, the most common

comorbidities are depression, substance abuse, and other anxiety disorders (Brady, Killeen, Brewerton, & Lucerini, 2000). Conduct disorders also occur comorbidly (Kessler et al., 1995).

Forty-five to 65% of patients with depression have a comorbid disorder (Kessler et al., 2005; Olfson et al., 1997; Zimmerman, Chelminski, & McDermt, 2002) with major depression most commonly associated with personality disorders (38%), anxiety disorders (36%), nicotine dependence (26%), alcohol abuse (14%), and drug abuse (5%). The most frequently reported personality disorders include obsessive-compulsive, paranoid, and schizoid disorders while the most common anxiety disorders are phobia, generalized anxiety, and social phobia (Hasin, Goodwin, Stinson, & Grant, 2005).

With respect to mortality, patients with PTSD and depression have a higher rate of death by the way of homicide, suicide, unintentional injuries, and cardiovascular disease. Combat Army veterans with PTSD have heightened risk of cardiovascular death, externally caused death, and cancer mortality compared to those without PTSD (Boscarino, 2006). Patients with depression are twice as likely to suffer from coronary heart disease (Rugulies, 2002). Veterans with PTSD also have an elevated incidence of coronary heart disease (Kubzansky, Koenen, Spiro, Vokonas, & Sparrow, 2007). Vietnam veterans with PTSD have more medical complaints than those without (Beckham et al., 1998). Furthermore, depression exacerbates osteoporosis, arthritis, type 2 diabetes, certain cancers, and periodontal disease (Kiecolt-Glaser & Glaser, 2002).

Deployed service members have high levels of somatic complaints with 77% in Iraq and 54% in Afghanistan reporting gastrointestinal illness, 69% reporting respiratory illness, and 35% reporting noncombat injuries, with higher reports of physical problems among those with PTSD and depression (Sanders et al., 2005). Among returning service members with PTSD there is a higher rate of reported abdominal, back, head, and chest pain, dizziness, fainting, racing heart, shortness of breath, bowel, and sexual complaints, and lost workdays. This group reports lower quality of life, health, well-being, and energy. Similar patterns exist for depressed patients (Hoge, Terhakopian, Castro, Messer, & Engel, 2007). Patients with PTSD and depression have increased levels of smoking (Lasser et al., 2000), sexual risk-taking behaviors, and sexually transmitted infections, including HIV (Holmes, Foa, & Sammel, 2005). Patients with PTSD and depression also have an increased prevalence of obesity (Simon et al., 2006; Vieweg, Fernandez et al., 2006; Vieweg, Julius et al., 2006). The stark increased risk among psychiatrically ill veterans for comorbid medical illness was illustrated in one study at a Veterans Administration facility (Deykin et al., 2001) that found that patients with posttraumatic stress disorder, either alone or

in combination with depression, had higher use, and costs, of non-psychiatric medical care. These authors found that higher use and costs were related to a significantly increased number of medical conditions, highlighting the fundamental linkage between mental and physical health.

Patients with substance abuse co-occurring with other psychiatric diagnoses have more severe symptoms and poorer outcomes than patients with a single disorder (Ouimette, Brown & Najavits, 1998). Seventy-five percent of Vietnam combat veterans with PTSD meet criteria for substance abuse or dependence (Kulka et al., 1990). In the general population, depressed patients are 3.7 times more likely to have alcohol dependence, 1.2 times more likely to have alcohol abuse, and 9 times more likely to have drug dependence (Grant et al., 2004). Even short-term drug use during military service has long-term consequences and is associated with alcohol abuse, depression, and poor social adjustment. Vietnam veterans that have continued using opiates after the war are more likely to have a premature death (Price, Risk, Murray, Virgo, & Spitznagel, 2001).

Tobacco-related morbidity and mortality costs the U.S. military \$952 million per year (Robbins, Chao, Coil, & Fonesca, 2000). Smoking also affects employee habits, and is associated with disability, lowered productivity, and greater absenteeism (Helyer, Brehm, & Perino, 1998). Within the population of Vietnam veterans with PTSD, there is a higher prevalence of heavy smoking than in those without PTSD (Beckham et al., 1997). It has been suggested that nicotine alleviates PTSD symptoms of arousal, numbness, and detachment (McFall, Mackay, & Donovan, 1992). Patients with major depression are also more likely to become daily smokers (Breslau, Peterson, Schultz, Chilcoat, & Andreski, 1998). Male patients with PTSD are more likely to abuse alcohol and women with PTSD are at greater risk for comorbid depression (Jacobsen, Southwick, & Kosten, 2001).

The immediate symptoms of post-deployment psychiatric illness affect interpersonal relationships and can worsen over time leading to negative consequences that can accumulate and limit options for productive employment and can trigger a cascade of negative consequences that may affect the life course of the veteran (Caspi, Elder, & Bem, 1987). Early interventions may have important long-term benefit (Karney et al., 2008).

With respect to employment, Vietnam veterans with PTSD are less likely to be employed than those without PTSD (McCarren et al., 1995; Savoca & Rosenheck, 2000; Smith, Schnurr, & Rosenheck, 2005; Zatzick et al., 1997). For this population, the likelihood of securing a job decreases as the severity of symptoms increases (Smith et al., 2005).

Similarly, depression in veterans is associated with a negative effect on employment. Vietnam veterans with depression, PTSD, or substance abuse have significantly lower wages than veterans who do not (Savoca & Rosenheck, 2000). PTSD and depression adversely affect veterans' future employment, productivity, and educational attainment (Karney et al., 2008). Clearly, programs and policies that promote extended healthcare coverage and employment after return from military service are important in addition to psychiatric care for a specific diagnosis.

According to a 2007 publication, 1,000 returning Iraq and Afghanistan veterans are at risk for homelessness (Perl, 2007). Among veterans, psychiatric illness and substance abuse are stronger predictors of homelessness than combat or other military experience (Rosenheck & Fontana, 1994). Post-combat mental disorders also have a negative impact on the families of service members (Galovski & Lyons, 2004). Emotional numbing and avoidance symptoms of PTSD are associated with poor parenting in Vietnam veterans (Ruscio, Weathers, King, & King, 2002). Depression is also associated with increased hostility, irritability, and compromised parenting skills (Downey & Coyne, 1990). The presence of depression in a parent can also have indirect, long-term, deleterious effects in that it can affect the development of their child, and may increase the child's risk for behavior problems, academic problems, and psychiatric illness (Beardslee, Bemporad, Keller, & Klerman, 1983; Beardslee, Versage, & Gladstone, 1998; Cummings & Davies, 1999). Similarly, children of veterans with PTSD have more behavior problems, academic difficulties and a 23% rate of receiving psychiatric treatment (Davidson, Smith, & Kudler, 1989). Overall, there is a greatly increased risk of familial difficulties, distressed relationships, intimate-partner violence, and divorce in the families of patients with PTSD and depression. The effect of post-combat mental illness affects veterans' families and future generations (Karney et al., 2008, Rosenheck & Fontana, 1998; Solomon, Waysman, Belkin et al., 1992).

Between 2004 and 2009, active duty military suicide rates initially were lower than civilian rates, but increased to reach levels higher than the civilian rate (Schoenbaum et al., 2014). By 2010, the average rate of suicides among veterans reached 22 per day (Kemp & Bossarte, 2012). Male veterans have twice the risk of completed suicide as their civilian counterparts (Kaplan, Huguet, McFarland, & Newsom, 2007). In a study of nearly one million active duty Regular Army soldiers between 2004 and 2009, the suicide rate among never, currently, and previously deployed Regular Army soldiers rose and exceeded the civilian rate by 2008 with a total of 569 deaths classified as suicides. Suicide among enlisted soldiers was inversely related to rank, was elevated among deployed women soldiers, soldiers without high school diplomas or

GEDs, white race ethnicity, and soldiers who had been demoted within the past two years, and was inversely related to length of Army service with the highest risk in the first two years for currently and previously deployed soldiers. Pre-enlistment mental disorders were associated with one-third of post-enlistment suicide attempts with a consistently increased rate among currently or previously deployed soldiers compared to those never deployed, the highest among those with three or more deployments, suggesting deployment-related factors. However, soldiers who were never deployed also had an elevated risk of suicide. The risk of suicide was also significantly elevated among soldiers with post-enlistment and likely deployment-related onset of major depressive disorder or intermittent explosive disorder (Schoenbaum et al., 2014). Patients with major depression are at 10 times the risk for suicidal ideation and 11 times the risk for suicide attempts than non-depressed patients. In the civilian population, patients with PTSD have a significantly higher rate of suicidal ideation and suicide attempts than those with other anxiety disorders (Kessler, Borges, & Walters, 1999). Schoenbaum et al. found that posttraumatic stress disorder was not correlated with suicide attempts within their study population. This finding is the opposite of findings within the civilian population. Furthermore, the results of the Schoenbaum et al. study showed that along with panic disorder, PTSD had an inverse or nonsignificant association with suicide among soldiers (2014). Never-married soldiers had a lower rate of suicide attempts compared to married soldiers, a finding inconsistent with civilian populations, suggesting unique marital stressors in military personnel (Friedman, 2014; Nock et al., 2014).

THE COST OF POST-DEPLOYMENT PTSD AND DEPRESSION

Eibner and colleagues' (2008) statement with respect to the needs of returning service members should serve as a principle for national policy with respect both to monetary and all other human costs subsequent to military service: "In our analysis, we consider the U.S. societal perspective because we believe that the cost of treating service members injured in Afghanistan or Iraq is a national responsibility and that we as a society should be committed to minimizing all costs, regardless of whether they accrue to government agencies, military service members, their families, taxpayers, or others" (Eibner et al., 2008, pp. 169-170). In addition, "Understanding the costs of these conditions, and the potential reduction in costs associated with evidence-based care, is valuable because the nation has obligated itself to providing health care for all returning service members, regardless of where their injuries were sustained" (Eibner et al., 2008, p. 177).

According to the RAND Corporation assessment, while treatment could be costly in the short term, providing evidence-based care according to the Veterans Administration/Department of Defense treatment guidelines to all returning veterans with a mental health condition could be cost saving over the long term. The RAND model used to measure the impact of returning service member illness includes the societal costs of inadequate or absent care, treatment costs for relapses, suicide attempts and completions, and lost productivity, but not costs connected to domestic violence, homelessness, or substance abuse. Savings from evidence-based care come from improved productivity, health, and quality of life. Any calculation of post-deployment mental health treatment costs should include both the costs of treatment and any offsetting savings from improving mental health in veterans (Eibner et al., 2008).

Depression is the most costly illness within two years post-deployment, followed by comorbid depression and PTSD, and PTSD as sole illness (Eibner et al., 2008). According to the RAND data, 5% of returning service members have PTSD immediately after their return, which increases to 15% over two years. Half of these service members will have comorbid major depression and 7.2% will have major depression alone. The impact on productivity is the largest factor, accounting for 55.3% to 94.5% of illness-related costs for service members with PTSD and major depression (Eibner et al., 2008). According to one RAND estimate, there could be a 15.75% reduction in wages for returning veterans with PTSD and a 45.23% reduction for those with major depression (Eibner et al., 2008). Christensen, McMahon, Schaefer, Jaditz, and Harris (2007) found that veterans in their 20s and 30s with service-related disabilities had a 5% lower probability of working than those with no disability and a 14% lower wage rate overall. Veterans with a 10% mental health disability had three times the annual income loss compared to veterans with a 10% physical disability (Eibner et al., 2008).

Estimates of two-year costs were created by modeling three care alternatives for veterans returning to the states with PTSD or major depression assuming three different care alternatives: usual care, evidence-based care, or no care (Eibner et al., 2008). One example is a calculation of the two-year costs of PTSD and major depression for 50,000, 25-year-old returning veterans with an average E-5 rank. For this situation, several different estimates were made with varying basic assumptions, with the "status quo" scenario assuming that 30% of these returning service members receive any treatment, 30% of which is evidence based (according to the VA/Dept. of Defense treatment guidelines at that time). For this model, two-year costs of PTSD and major depression ranged from \$119.8 million to \$204.7 million (at 2007

prices) depending on whether or not the value of lives lost to suicide were included in the estimates (Eibner et al., 2008). If the costs of lives lost to suicide are included, increasing treatment rates for this group from 30% to 100% and providing evidence-based treatment could save society \$86.2 million over two years (Eibner et al., 2008).

Looking at the larger cohort, total PTSD and major depression-related costs for 1.6 million troops (deployed since 2001 until the time of this study) within the first two years post-deployment could range from \$4.0 to \$6.2 billion depending on the value assigned to the loss of life from suicide (Eibner et al., 2008). Providing all of these patients with evidence-based care (based on then current Dept. of Defense Treatment Guidelines) could reduce these costs up to 27.3% and more than pay for itself from a total societal perspective, largely from increased productivity. Considering costs flowing from homelessness, domestic violence, and negative impact of veterans' illness on families could well increase this estimated benefit of providing evidence-based treatment. For total case estimates of PTSD and major depression in returning service members, there is a potential cost savings of providing evidence-based treatments within the first two years of up to \$1.7 billion or \$1,063 per returning veteran. Increased productivity from successful treatment also reduces costs of unemployment, disability payments, and public assistance (Eibner et al., 2008).

TREATMENT NEEDS OF RETURNING SERVICE MEMBERS AND VETERANS

Based on a review of relevant literature, the Veterans Administration and the Department of Defense recommend several different psychotherapeutic approaches along with appropriate psychotropic medication as needed, for the treatment of PTSD. According to the VA/DoD Clinical Practice Guidelines for PTSD, the most strongly supported "A level" psychotherapies are trauma-focused psychotherapy, stress inoculation training, and other approaches that include combinations of the ingredients of exposure, cognitive restructuring, relaxation/stress modulation, psychoeducation such as in prolonged exposure, cognitive processing therapy, and reprocessing such as in EMDR.

Brief psychodynamic therapy was recommended as a therapy less highly supported by research and it was concluded that dialectical behavioral treatment (DBT) and group therapies had insufficient research evidence to recommend for or against them. While supportive psychotherapy was not considered by a high standard of research to be conclusively demonstrated as effective for PTSD, it has been demonstrated at least to be significantly more helpful than no treatment.

The guidelines stress that PTSD is often comorbid, especially with substance abuse and major depressive disorder (MDD). The guidelines further instruct that comorbid conditions should be treated concurrently, considering patient preferences, provider experience, severity of the conditions, and availability of resources. They also recommend referral to specialty care for severe MDD, MDD with suicidality, unstable bipolar disorder, severe personality disorders, psychotic disorders, and substance abuse. The guidelines stress that symptoms causing the most impairment should be addressed and treated, regardless of the cause.

The Veterans Administration/Department of Defense Clinical Practice Guidelines for Major Depressive Disorder (U.S. Dept. of Veterans Affairs, 2009) recommend the use of psychotropic medications including antidepressants in the treatment of moderate and severe major depression, in conjunction with psychotherapy. Electroconvulsive shock therapy can be used for very severe, psychotic, and treatment-resistant major depression.

With respect to psychotherapy, the guidelines recommend cognitive behavioral therapy (CBT), interpersonal psychotherapy, problem-solving therapy, and client-centered counseling for major depression. DBT is recommended as an adjunctive treatment to pharmacotherapy for major depression in older patients and couples/marital-focused therapy is recommended for patients with comorbid depression and relationship distress. The guidelines also recommend short-term psychodynamic psychotherapy for older patients who have recently become caregivers for a disabled family member. Computer-based cognitive behavioral therapy or guided self-help can be used for mild to moderate depression as alternatives, particularly when standard psychotherapy is not readily accessible.

In addition, a literature not referenced by the VA/DoD guidelines (which almost exclusively reference briefer treatments) reviews the superior usefulness of longer-term psychotherapies for certain patients with serious chronic complex disorders including personality disorders, multiple mental disorders, and complex depressive and anxiety disorders (i.e., associated with chronic course and/or multiple mental disorders). Some of the longer psychotherapies reviewed include psychodynamic therapy and psychoanalysis.

For patients with chronic, complex disorders who require more extended psychotherapy, frequency and duration of sessions are separate but additive positive factors in psychotherapy outcome (Sandell et al., 2000). While a number of psychotherapeutic approaches are effective for various personality disorders (Bateman, 2012; Hadjipavlou & Ogrodniczuk, 2010; Linehan, Armstrong, Suarez, Allmon, & Heard, 1991), longer courses of psychotherapy are often needed for these pa-

tients (Høglend, 1993; Howard, Kopta, Krause, & Orlinsky, 1986), which yield superior and more long-lasting recovery. The British National Institute for Health and Care Excellence (2009) guidelines recommend a longer course of psychotherapy for borderline personality patients in particular.

Patients with personality disorders and other serious chronic psychiatric conditions very frequently have disturbed interpersonal relationships that contribute to family dysfunction, experience decreased work productivity, and have a higher risk factor for mortality than smoking, alcoholism, obesity, and hypertension (Holt-Lunstad, Smith, & Layton, 2010). A number of studies point to psychodynamic as opposed to cognitive-behavioral psychotherapies as the superior treatment in ameliorating disturbed interpersonal relationships (Clarkin, Levy, Lenzenweger, & Kernberg, 2007; DeMaat, de Jonghe, Schoevers, & Dekker, 2009; Gregory, DeLucia-Deranja, & Mogle, 2010; Huber, Zimmerman, Henrich, & Klug 2012; Leichsenring & Rabung, 2008; Leichsenring & Rabung, 2011; Levy, Meehan, Kelly, Reynoso, Weber, Clarkin, & Kernberg, 2006; Shedler, 2010; van den Bosche, Verheul, Schippers, & van den Brink, 2002). Other studies purport psychodynamic psychiatric as being the more effective and cost-effective treatment for a broad range of psychiatric diagnoses, as well as yielding superior results in other outcome measures such as increased work productivity, decreased sick leave, and medical and hospital costs (Bateman & Fonagy, 1999; Bateman & Fonagy, 2003; Bateman & Fonagy, 2008; Berghout, Zevalkink, & Hakkaart-Van Roijen, 2010a, 2010b; Beutel, Rasting, Stuhr, Ruger, & Leuzinger-Bohleber, 2004; Clarkin et al., 2001; Clarkin et al., 2007; DeMaat, Phillipszoon, Schoevers, Dekker, & De Jonghe, 2007; Dossmann, Kutter, Heinzl, & Wurmser, 1997; Düehrsen, 1962; Duehrssen & Jorswieck, 1965; Hall, Caleo, Stevenson, & Meares, 2001; Heinzl, Breyer, & Klein, 1996; Keller, Westhoff, Dilg, Rohner, & Studt, 2002; Meares, Stevenson, & Comerford, 1999; Stevenson & Meares 1999; Teufel & Volk, 1988).

Many chronically depressed patients treated with short-term psychotherapy are left with residual depressive, introjective, perfectionistic, or interpersonal problems that are prodromal symptoms leading to recurrence (Blatt, Quinlan, Pilkonis, & Shea, 1995; Fava, Ruini, & Belaise, 2007). Perfectionistic, chronically depressed patients do better with intensive, extended psychodynamic therapy (Blatt, 1992). Many chronically depressed patients need more extended psychodynamic psychotherapy and if treated with more intensive, extended psychodynamic psychotherapy, compared to those treated with long-term CBT, have more sustained improvement and fewer interpersonal problems at three-year follow-up (Huber et al., 2012), as well as beneficial brain changes after treatment (Buchheim et al., 2012). (See "The Cost-Effec-

tiveness of Psychotherapy for the Major Psychiatric Diagnoses," Lazar, 2014, this issue, for a fuller discussion.)

Additional studies specifically link personality disorders with treatment resistant, persistent, and recurrent depression. Patients with major depressive disorder and a co-occurring personality disorder had significantly more role limitations due to impaired social functioning and significantly longer time to remission than patients with solely major depressive disorder (Grilo et al., 2010; Skodol et al., 2005). In addition, borderline and obsessive-compulsive personality disorders at baseline are particularly robust predictors of accelerated relapse after remission from an episode of major depressive disorder (Grilo et al., 2010). Borderline personality disorder is a robust predictor of chronicity (accounting for approximately 57% of persistent cases) and is also the strongest predictor of persistence of major depressive disorder, followed by schizoid and schizotypal personality disorder, any anxiety disorder (the strongest Axis I predictor), and dysthymic disorder (Skodol et al., 2011). Poor psychosocial functioning can compound the impairments of major depressive disorder, and affect the course of the illness. In one study, subjects whose personality disorders remitted had improvement in social functioning and were more likely to achieve remittance of their depression than those with major depression and persisting personality disorders (Markowitz et al., 2007).

Taking the long view from a cost-effective perspective, since depression is the most costly illness within two years post-deployment, it would seem clear that returning service members and veterans with major depression and a comorbid personality disorder need both illnesses treated to avoid recurrent and persistent depressive illness, even though the treatment of the personality disorder may require a longer and more intensive treatment.

In summary, mental illnesses in military service members and veterans include major depression, posttraumatic stress disorder, and the entire spectrum of psychiatric diagnoses. The costs and sequelae of their illnesses are protean and include increased morbidity and mortality from other medical illness, decreased work productivity, serious interpersonal and family dysfunction, homelessness, high rates of suicide, and substance abuse. The backlog for treatment by the VA has been unacceptably long. Currently we fall far behind the standard of the RAND Corporation's recommendation that the nation be obliged to shoulder the entire

cost of treating service members injured . . . (as) a national responsibility and that we as a society should be committed to minimizing all costs, regardless of whether they accrue to government agencies, military service

members, their families, taxpayers, or others . . . because the nation has obligated itself to providing health care for all returning service members, regardless of where their injuries were sustained. (Eibner et al., 2008, pp. 169-170)

If one also extends this responsibility to cover all psychiatric illness in returning service members then our understanding of the clinically and research-based treatments required has not been fully up to date. Awareness and availability of optimal treatment for the needs of patients with serious chronic complex illnesses, including personality disorders, multiple chronic mental disorders, severe anxiety, and depression have not been adequate. If this is true within the military environment, how do veterans fare in the private insurance market especially if we take their needs for treatment for all of their psychiatric illnesses seriously, whether originating in military service or antedating it? Given the current national state of poor compliance with mental health parity requirements, we are surely neglecting our returning service members and veterans at great cost to themselves, to their families, and to the country.

(One important resource for the epidemiology and cost data in this article was *Invisible Wounds of War, Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, edited by T. L. Tanielian and L. Jaycox, Rand Center for Military Health Policy Research, Rand Corporation, 2008.)

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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-

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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, Ehrental, 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 non-medical 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, & Oliniski, 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 neuropsychanalysis 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.

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Workplace Effectiveness and Psychotherapy for Mental, Substance Abuse, and Subsyndromal Conditions

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Abstract: While it is known that psychiatric illness and subclinical psychiatric illness can be very disabling, their impact on workers' productivity has been little appreciated or appropriately addressed. Complex variables are involved in fashioning an appropriate policy to ameliorate the impact of mental illness on productivity including the identification of effective treatments and potential negative effects of controlling patients' access to them. The cost-effectiveness of such treatments is considered from the differing perspectives and goals of the various stakeholders involved, including employers, insurers, and workers with psychiatric illness. Depression in workers leads to significant absenteeism, "presenteeism" (diminished capacity due to illness while still present at work), and significantly increased medical expenses in addition to the costs of psychiatric care. In addition to the specific usefulness of psychotropic medication, there are a variety of studies on the cost-effectiveness of different psychotherapeutic treatments that improve health and productivity in psychiatrically ill workers. Research indicates the usefulness of approaches including employee assistance programs, specialized cognitive-behavioral treatments, and brief and longer term psychodynamic interventions. It is clear that substance abuse disorders and especially depression and subsyndromal depression have a profound negative effect on work productivity and increases in medical visits and expenses. The current system of mental health care suffers from ignorance of the negative effects of psychiatric illness in workers, from a lack of subtle awareness of which treatments are most appropriate for which diagnoses and from the reluctance by payers to invest in them. Access to evidence-based ap-

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appropriate treatment can improve the negative impact on productivity as well as workers' health. This article considers these issues and argues for a role of psychotherapy in the treatment of mental illness and substance abuse from the perspective of worker productivity.

THE IMPACT OF PSYCHIATRIC ILLNESSES ON WORK PRODUCTIVITY

The impact of mental illnesses and subclinical mental illness on work productivity has received modest attention in the medical services and policy literature given the salience of the topic. There is a dearth of published studies given the substantial interest in worker productivity and the high incidence of mental illness, particularly depression and subsyndromal depression. However, there are compelling studies that given their uniformity of findings can be examined to give some guidance to future policy and service development. The published findings are striking; if there is disagreement among investigators, it is one of degree not quality or direction. Furthermore, these studies suggest themes that can be woven into an approach to policy development.

We know that mental illness, substance abuse, and subsyndromal versions cause significant disability by their presence alone and when the prevalence of the illnesses, and, at times, severity of the disability and disruption are taken into consideration, the negative results on work productivity can be substantial. While there are multiple mental illnesses and substance abuse disorders that cause work-related disability, depression and subsyndromal depression are probably the most widely studied among psychiatric illnesses. Perhaps the reason for this tilt toward depression is not only the relatively high prevalence of the disorder but also the fact that people can still function at work and yet be quite impaired by depression. According to a report from the RAND corporation (Miranda et al., 2008), depression is the second leading cause of disability world-wide and accounts for as much loss in function as most chronic illnesses. Within the U.S. the estimation of costs ranges from \$51 billion (Miranda et al., 2008) per year to \$83.1 billion (Greenberg et al., 2003) in lost productivity (independent of the costs of treatment). Treatment (case management, medication, and psychotherapy) is effective for many if not the majority of depressed patients. But effective outcomes are hampered by consistently low rates of detection and utilization as well as the lack of appropriate treatment in primary care settings, where most depressed patients go for care if they go at all

(Miranda et al., 2008). Overall, only about one-fourth of people with depression receive treatments with consistent and accepted guidelines. Rates are especially low among underserved minority groups (Miranda et al., 2008).

Of note is the finding that the direct treatment costs account for only about 25% of the total societal cost of depression. Indeed, the great majority of the cost of depression (\$52 billion, or 62%) is incurred in the workplace as lost productive work time (Greenberg et al., 2003). Other researchers using different methodology have arrived at similar estimates of relative magnitude. For example, according to Druss et al. (2001), the cost of work loss among all U.S. citizens treated for depression would be \$11.5 billion in 1996. In another study, if all workers with depression, regardless of their treatment status, were counted, the sum went up to \$44 billion (Stewart, Ricci, Chee, Hahn, & Morganstein, 2003). The estimates according to the National Comorbidity Survey Replication amounted to \$36.6 billion (Kessler, Merikangas, & Wang, 2007). Goetzl, Ozminkowski, Sederer, and Mark (2002) revealed from a reanalysis of a HERO (Health Enhancement Research Organization) study that the risk factor predicting the largest medical cost increase was depression. Employees who reported being depressed were 70% more expensive than their non-depressed counterparts. Those who reported being highly stressed, and incapable of managing that stress, were 46% more costly than non-stressed employees. And, employees who were unfortunate enough to experience both depression and high stress were 147% more expensive. The authors focused on the barriers to effective treatment in the workplace.

In a study that examined role disability in depression, Merikangas et al. (2007) estimated that 53.4% of U.S. adults have one or more of the mental or physical conditions assessed in the replication of the National Comorbidity Survey. These respondents reported an average 32.1 more role disability days in the past year than demographically matched controls, equivalent to nearly 3.6 billion days of role disability in the population. Musculoskeletal disorders and major depression had the greatest effects on disability days. Mental conditions accounted for more than half as many disability days as all physical conditions. Associations of specific conditions with disability decreased substantially after controlling for comorbidity, suggesting that prior studies, which generally did not control for comorbidity, overestimated disease specific effects. This group called attention to the staggering amount of health-related disability associated with mental and physical conditions and called out for this fact to be considered in establishing priorities for the allocation of healthcare and research resources.

However, mental illnesses other than depression count, too. Eaton et al. (2008) gives a comprehensive review of the burden of specific mental illnesses and characterizes the burden in terms of prevalence, mortality, and disability and costs of individual illnesses. They found as a group, mental disorders have a high prevalence when compared with many other health conditions. Even schizophrenia and bipolar disorder, with the lowest prevalence among the disorders considered in their report (i.e., < 1%), have a higher prevalence than many other diseases and health conditions. These relatively less common disorders have high associated impairment. These two disorders might be termed the "less common and severe mental disorders." Three other disorders—panic disorder, obsessive-compulsive disorder, and drug abuse or dependence—also have a median prevalence of less than 2% and might thus be considered "less common." Of these three, drug abuse/dependence has substantial health and personal consequences, including a Global Burden of Disease (GBD) disability weight of 0.25, a median relative risk of mortality of 2.0, and an estimated annual cost of over \$200 billion.

Major depressive disorder, the phobias, and alcohol abuse or dependence have median prevalence rates of more than 5% and are the "common" mental disorders. Major depressive disorder stands apart from these because of its high associated impairment, either by the GBD rating (major depressive disorder, for example, in the so-called severe form has a rating of 0.62, identical to that for blindness) or the percentage with extreme disability on the Sheehan Disability Scale (SDS) which explains its place in the GBD study as the mental disorder claiming the highest percentage of disability-adjusted life years. Of note in these comparative results is the high median prevalence of personality disorder, at more than 9%, as well as the high associated mortality risk, with a median relative odds ratio of 4.0 (Eaton et al., 2003). In a word, mental illness is an expensive condition, especially depression, for the workplace.

The struggles in Psychiatry of creating a clinically meaningful cartography (by which we mean reproducible, etiological based, treatment outcomes and courses of illness) are known and the dearth of cost-effectiveness oriented approaches in general have not allowed the field of psychiatry, and more specifically the practice of psychotherapists, to proceed with the scientific rigor that exists in some medical specialties in developing specific and effective treatments for illnesses aimed toward the cause of the illness. In addition, the measure of the effectiveness of psychotherapy is a difficult enterprise in its own right, the challenges of which will not be discussed in this article; however some of the barriers to the provision of psychotherapy will be considered.

The barriers to the effective use of psychotherapy are basically six-fold. Added to the real scientific problems of (1) using quantitative, objective measures to capture the impact of subjective states and concepts such as salience and meaning that haunt the rational use of psychotherapy are (2) the lurking element of stigma and shame related to those who suffer from mental illness as well as their families and those who try to take care of them. And (3) there is also the limiting and inhibiting effect of ignorance, to the extent that ignorance can be separated from stigma. Other barriers are (4) an inaccurate and inadequate means of identifying psychiatric illness leaving open a large gap of knowledge and contentious disagreement about how to define mental illnesses. Into this gap of uncertainty thrives the risk-adjustment departments of insurance business who are subsequently less constrained in being able to dictate the definition of illness that suits their business plans and to define medical necessity, (5) a disjointed care system with conflicting incentives and agendas for practitioners and patients thereby leading to conflicting goals for measuring success, and (6) in the case of psychotherapy as well as behavioral health in general, a lack of well-trained providers.

PAYMENT PROBLEMS AND PSYCHOTHERAPY

Our present fee for service system of reimbursement rewards creativity, initiative, and hard work at the expense of overutilization, waste, and the proliferation of ineffective treatments. As has been noted by Frank and McGuire (2000), the mental health system is plagued by simultaneous overuse and underuse. Overuse of some interventions that have not demonstrated cost-effective results but whose use benefits the practitioner (in addition to providing income, such use could be considered as being easy and satisfying to use or ideologically consistent with one's beliefs) and underuse because of ignorance, or undesirability or unfamiliarity to the practitioner despite demonstrated effectiveness. At this point it may be beneficial to consider two concepts in some detail, moral hazard and adverse selection, as these features of a payment system require examination in order to understand policy development for a rational system of insurance. Adverse selection is a form of information asymmetry and refers to the process in which people who are more likely to use coverage from insurance choose better coverage in order to protect themselves from risk and the insurance provider is not able to protect himself, possibly because of regulation or different access to information such as the state of health and therefore, risk of the insured. This is to be distinguished from another form of information

asymmetry called moral hazard in which better coverage leads to an increased demand response for the service, thereby encouraging patients to take on more risk (i.e., expense for healthcare) to better their coverage because their responsibility for the action or risk is transferred to others (Frank & McGuire, 2000). The idea of parity is particularly perilous for the insurance providers using these ideas in the following way: in a system in which the insurance providers do not know as much about the risks of their prospective patients as the patients themselves do and are not allowed to select out those who may pose greater risk (i.e., older patients, those with pre-existing conditions, etc.), the insurer may pitch a relatively low cost, but generous, benefit plan in order to encourage a larger risk pool to mitigate the adverse selection but in doing so might encourage moral hazard in the form of "overuse." The implied assumption behind this reasoning is that the increased utilization has no or diminished utility to society in the form of health improvement of the patient who is engaging in so-called "moral hazard." These ideas might be active in the provision of services such as psychotherapy that have a relatively open-ended or difficult to determine maximum benefit for the insurance consumer (i.e., patient), thereby encouraging discretionary overuse by people with a severe mental illness or simply by those who want to get the most out of the experience as possible. There is a concern that since "the top benefit" is poorly or indistinctly defined, patients may have difficulty recognizing when the maximum benefit is achieved and may confuse secondary non-medical benefits with the medical outcomes.

Frank and McGuire (2000) believe that the preponderance of the available evidence, experimental or observational (from the managed care era), points in the direction of greater price response for ambulatory mental health than other healthcare services. Moral hazard has been a preoccupation in some scholarship on the cost of psychotherapy (Frank & McGuire, 2000). However, it would appear that one of the major economic issues in 2014 is the risk of underinsurance, which leads to under-treatment of mental illness and/or mental conditions such as personality disorder or subsyndromal states and potential substantial risks for inappropriate (namely inadequate) care. In such cases, we see repeatedly the disproportionate rise of physical care in the face of inadequate mental health care. Inadequate psychiatric care seems to frequently lead to more costly inadequate medical care.

However, the idea of moral hazard contains another fallacy and is an artifact of our profit-driven business of insurance. Is insurance a business to make high profits for some who take the time and risk to organize the business and invest the funds or is it a means to spread risk through a population thereby smoothing out the means to pay for

high-cost healthcare interventions? Of course, the answer depends on the perspective one takes in this complex interaction. And what is left out, of course, is that many other areas of medicine which seem objective and straightforward are full of moral hazard actions on the part of practitioners who make decisions based on the ability to make money and do so based on the nature of the insurance coverage.

Sturm, Zhang, and Schoenbaum (1999) further addressed the concept of moral hazard empirically, and noted that providing comprehensive unlimited substance abuse health benefits costs just \$.06 more per member. Sturm et al. (1999) also addressed the issue of moral hazard in a study of the possible overuse of psychotherapy when it was provided free; his group found the incremental utilization came to about 6 cents per member per year. Furthermore, Landerman, Burns, Swartz, Wagner, and George (1994) noted that the apparent price elasticity that is a part of the concept of moral hazard that Frank and McGuire (2000) have noted is due to the inability of poor people to pay for psychotherapy services when their benefits are aggressively managed. Ultimately how the concept of moral hazard gets applied is itself a moral one.

Subsyndromal conditions are an excellent case in point of this dilemma of what is to be insured and what is the illness. We have depended on a concept of medical necessity, which implies, if not demands, the presence of a diagnosable illness. But if illnesses are dimensional on a continuum, how do we decide and who decides when a mild to moderate disability is an illness? There is no doubt that many of the conditions that we consider mental illnesses are best considered on a spectrum of symptom expression and exist more as tendencies variously expressed at the milder end of the spectrum with fixed debilitating conditions at the other end. Depression is such a condition. For a while the idea of subsyndromal depression was relatively well recognized (Judd, Paulus, Wells, & Rapaport, 1996; Klerman & Weissman, 1992). With the advent of managed care, however, the creation of categories with clear, strict boundaries for reimbursement became ensconced in the medical coding and billing system. Categories were conceived in order to meet the demand, however premature, for certainty. Subsyndromal, then, occupies a unique position in this consideration of the impact of mental illness. Most clinicians would consider subsyndromal depression a medical reality, that is debilitating and inhibiting to its sufferers. However, by the medical insurance business standards, it is not considered an "illness" and thereby possibly not eligible for reimbursement of costs for treatment. This is an example of the devil's bargain that professional organizations make in defining illnesses with an eye toward reimbursement. We will treat subsyndromal depression as a le-

gitimate mental illness, because that is what the literature instructs us to do. A similar case could be made for some “personality disorders.”

COST-EFFECTIVENESS

General Considerations

Studies on cost-effectiveness take the perspective of a party in the relationships among several parties—patient, treater/provider, insurer/payor, and/or society. Because the goals of these four perspectives have not always been congruent, there has been, over the past 25–35 years, conflict over policies whose incentives do not line up in a fee for service world to provide the most effective and cost-effective care from the perspectives of society or the individual.

From the point of view of any one party to the cost of treatment, we take the cost of the illness to that party as well as the cost of its treatment and line it up against the benefit expressed economically to the perspective(s) being considered. If the perspective is that of the employer, then the benefit consideration (setting aside general humane considerations) is the productivity of the worker being treated versus the productivity when not being treated against the cost of being treated versus the cost of not being treated. If the employer is providing care through insurance, then the insurance costs or the cost of care are weighed against productivity costs of not providing care. Therefore, employers should have as much or perhaps even more interest in insurance plans and their effectiveness in mitigating health-related productivity loss as the insurance planners. And certainly employers are as interested in the health (and productivity) of their workers as the workers themselves. Employers then occupy a position of cost-effectiveness consideration somewhere close to the perspective of society, namely a utilitarian, balanced perspective that takes into consideration all elements of the cost-effective relationships, balancing according to the employer’s needs for a positive balance of revenue and expenses as well as humanitarian goals.

Work Productivity and its Metrics

Work productivity measures and costs fall into two basic categories that are unique to considering this function: presenteeism and absenteeism. Presenteeism is reduction of work effectiveness while staying at work. The mechanisms of presenteeism have rarely been studied di-

rectly but may be based on impaired concentration, communication, imagination, a restricted field of resilience, and sometimes interpersonal strife. In some studies, these features are measured separately. Lerner (Lerner et al., 2011, 2012, 2013) and Kessler, Merikangas, and Wang (2007) have contributed substantially to this literature. Absenteeism is absence from work due to illness. Additionally, healthcare costs for the employees are considered in addition to the measures of worker productivity. There is evidence that the lack of provision for adequate mental health services drives a greater cost of medical services (Rosenheck, Druss, Stolar, Leslie, & Sledge, 1999).

Furthermore, it is useful to consider the incremental cost-effectiveness ratio (ICER) and quality adjusted life years (QALY), two important concepts in monetizing the benefits of psychotherapy or any healthcare intervention. ICER is the ratio of net cost and net benefit when one intervention is proposed to replace another. The equation is essentially the cost of the intervention, minus the cost of the control condition divided by the difference between the benefits of the intervention and the benefits of the control condition.

QALY is a relatively simple concept with a challenging measurement. It is a measure of the disease burden that is based on the number of additional years a person would live with the intervention versus the number of years lived if one did not have the intervention with an adjustment for quality of life of those additional years. The measure of quality of life is expressed in utilitarian values of subjectively valued (by the patient) health states as part of a cost-utility analysis. This cost-utility analysis is a look into states and conditions which are based on the patients' values. This subjective approach is hard to measure and raises questions about the accuracy of the endeavor. Some have questioned whether it can be appropriately quantified. Its main value at the present is as a rough calculation to derive comparable monetized quality of life effects and choices.

EFFECTS OF TREATMENT ON PSYCHOPATHOLOGY AND WORKER PRODUCTIVITY

For most, the idea that mental illness negatively impacts worker productivity may seem obvious. Any illness that requires time away from work for treatment, including hospitalization, is obviously costly to employee performance. When a mental illness challenges one's ability to read social cues accurately, to communicate appropriately, to understand and adhere to a social role and its expectations, to learn new

skills, to be adaptable to challenging and/or monotonous conditions or to use proper realistic judgment, one may well imagine that employee effectiveness would be a matter of concern and would be complex to operationalize and to measure. This perspective of the negative impact of certain mental illnesses on employee effectiveness is incorporated into professional activities which the state regulates such as transportation workers, law enforcement personnel, some healthcare providers as well as others in employment conditions in which performance keenly impacts directly on public safety and welfare. But it also applies to the processes of production, sales, and administrative tasks that are a part of everyday social and economic life.

In many studies of the impact of illness on worker productivity, depression has been the leading source of impaired work productivity. It will be the emphasis but not exclusive focus of this article. One might hope then that there would be a rich literature on the impact of mental illness on specific functions, such as leadership, machine operation, group cooperation, innovation, etc. However, this is not the case; rather the existing studies, typically, take the records of large corporations and show the impact of changing access to mental health or substance abuse treatment for specific conditions and their apparent impact on worker productivity. Here we will review the highlights of that literature. There are two standardized questionnaires that are typically used in the higher quality designs, the Health and Work Performance Questionnaire (HPQ; Kessler et al., 2003) and the Work Limitations Questionnaire (WLQ; Lerner et al., 2001).

We know that mental health and physical health utilization can be in a reciprocal relationship when mental health services are constrained with net costs being much higher as a result of the constraint or unavailability of mental health services. Rosenheck and colleagues (1999) examined the experience of employees in a Fortune 500 organization undergoing a change in benefit plan in which the access to mental health services was reduced. They found that the move to an aggressive managed care carve-out resulted in substantial changes in the use of mental and general health services and in annual sick days among 20,814 employees from 1993 to 1995. Mental health service use and costs declined by more than one-third, more than three times as much as the decline in non-mental health service use under the new managed care approach. However, employees who used mental health services showed a 37% increase in use of non-mental health services and a significant increase in sick days, whereas other ill employees showed no such increases. Savings in mental health services were fully offset by increased use of other services and lost workdays by a ratio of roughly 3:1. In Druss, Rosenheck, and Sledge (2000) the senior author, Sledge, and colleagues

studied the same organization as in Rosenheck et al. (1999), examining the 1995 health and employee files of 15,153 employees who filed health claims in 1995. Analyses compared the mental health costs, medical costs, sick days, and total health and disability costs associated with depression and four other conditions: heart disease, diabetes, hypertension, and back problems. Regression models were used to control for demographic differences and job characteristics. It was found that employees treated for depression incurred annual per capita health and disability costs of \$5,415 which was significantly more than the cost for hypertension, and was comparable to the cost for the three other medical conditions. Employees with depressive illness plus any of the other conditions cost 1.7 times more than those with the comparison medical conditions alone. Depressive illness was associated with a mean of 9.86 annual sick days—significantly more than any of the other conditions. Depressed employees under the age of 40 years took 3.5 more annual sick days than those 40 years old or older. The cost of depression to employers, particularly the cost in lost work days, was as great as or greater than the cost of many other common medical illnesses with the combination of depression and other common illnesses being particularly costly. The strong association between depressive illness and sick days in younger workers suggest that the impact of depression may increase as these workers age (because the cost of care goes up if people are allowed to age).

A similar displacement and transfer of costs is seen in Loeppke et al. (2009) who examined healthcare conditions among 10 employers by reviewing the medical and pharmacy claims of over 51,000 employees. They discovered that the negative influence of health conditions on productivity at work far outweighed the medical and pharmacy costs of their employees (average 2.3 to 1) and that the most common sources for these costs were chronic illnesses such as depression, anxiety, obesity, arthritis, and back/neck pain.

The role of social and relational factors is highlighted in a report, *The Impact of Chronic Conditions and Comorbidity on Lost Work Time*, in which the Integrated Benefits Institute (IBI; 2009) reviewed databases available to them. While cardiovascular illness accounted for the most absenteeism (only 3% of the patients but 10.8% of the lost days for the cluster of patients with only one chronic illness), social and emotional (i.e., behavioral health) problems accounted for 56% of the patients who had absenteeism. When absenteeism (2.5 days) is added to presenteeism (10.8 days), social and emotional disorders accounted for 13.3 days of lost productivity per year—by far the highest lost productivity in this group of chronic illnesses. The authors drove home the idea that chronic diseases tend to occur in clusters and that these comor-

bidities confound conventional care making their effective treatment and recovery extremely difficult. A similar phenomenon has also been studied by the Sledge primary care cost research group in which they described a process termed the “cascade effect” (multiple things going wrong in social and medical realms creates a crisis for high cost primary care patients in which the solution is to default to hospitalization as a remedy; Sells et al., 2009; Sledge et al., 2011).

That these social and emotional factors can be mitigated by treatment is found in Hilton et al. (2009) who examined the association of productivity and mental illness in treated and untreated employees in a large cross-sectional study; they also investigated associations between employee work productivity, psychological distress, and the treatment of mental disorders. They surveyed 60,556 Australian employees who completed the Health and Work Performance Questionnaire (HPQ), which quantifies treatment-seeking behavior for depression, anxiety, or other mental disorders. The HPQ also evaluated the level of psychological distress (Kessler 6 [K6]) and productivity in employees. The investigators found the productivity of employees without psychological distress, who had not been in treatment for a mental disorder, was 20% ($SE = 0.3\%$). The productivity of employees successfully treated (low K6) for a mental disorder was 17% ($SE = 0.6\%$). They concluded that treatment of mental disorders resulting in normalization of symptoms is associated with employees’ productivity returning to values approaching those of employees without a history of a mental disorder.

TREATMENT

Overview

In order to have an accurate account of what we know about treatment and work productivity for mentally ill and substance abusing patients, it is important to differentiate between treatments that help restore people to productivity at work from the effectiveness of treatments for defined conditions. No doubt there is considerable overlap between the two, but we must keep in mind that by definition people who are able to work are already a somewhat select group in that they have demonstrated adaptive behavior at some level, so that there may be a selection bias in generalizing results from treatment of psychopathology to expectations for work. If one wants to know about the effect of treatments on ability to work productively, that is what must be measured. Also, we do not have a deep or thorough understanding of the impact of mental illness on the ability to work except in broad strokes.

Also, it is clear that the recovery from a mental illness like depression may not always be complete and that this may have profound impact on accurate measurement of how well the treatment works (Fava, Ruini, & Belaise, 2007; Lerner et al., 2012). Studies exist that demonstrate effectiveness in mitigating or eliminating the deleterious effects of diagnosable mental illness, especially depression and subsyndromal depression. Effective treatments for both specific psychopathological conditions and work productivity have been demonstrated, as well through the use of EAPs, medications, and psychotherapy. Here we provide reviews of these three approaches separately and combined (in some studies of medications) giving the saved days when there is an adequate control to compare. Weaknesses in this literature are some of the usual weaknesses in the psychotherapy literature, such as: poor designs (pre- and post-comparisons), weak methods (lack of blinding of raters, self-report of subjective measures), unclear definitions of the treatment, lack of long-term follow-up, and lack of accurate measurement of outcomes. The preponderance of the evidence is that there is a tendency to underestimate the value of the treatment in improving economic productivity. The results of studies in which strong design does exist frequently show that the weaker designs underestimate the effectiveness of the treatment being considered. Our focus will tend to be on the effects of these treatments on worker productivity although in some instances we include their effects on the patient's general well being and his/her symptoms and illness.

There is little literature on the differential effects of treatments, related to work and mental illness. Lerner et al. (2013) performed systematic review of work-related health promotion programs and intensively reviewed 44 and concluded that only one addressed behavioral health, which was the telephone CBT program of Wang and colleagues (Wang, Simon, Avorn, Azocar, Ludman, McCulloch et al., 2007).

Psychiatric Treatments

Here we will focus on depression both for its prevalence among those who work and consequently its impact in the work force as well, because most of the publications addressing mental health in the work place have been oriented toward depression. Depression is unique because of its expression over a wide range of symptoms. In other words, people can be well enough to come to work in some instances, but not work at full capacity (hence the idea of the "walking wounded"; Styron, 1990). As noted above, the cost of depression is estimated to be \$83

billion for the year 2000 in the U.S. alone (Greenberg et al., 2003). This societal cost is second only to that of hypertension and is indeed far greater than that of other chronic conditions such as diabetes, heart disease, and asthma (Druss et al., 2001). Therapies that can better manage depression will provide opportunities for savings to employers.

Medications

Curkendall, Ruiz, Josh, and Mark (2010) examined the productivity-related cost of depression in an employed population through administrative data and found annual short-term disability (STD) and absenteeism costs (\$2,005) were compared for depressed patients who were treated with antidepressants and for a matched control group without depression. They found that annual STD costs were \$1,038 among treated depressed patients versus \$325 among controls and \$1,685 among a subgroup of severely depressed treated patients versus \$340 among their controls. After controlling for demographic and employment characteristics, treated patients with depression had STD costs that were \$356 higher per patient and those with severe depression had costs that were \$861 higher than non-depressed patients. The marginal impact of treated depression on absenteeism was \$377. They concluded that even when depressed patients are treated with antidepressants alone, there are substantial productivity losses.

Birnbaum et al. (2010) sought to assess the effects of antidepressant treatment compliance on health care and workplace costs by using workplace survey data linked to two groups of employers' healthcare claims. Those with depression and those treated with antidepressant use were categorized into noncompliant or compliant groups. Annualized costs were compared between compliance groups, for the employees with antidepressant use and a subset of those using antidepressants who were diagnosed with depression. They found among antidepressant users ($N = 1224$), medical costs were not statistically different for compliant versus noncompliant patients; drug costs were higher for compliant patients, primarily because of antidepressants' costs. Similar associations were observed among depressed patients ($N = 488$); however absenteeism costs were lower for compliant patients with antidepressant use (\$3857 vs. \$4,907, $P = 0.041$) and among depressed compliant patients (\$3976 vs. \$5899, $P = 0.047$). Presenteeism costs were higher for depressed compliant patients (\$19,170 vs. \$15,829, $P = 0.011$) than for noncompliant depressed patients. They concluded increased compliance with antidepressants is significantly associated with reduced

absenteeism costs, allowing some patients to be at work who are not as effective as those remaining at work who are not depressed. This study and that of Curkendall et al. (2010) above suggests that the problem noted by Fava et al. (2007), that some people do not completely recover with depression, may mean that medications will be helpful but maybe not completely restorative for some.

EAPs and Case Management Approaches

Hargrave, Hiatt, Alexander, and Shaffer (2008) reported data on increased work productivity that resulted from the employee assistance program (EAP) treatment approach. Participants ($N = 155$) who had various psychiatric diagnoses were seen in individual counseling by network clinicians. Measures of presenteeism, absenteeism, and degree of problem resolution were obtained from members' ratings. The results indicated that 80% of costs associated with lost productivity were associated with presenteeism, with the remaining 20% accounted for by absenteeism. Characteristics associated with lost productivity were energy level, concentration, and work quantity and quality. A return on investment (ROI) calculated using these data in a typical EAP indicated that for every dollar spent for the program, there is an expected return of between \$5.17 and \$6.47. The authors note that EAPs may have a superior return on investment among the treatment options as they address problems in living as well as symptoms. The authors also note that untreated subsyndromal depression has about the same workplace disability (mainly in terms of presenteeism) as major depression. Another implication is that work-related treatment might be more effective in supporting people at work.

Rost and colleagues (Rost, Smith, & Dickinson, 2004) compared enhanced care against usual care for workers visiting 12 community primary care practices in the U.S. In addition to the usual care by the primary care physicians, the enhanced care involved telephone contacts by care managers who reassessed the patients' depressive symptoms, educated them about depression and its treatment, reported the patients' status to the physicians and made recommendations for adjustment of treatment in accordance with the treatment guideline. Therefore, it included the three features termed "active ingredients" (Bower, Gilbody, Richards, Fletcher, & Sutton, 2005) identified as associated with success, namely: systematic screening, mental health professionals as care managers, and regularly planned manager supervision. Over two years, the intervention had some limited impact on depression (p

= 0.09) but significantly improved productivity by 6.1% ($p < 0.05$) in all employees and tended to improve absenteeism by 22.8% ($p = 0.06$). In monetary terms, the gain translated into \$1,491 for decreased presenteeism and \$539 for absenteeism per one depressed employee per year. These effects were more salient among consistently employed subjects.

When these results were compared to others, it was noted that Wang et al. (2007) examined a more aggressive outreach-treatment program in the workplace and first screened employees from 16 large companies from diverse sectors. Those who screened positive for possible depression were randomly allocated to usual care or intervention. Those assigned to usual care were informed that their responses indicated possible depression and were advised to consult with a clinician. Those assigned to the intervention received a systematic telephone intervention program, which assessed needs for treatment, facilitated entry into in-person treatment, monitored and supported treatment adherence and, for those who declined in-person treatment, provided structured telephone psychotherapy. The intervention not only significantly reduced depression severity ($p = 0.001$, effect size of a -1.0 or $1/3$ of a SD), it also increased effective hours worked ($p = 0.002$, 3.3 increased hours worked) and job retention ($p = 0.02$) through 12 months. The gain translated into 2.6 more hours worked per week, or 2 more weeks per year than before the intervention.

Psychotherapy

Here we examine various psychotherapies including psychoanalytic and behavioral. As one might expect cognitive behavioral therapy (CBT) makes many appearances in this field. Blonk, Brenninkmeijer, Lagerveld, and Houtman (2006) compared a version of CBT administered by mental health professionals and a similar combined psycho-education program administered by labor personnel. Both were associated with favorable outcomes in returning people to work but the combined program was superior in this regard yielding 17 and 30 days earlier return (partial and full, respectively) for a total benefit of 200 days better than the control group. The authors concluded that a brief, combined intervention based on CBT principles with a strong focus on graded activity and workplace interventions conducted by labor experts appeared to have promoted work resumption among self-employed individuals who were on sick leave owing to work-related psychological complaints. Individuals who had received this intervention returned to work earlier than those in a no-treatment control group and

a CBT intervention conducted by psychotherapists. As partial work resumption and workplace interventions were central components of the intervention delivered by labor experts, our results suggest that these aspects may be crucial for helping individuals return to work. In other words, work-specific therapy may have an advantage.

Along similar lines of assisting people to get back to work, Della-Posta and Drummond (2006) carried out a study, the aim of which was to determine whether CBT would enhance employment outcomes in worker's compensation clients (people injured at work) who were seeking employment. Participants were randomly assigned to a standard job search assistance group that met for 4 hours/week for four weeks, or to a group that received standard job search assistance for 4 hours/week for the first two weeks and CBT for 4 hours/week for the next two weeks. Depression, anxiety, and stress states (DAS) were measured prior to and on completion of the intervention; employment outcomes were assessed at four- and ten-week follow-up as were conventional clinical measures such as measures of depression, anxiety, and stress. Results revealed that employment was found more rapidly after CBT than after standard job search assistance and that all three dysphoric states improved, usually before employment, in the CBT group at a statistically significantly greater degree than the control group. These findings indicate that CBT has a useful role in the rehabilitation of people on worker's compensation who are seeking employment even if they are not identified with a psychiatric condition.

And in a similar study, Proudfoot, Guest, Carson, Dunn, and Gray (1997) adapted the principles of CBT to create a group training program for a group of non-psychiatric, long-term (> 12 months) unemployed people. The aim was to investigate the effects of the program on measures of mental health, job-seeking, and job-finding. They evaluated 289 volunteers who were randomly assigned to a CBT program or control program without CBT. They were matched for all variables other than specific content that emphasized social support; 244 (134 CBT, 110 control) people began the program while only 199 (109 CBT, 90 control) completed the whole 7 weeks of weekly 3-hour sessions (including three CBT, seven control participants who withdrew because they obtained employment or full-time training). Questionnaires completed before training, on completion, and 3–4 months later assessed mental health, job-seeking activities, and success in job-finding. The analyses reported were based on those who completed the programs.

Participants were not aware that two interventions were being used. Investigators were aware of group allocation, but were accompanied in all programs by co-trainers who were non-investigators. The findings revealed that before training, 80 (59%) CBT-group participants and 59

(54%) controls scored 5 or more on the general health questionnaire (GHQ). After training, 29 (21%) and 25 (23%), respectively, scored 5 or more ($p < 0.001$ for both decreases). Improvements in mean scores with training on the GHQ (between-group difference 3.91, $p = 0.05$) and in other measures of mental health were significantly greater in the CBT group than in the control group. There were no significant differences between the groups in job-seeking activity during or after training, but significantly more CBT group participants than control group participants had been successful in finding full-time work (38 [34%] vs. 13 [13%], $p < 0.001$) by 4 months after completion of training. These results suggest that group CBT training can improve mental health and produce tangible benefits in job-finding. Application of CBT among the unemployed is likely to benefit both individuals and society in general. In other words, CBT therapists seemed to have an advantage in helping their clients achieve employment, whether it was improvement in their depression or an emphasis on developing the skills to get a job or both together in this integrated fashion. These studies raise the question as to whether there is a differential effect of CBT relative to other forms of psychotherapy although we were not aware of any direct head-to-head comparisons.

In looking at other forms of psychotherapy, in this instance, long-term psychoanalytic psychotherapy, de Maat, Philipszoon, Schouwers, Dekker, and De Jonghe (2007) examined the cost-effectiveness of a long-term psychoanalytic psychotherapy (LPT) in a review of 73 publications (7 studies of 861 patients) that met their strict criteria of outcome interventions of high quality design (RCT or cohort studies), for individuals between 18 and 65 years of age, who were "standard" psychoanalytic patients, with a treatment that lasted at least a year or 50 sessions. The cost per patient was €20,900 (U.S. \$26,245 using average exchange rates for 2006, the year for which these data were calculated) per year. During the year preceding treatment termination and the year preceding mean follow-up (2.9 years), the average reduction was 85% and 59%, respectively, in the number of hospital days; 54% and 56%, respectively, in the number of medical consultations; 70% and 19%, respectively, in the number of medication users, and 61% and 67% in days of sick leave. Healthcare use and absenteeism costs fell by an average of €5,584 (U.S. \$7,012), or 66%, between the year preceding the start of psychotherapy and the year preceding treatment termination. At mean follow-up (2.9 years) these cost reductions were still apparent, as the reduction was €5,372 (U.S. \$6,745), or 64%, in the year preceding follow-up. The break-even point for benefits and treatment costs was approximately three years after treatment termination. The reduction in work impairment appears to be the main factor (65% to 75%) in these

positive results. Their interpretations of the resulting data suggest that LPT substantially reduces healthcare use and absenteeism. The benefits seem to endure for years after termination and reach the point of counterbalancing the costs of treatment approximately three years after treatment termination.

Beutel, Rasting, Stuhr, Rüger, and Leuzinger-Bohleber (2004), in the context of a retrospective, long-term follow-up study, assessed work loss and hospitalization days before, during, and after psychoanalytic treatments based on patients' self-reports and health insurance records. Health insurance records showed evidence of a lasting reduction in work absenteeism and a low level of inpatient medical consultations and treatments. These trends contrasted favorably with the age-related increase in sick leave among the general population. Even disregarding other illness-related costs, based on health insurance records, considerable savings accrued over the 7-year follow-up period in terms of reduced absenteeism from work. While this study has some methodological weaknesses, (i.e., small participation, a before and after design, and reliance on self-report), it is one of the few that attempts to correlate healthcare use with the course of long-term psychotherapy (LTP) and demonstrates the economic savings in reduced absenteeism and co-occurring medical costs.

Berghout, Zevalkink, and Hakkaart-van Roijen (2010a) examined the experience of psychoanalysis versus psychoanalytic psychotherapy. They estimated incremental costs and effects by means of cross-sectional measurements in a cohort design (psychoanalysis, $n = 78$; psychoanalytic psychotherapy, $n = 104$). QALYs were estimated for each treatment strategy using a revision of the Short Form Health Survey (SF-36), a six-dimensional health state classification tool called the SF-6D (Brazier, Roberts, & Dervill, 2002). Total costs were calculated from a societal perspective (treatment costs plus other societal costs) and discounted at 4%. Not surprisingly they found that psychoanalysis was more costly than psychoanalytic psychotherapy, but also more effective from a health-related quality of life perspective. The ICER—that is, the extra cost to gain one additional QALY by delivering psychoanalysis instead of psychoanalytic psychotherapy—was estimated at €52,384 (U.S. \$65,780) per QALY gained. They concluded that their findings show that the cost-utility ratio of psychoanalysis relative to psychoanalytic psychotherapy is within an acceptable range. More research is needed to determine whether cost-utility ratios vary among different types of patients.

Berghout, Zevalkink, and Hakkaart-van Roijen (2010b) also studied the perception that long-term psychoanalytic psychotherapy is more expensive than other forms of medical care and psychological treat-

ments. They addressed the hypothesis that psychoanalytic treatment can result in cost savings in the long term. In this study, they investigated the effects of long-term psychoanalytic treatment on healthcare utilization and work impairment and calculated the associated societal costs. Healthcare utilization and work impairment of patients were assessed before, during, and after long-term psychoanalytic treatment ($N = 231$). Their results demonstrated that the difference in total costs associated with healthcare utilization and work impairment between pre- and post-treatment was €2,444 (U.S. \$3,070 using average exchange rates for 2006, the year for which these data were calculated) per person per year. Two years after treatment termination, these cost savings had increased to €3,632 (\$4,563) per person per year. This indicates that one can expect decreased consumption of medical care and higher work productivity immediately following the termination of psychoanalytic treatment, but also that long-term psychoanalytic treatment can continue to generate economic benefits after the treatment is terminated, the so called "sleeper effect," documented in other studies. However, we cannot conclude that all invested costs will be earned back eventually. More research is needed on the cost-effectiveness of psychoanalytic treatment.

Combined Treatments

Burnand, Andreoli, Kolatte, Venturini, and Rosset (2002) compared a combination of clomipramine and psychodynamic psychotherapy with clomipramine alone in a randomized controlled trial among patients with major depression. They treated 74 patients between the ages of 20 and 65 years who were assigned to ten weeks of acute outpatient treatment for major depression. Bipolar disorder, psychotic symptoms, severe substance dependence, organic disorder, past intolerance to clomipramine, and mental retardation were exclusion criteria. Marked improvement was noted in both treatment groups. Combined treatment was associated with less treatment failure, better work adjustment at ten weeks, better global functioning, and lower hospitalization rates at discharge. A cost savings of \$2,311 per patient in the combined treatment group, associated with lower rates of hospitalization and fewer lost workdays, exceeded the expenditures related to providing psychotherapy. Provision of supplemental psychodynamic psychotherapy to patients with major depression who are receiving antidepressant medication is cost-effective.

This study combined with the limitations noted in Birnbaum et al. (2010) above, namely that while absenteeism is diminished substantially in compliant depressed patients, presenteeism is extended in many of those who go back to work, suggests that psychotherapy and psychopharmacology work in different ways in terms of considering costs of care and work productivity. It could be that psychopharmacology creates conditions favorable to symptom reduction and mitigation of depression, and for some people that will be enough to restore them to their usual level of functioning. However, for others, those who could benefit from combined therapies, the psychopharmacology creates the opportunity for psychotherapy to produce other changes related to social roles, interpersonal relationships, and ultimately to productivity.

Lam et al. (2013) carried out a combined therapy of escitalopram plus telephone administered CBT in comparison to escitalopram plus a telephone reminder system which demonstrated significant advantages for CBT plus escitalopram, with improvement in some self-reported work functioning outcomes, but not symptom-based outcomes, compared with escitalopram alone as the active agent. The authors concluded that the CBT combined treatment was more effective than the medication plus supportive reminders. This study supports the idea that treatments are multi-faceted in their mechanisms of action (how could it be otherwise!) and that with an outcome as complex as work productivity, this multi-faceted approach has much to offer.

Subsyndromal Depression

Those with subsyndromal depression have been left out of the fold of medical care by virtue of having a condition that does not qualify for medical necessity. Consequently programs based on screening depression may miss them and they may not qualify for benefits provided to those who meet the criteria for depression. Judd, Paulus, Wells, and Rapaport (1996) address the socioeconomic burden of subsyndromal depression and major depression in the general population with a goal to evaluate the association between impairment in daily function and subsyndromal depression and major depression in order to determine the economic significance of these conditions. They used the Epidemiologic Catchment Area Program (ECA) assessments in the Los Angeles ECA site to divide 2,393 subjects into three groups: those with subsyndromal symptoms of depression ($N = 270$), major depression ($N = 102$), and no depressive symptoms ($N = 2,021$), and compared them on ten domains of functional outcome and well-being. They found that sig-

nificantly more subjects with depressive symptoms when compared to those with no depressive symptoms had high levels of household strain, social irritability, and financial strain as well as limitations in job and social functioning, restricted activity days, bed days, and poor health status. Significantly more of those with major depression, than those with no disorder, reported major financial losses, high levels of financial strain, bed days, limitations in physical and job functioning and poor health status. Except for lower ratings in health status, there were no differences in those with subsyndromal depression and major depression. This study, of course, makes the case for subsyndromal depression being a major element in reduced worker productivity.

Smit et al. (2006) addressed the treatment of subsyndromal depression in primary care with a program called "minimal contact psychotherapy" in a random control study comparing it to usual care. They carried out an economic evaluation in the process in order to study the cost-effectiveness of treatment as usual (TAU) plus minimal contact psychotherapy relative to usual care alone in preventing depressive disorder. An economic evaluation was conducted alongside a randomized clinical trial. Primary care patients with subthreshold depression were assigned to minimal contact psychotherapy plus usual care ($N = 107$) or to usual care alone ($N = 109$). They found that their primary care patients with subthreshold depression benefited from minimal contact psychotherapy as it reduced the risk of developing a full-blown depressive disorder from 18% to 12%. In addition, this intervention had a 70% probability of being more cost-effective than usual care alone. A sensitivity analysis indicated the robustness of these results. They concluded that the intervention was superior to usual care and cost-effective.

On the other hand, for patients with more chronic dysthymia and subthreshold depression, the findings of Fava, Ruini, and Belaise (2007) may be germane, in that in their review of the literature on the treatment of depression, they found an unsatisfactory degree of remission from current therapies. Apparently successful treatment is often accompanied by residual symptoms that have a strong prognostic value for predicting relapse and that progress to become prodromal symptoms of recurrence. Dysfunctional social and interpersonal patterns are positively correlated with poor long-term outcomes, and with persistent depression and relapse. The authors concluded that the fact that a patient no longer meets syndromal criteria is insufficient to designate full recovery despite the fact that the number and quality of subsyndromal symptoms is often not specified in treatments judged to be successful. Accordingly, treatments are needed that address ongoing characterological traits that put patients at risk for recurring illness. With respect to treatment resistant, persistent and recurrent depressive disorders

that do not remit with short-term treatments or that relapse shortly after apparent remission, additional studies specifically link personality disorders as a risk factor (Grilo et al., 2010; Skodol et al., 2011; Skodol et al., 2005). From the perspective of cost-effectiveness and the productivity of depressed patients over the long term, short-term treatments of depressive illness alone may not suffice for those with personality disorders. Patients with major depression and a comorbid personality disorder may need both illnesses treated to avoid recurrent and persistent depressive illness even when the treatment of the personality disorder may require a longer and more intensive treatment. Extended psychotherapy is often the treatment of choice for these illnesses.

Substance Abuse

Like psychotherapy and other treatments for work-related rehabilitation from mental illness, the literature for substance abuse treatments related to work function is thin. Here we will review reports that deal with presenteeism and absenteeism as well as effects of substance use on the job and efforts to cure and mitigate the loss.

Vice President Dan Quayle (1983) prepared an eloquent statement about the devastating impact of alcoholism and substance abuse on American productivity and seems like a good place to start. Published in 1983 in the *American Psychologist*, then Senator Quayle summarized the enormous workplace costs associated with alcoholism and substance abuse in the productivity of American workers noting that the U.S. had the highest use and addiction rate in the world. Noting the denial of substance users as a major barrier of their getting effective treatment, he maintained that much of American culture and specifically business and industry (both union and management) were in a state of denial about the extent of the problem as well as the solution proposed at that time (adequate and generous insurance). He cited employment assistant programs (EAPs) as a possible remedy.

Alcohol Use and Abuse

Since Senator Quayle made his eloquent pleas to come out of denial and to begin talking about this destructive force, Harwood (2000), reviewing the economic side of alcohol abuse, noted that in 1998, alcohol problems alone cost employers nearly \$134 billion in lost productivity, mostly due to absenteeism and poor work performance. Roche, Pidd,

Berry, and Harrison (2008) reviewed workers drinking habits and the impact on productivity in order to examine the relationship between Australian workers' patterns of alcohol consumption and absenteeism. A total of 13,582 workers 14 years and older were studied by questionnaire. More than 40% of the Australian workforce consumed alcohol at risky or high-risk levels at least occasionally. High-risk drinkers were up to 22 times more likely to be absent from work due to their alcohol use compared to low-risk drinkers. Short-term high-risk drinkers were also significantly more likely to be absent from work due to any illness or injury than employed low-risk drinkers. Young employees and males were more likely to report alcohol-related absenteeism compared to older workers and females. The authors concluded that the relationship between workers' alcohol consumption patterns and absenteeism is more substantial than previously recognized or documented. Alcohol-related absenteeism is not restricted to small numbers of chronic heavy drinkers, but also involves the much larger number of non-dependent drinkers who drink less frequently at risky levels. To improve workers' health and wellbeing and enhance productivity and economic prosperity, appropriate education, prevention, and policy strategies are warranted that extend their range to those who may not be qualified under present rules of medical necessity.

Effective approaches do exist and here we will highlight some work-oriented examples. Frone (2006) reported that recent survey data indicates that workplace alcohol use and alcohol-related impairment impact 15% of the U.S. workforce, totaling approximately 19.2 million workers (as cited in Doumou & Hannah, 2008). Research also indicates that substance abuse is associated with multiple negative outcomes.

Mangione et al. (1999) addressed the effects of drinking on the job by examining the independent effects of a variety of drinking indicators on self-reported work performance. Data from a cross-section mail survey (response rate = 71%) of managers, supervisors, and workers ($N = 6,540$) at 16 worksites were analyzed. Average daily volume was computed from frequency and usual quantity reports. Drinking on the job included drinking during any of six workday situations. Employees were also asked how frequently they drank to get high or drunk. Work performance was measured through a series of questions about work problems and their priority. The number of times respondents experience work performance problems was assessed during the prior year. The results revealed that the frequency of self-reported work problems increased generally with all of the four drinking measures. Interestingly, although moderately heavy and heavy drinkers reported more work performance problems than the very light, light, or even moderate drinkers, the lower-level drinking employees were more plentiful

and therefore accounted for a larger proportion of work performance problems than did the heavier drinking groups. The investigators concluded that employers should develop clear policies limiting drinking on the job and in addition EAPs for problem drinkers and should develop worksite education interventions aimed at informing all employees about the relationships between drinking behaviors and work performance.

There are notable differences between the mental health and substance abuse realms and one of them is the use of coercion in treatment. Miller and Flaherty (1999) report that their clinical experience and treatment outcome studies to date strongly suggest that coercion is fundamental to addiction treatment and to favorable outcomes from therapeutic interventions. Often the alcoholic/drug abuser must be given an opportunity to feel, face, or experience the "consequences" of their alcohol and drug addiction before the denial of their illness can be penetrated and motivation for treatment to recover from addictive illness can be developed. Continued use of alcohol and drugs is an unhealthy and dangerous state for those who are addicted and for others who are affected by their addictive illnesses. Effective therapeutic interventions and long-term recovery are more likely to succeed if avoiding "alternative consequences" are contingent on continued compliance.

The role of EAPs is prominent in the literature addressing work-related substance abuse. Since the effects of substance use are more pervasive, and active substance use can be carried out at work (and is more clearly devastating in the short- and long-term consequences, in reference to work than most mental illnesses), it is no surprise that EAPs have developed this line of work effectively for it addresses a gap in services. This is especially true of the treatment of alcoholism. Selvik, Stephenson, Plaza, and Sugden (2004) reported on a multi-site survey of federal occupational health (FOH) EAPs that covered more than 60,000 lives and that found improvements from clients in all six outcome measures of (1) productivity influenced by mental problems, (2) productivity influenced by physical health problems, (3) social relationships, (4) health status, (5) absenteeism and tardiness, and (6) GAF (global assessment of functioning).

EAPs appear to be economical as well. Blum and Roman (1995) reported on the cost-effectiveness of EAPs and note that providing employees with comprehensive health plan benefits that support a broad range of services, including screening, brief intervention, counseling and medical services, promotes customized treatment for each individual. Treatment tailored to the individual has been demonstrated to be most effective, while only costing about six cents more per person per year than restricted benefits. The company found that when employees

used its EAP for help with mental health and substance abuse problems: (1) those workers had fewer inpatient medical days than workers who participated only in the company's medical insurance plan, and (2) the company averaged \$426,000 in savings annually on mental health and substance abuse treatment.

Walsh et al. (1991) performed a trial of 227 employed individuals who were newly identified as alcohol abusers. Their study was a randomized design with patients assigned to one of three treatments through their employee assistance program. The treatments were: (1) compulsory inpatient treatment, (2) compulsory AA attendance, and (3) choice of treatment option. Two years after treatment, the three groups did not differ in measures of job performance. However, a major finding was that, overall, the cost of treatment for the compulsory inpatient group was only 10% more than it was for the AA and choice groups. The small cost difference was particularly true for study participants who had used cocaine in the six months before they began treatment. The overall cost results occurred because the choice and AA groups had a much higher inpatient treatment admission rate during the two-year follow-up period than did the group who initially received compulsory inpatient care. An implication of the small cost difference which was confirmed during the follow-up assessments was that, at least for some of the time after treatment, the compulsory inpatient group used less alcohol and drugs than did the other two groups. In this regard, the study suggests that more intense treatments may be less costly in the long run for some people, especially those who have more severe psychiatric or social difficulties.

Sharar, Pompe, and Lennox (2012) noted that despite the popularity and prevalence of EAPs, and the historical emphasis on how EAPs can improve work performance, there has been very little rigorous evaluation of the workplace effects of EAP counseling. Their study was to examine if and to what degree EAP counseling correlates with improved workplace effectiveness. They examined a sample of 197 subjects all employed by two Fortune 100 companies who received EAP counseling via an EAP affiliate provider in 2010. The Workplace Outcome Suite (WOS), a five-item, five-scale outcome measurement specifically designed for EAPs, was employed as a pre/post measure, with the post-measure occurring about 90 days after the EAP intake. A paired *t*-test was used to compare the pre- and post-means on four of the scales, and a Wilcoxon test was used for absenteeism due to skewing. All scales show positive change from the pre- to post-test, with two scales meeting the .05 level and two showing high significance at the level of $p < 0.0001$. Even though EAP affiliate network models rarely provide "pro-

tolcol" driven intervention and may not specifically focus on workplace issues, they still seem to produce workplace-related improvements.

Other Substance Abuse Treatments

The treatment of each drug of abuse has its own culture and its own technology and we will not review that in any detail. Rather we will present the work of some of those who have taken an economic approach to considering this care.

Cost-Effectiveness in the Treatment of Addictions

As noted above Blum and Roman (1995) found a substantial return on investment when the care is focused and conducted well. Fleming et al. (2000) found that heavy drinkers who received brief intervention over a 2-month period had significantly fewer accidents, hospital visits, and other events related to problem drinking during the following year. The cost for each brief intervention was \$166 per patient; the medical savings were \$523 per patient.

Another study, The Alcohol and Drug Services Study (ADSS), produced by the Substance Abuse and Mental Health Services Administration, Office of Applied Studies (Shepard, Beaston-Blaakman, & Horgan, 2003), showed that outpatient treatment costs less than inpatient treatment. The National Institute on Drug Abuse (1999) also found that outpatient treatment: (a) minimizes an employee's time away from work, (b) costs less than inpatient treatment, (c) can motivate people to change their behaviors, thereby reducing the risks and negative consequences associated with substance abuse.

POLICY IMPLICATIONS AND FUTURE DIRECTIONS

In considering the implications for policy development and new directions, we offer the following summary facts from our literature review. Mental illness is highly prevalent (at any time somewhere between 15% and 20% of the population have mental illness). Active mental illness for those who are working frequently interferes with work by causing an increased number of days off (absenteeism) and/or interference with effective work performance when not off from work (presen-

teism). Overall the U.S. economy loses over 200 billion dollars per year due to mental illness and substance abuse among workers.

Depression is among the most prevalent mental illness with 1 in 10 Americans affected in any given year, and 1 in 5 being affected by the disease over their lifetime. And much of the time depression coexists with other illness making it even more difficult to integrate the treatment resources available. In addition, with depression as with other illnesses, the condition exists on a continuum of disability and severity. This is especially true with depression in the form of subsyndromal depression which has been not only demonstrated to exist but also to have a substantial work interfering capacity that equals that of depression proper. In some insurance approaches subsyndromal depression is not considered to meet the medical necessity requirements, and thus, is not eligible for reimbursement. Furthermore, despite increased attention being directed at the treatment of depression, and evidence that the use of psychotropic medication has increased sharply over the past decade, a significant segment of the population suffering from depression remains undiagnosed, untreated, and/or under-treated. Depressed workers, especially untreated ones, are a significant cost burden on employers. Although estimates vary, a 1998 analysis found that depressed workers cost their employers 70% more in annual healthcare costs when compared with their non-depressed colleagues (Goetzel et al., 2002). Also the greatest impact for productivity losses is in the form of absenteeism and presenteeism.

Treatment for depression can be effective, with a large proportion of patients improving from medications, psychotherapy, or a combination of the two. While medications are typically helpful, there is some evidence that the approach of medications alone is limited as a treatment for all patients and limited in its restoration to full work productivity. Furthermore, in many if not all settings, in addition to the medications frequently prescribed and effective psychotherapy engaged, a case management approach offers a supportive approach to work-related effectiveness and treatment. Several investigators note that having an intervention specifically oriented to work has better results than more generic treatments. Combining medications with psychological approaches may be effective for both CBT and long-term psychodynamic psychotherapy (LTPP) as well. LTPP, while more expensive, seems to provide more benefit for those who are working according to the studies cited here. The effect of psychodynamic psychotherapy seems to maximize the capacity to focus on work and personal relationships. The benefits of LTPP not only persist following therapy termination but continue to grow (Berghout et al., 2010a). CBT seems to benefit by a similar process, namely that the medications facilitate learning or reduce the barriers

to learning and the incorporation of the skills into daily life. Perhaps by conceptualizing job-seeking as a skill, those given CBT did better at finding work while their depressive symptoms improved at the same rate as the control group. Unfortunately we do not really know how different treatments focused on working benefit depressed patients. Speculatively, perhaps medications allow patients to achieve a normalization of the biological system dysregulation that influences mood states and their responsiveness to social and psychological events. Untreated depression could simply interfere with learning. For some, correcting that is enough for a good enough recovery. For others medication may be an essential underpinning for the modification of a system of mental representations that leads to dysfunction at work in the first place, which can best be achieved through psychotherapy.

At another level the success of the EAPs around substance abuse and to some extent for all other mental health problems seems to signal that some form of supportive case management may be necessary to remove the barriers to effective treatment. The system that has been formulated by Lerner and colleagues (Lerner et al., 2011, 2012) is particularly attractive in that regard and seems to have much promise.

Whatever the mechanism of action, the system of the funding of care in the U.S. is now fragmented and disjointed making it difficult to put together the range of services needed to support the recovery of mentally ill patients and to support their sustained (or episodic for that matter) recovery over time. The business goals of the insurance industry are based on short-term profits and the treatment of some of these patients is a long-term prospect. In addition, there are simply not enough therapists who are well trained and skilled to provide necessary services from a psychotherapeutic perspective for all the people who could use it. There needs to be a system of care that can bring together the essential elements, present them to the working patient in a manner in which they can be used, and ensure the proper follow-up and improve adherence.

We clearly have an access problem and our biggest challenge might be the way that we consider access. We now have the ironic situation that one illness with high prevalence and substantial impact on worker productivity that has a reasonable array of effective treatments available is still ignored or poorly understood in the workplace. Even if we had the workforce resources and the proper insurance reform we do not have the patient compliance with treatments that could benefit them substantially. Part of access has to be education of patients and families and more work to eradicating stigma.

The Appendix summarizes representative literature that has been reviewed here and there are some recommendations to be added to

the prescription to offer more insurance benefits. Now is the time, as we enter into a new way to deliver care and to manage the healthcare resources of the U.S., to create a more healthy population, and to consider how to make the treatment of mental illness and substance abuse more available to those who can benefit from it. For those who recognize that they have depression (could be true for any mental illness or substance abuse) and want treatment and will seek treatment, a large part of the answer is simply to have an appropriate insurance plan that will not punish one economically for seeking the appropriate treatment for this disabling illness. For these people the major barrier to access is economical and the solution is insurance reform.

For those who recognize that they are depressed but who do not seek treatment, we must understand and address their reasons why. If the matter is economic, we must have policies that do not punish people for their illness. They must have assurances that they can return to work if they need to have time off during the processes of treatment and recovery. "No fault" leave policies for the time to have the kind of treatment that a person requires may be helpful. The role of ignorance about the illness, treatment, and the ongoing impact of stigma must also be addressed as much as possible without wearing out the message.

For those who do not know that they are depressed or fearful about the consequences, the approaches employed for other illnesses (public education and public demonstrations of the ubiquity of the illness, the "disease" nature of the illness, and the course, treatment, and recovery options available) must be developed and deployed with a new rigor and inventiveness.

We also need to be discerning about what the literature might be telling us about the treatment of these illnesses. It is clear that three very different approaches are effective: (1) medications, (2) psychotherapy (two forms at least), and (3) organized support at work through aggressive EAP outreach, engagement, and treatment, as well as thoughtful combinations of these treatments.

Medications clearly are effective but when compared to psychotherapy they are certainly not more effective and sometimes less so. Perhaps we could say that they are differentially effective, being more powerful in some rather than other conditions and people. And there is a suggestion that they help in a different way—they take away whatever it is that reduces the capacity of the depressed patient to work and relate within an average expectable condition of employment. It enhances capacity, but does not ensure the exercise of it.

EAPs, especially when deployed along with medications, allow people to learn more about their illnesses, to destigmatize their condi-

tion and to see more closely what they experience and what they bring to their work that is unproductive. EAPs have the ability to relate the work problems more directly to the depression and hence enhance the patients' chances to gain intellectually in knowledge and skill as well as to diminish the distress that interferes with high level psychological functioning.

Finally, psychotherapy has a strong place in the treatment of workplace depression and reduced productivity by its capacity to address a person's reluctance to work in the first place. Behavioral oriented approaches (cognitive and behavioral therapy is by far the most widely accepted version of this approach), and psychoanalytic psychotherapy and psychoanalysis are empirically supported as effective and cost-effective approaches. The theories, methods, and outcomes of these two psychotherapeutic approaches are different and appeal to different people. Both CBT and LTPP have something to offer for the disability of mental illness in the work place. They both can provide a type of learning and growth that may be necessary at the individual level for high-level psychological functioning required for success in most modern industrial cultures. But they probably address different forms of growth and adaptation. And they call on different temperaments and choices for how the world is organized in the minds of patients.

But for this to work the way we desire it to, there must be something from the work site itself that addresses how work may or may not be healthy for some. For those who are eager to recover and return to work, there must be appropriate structures in place to give that assistance. A novel approach that is specific to restoration of work has been implemented and reported as a pilot by Lerner et al. (2011). Termed the Work and Health Initiative (WHI), this program combines web-based screening, care coordination, work-oriented coaching specific to the effects of the work on behaviors related to work, and CBT strategies for the individual worker that are tailored to the work. The pilot has been embedded within existing EAPs and preliminary results show great promise (Lerner et al., 2011, 2012).

POLICY RECOMMENDATION

Our recommendations fall into four domains: care system reform, insurance reform, education, and research.

Care System Reform. This is underway with the PP (Patient Protection) and ACA (Affordable Care Act) as well as the evolving parity legisla-

tion and implementation noted in this issue. However, there are perils in realizing meaningful reforms. There are not enough psychiatrists to carry the clinical work of what needs to be done and there may not be enough mental health practitioners including psychologists, nurses, and social workers. The concepts of access and engagement of patients needs serious re-conceptualization—it is not enough simply to offer the services, they have to be offered in a way that they can be used, and we need to redefine illnesses eligible for assistance to include those with subsyndromal conditions. To the extent that much of this will fall to primary care clinical structures, we must develop strategies for mental health professionals to have meaningful, embedded roles within these settings. Strategies need to be developed to bring psychiatrists into the operation of these complex organizations. All participants need to understand that mental illness is a different kind of illness, not nearly categorical in most cases (you have diabetes or not) blending in as it does to the population along with the ambiguity of the subsyndromal dimension of the disorders (one's depression may be susceptible to life events). We must find ways to engage people who see themselves as basically just out of luck for being the way they are as to being able to change their reactions to the world. More sensitive and creative solutions to case finding are needed to help move forward the drive for better mental health and the processes for engaging them into therapy.

Insurance Reform. Again this is underway under the ACA legislation and various parity legislation and its implementation, but there is much unknown about how this will fare in the long run. Surely meaningful parity is necessary as is the move to measure and regulate by outcomes instead of delivery and utilization as is currently the practice. The claim of the past that psychological treatments are susceptible to moral hazard must be put aside and replaced with sound treatment protocols. Patients must be educated as to what works and how, and to be encouraged to select and believe in their treatment. It will be a determinative experiment to see how professionals, now given more opportunity to organize the care system, will respond.

Education. There has to be better education of everyone—psychiatrists, other physicians, insurance leaders, but most of all, patients and their families. People who suffer from mental illness need to learn that there are mental health professionals, who have their interests at heart and who have the knowledge and skill as well as the wisdom to treat them effectively.

There also has to be better education of the primary care MDs so that the collaboration of primary care physicians and psychiatrists is

smooth and based on mutual respect and good intentions. Employers need to know that it is clearly in their best interest to have a mental health system that is responsive and effective and it is what we can do with their mentally ill workers and what they can do to help with these processes. In short we need an integrated care system that educates, screens, treats, follows up, and supports those who are hampered by mental illness and substance abuse. And it should be brought into alignment with systems of employment.

Research. Now more than ever we need the kind of research that is going to answer quickly some of the mysteries that face us. Just where is the cutoff point to consider where illness begins and/or leaves off and how we can determine it?

SUMMARY AND CONCLUSION

Mental illness (especially depression), substance abuse, and subsyndromal mental illness are prevalent and reduce workplace productivity substantially. These conditions can be effectively mitigated and treatment works. Furthermore, there seems to be a specific effect of psychotherapy.

We emphasize that the first step is to recognize the prevalence of mental illnesses and substance abuse problems within the workforce. Industry leaders must take a proactive approach to the nature of benefit plans for healthcare and insure that effective benefits are present in the programs supported. There should be a mental health professional who advises the leadership of a corporation on the value of a benefit array that addresses the needs, especially the mental health needs, for they are so often ignored or misunderstood. We should stop worrying about moral hazard and adverse selection. It is a hazardous morality that seeks to deny care to those who want it, have identified that they need it, and who will use it.

This article is accompanied by an Appendix that contains the major references of this work that address the impact of the treatment being investigated or reviewed through a clinical trial or a critical review of the literature. The Appendix summarizes the details of the study and presents the findings for disability, presenteeism, absenteeism, effectiveness, cost-effectiveness, and medical costs as appropriate.

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APPENDIX. Summary of References Demonstrating Costs, Effectiveness, and Cost-Effectiveness

Article	Berghout (2010a), The effects of long term psychoanalytic treatment on health care utilization and work impairment and their associated costs, Journal of Psychiatric Practice
Disability	
Presenteeism	Pre treatment reduced efficiency costs: \$1,355; Post treatment: \$918; Follow up: \$500
Absenteeism	Pre treatment absence from work costs: \$2,435; Post treatment: \$1,255; Follow up: \$595
Effectiveness	
Cost Effectiveness	Difference between pre and post treatment societal costs: \$3,070/person/yr. After follow up the total cost savings had increased to: \$4,563/person/yr
Medical Care Costs	Direct medical care costs: Pre-treatment: \$1,570; Post treatment these costs decreased to \$866; At follow up, these costs had further decreased to \$738.
Article	Berghout (2010b), A cost utility analysis of psychoanalysis (PA) vs. psychoanalytic psychotherapy (PT), International Journal of Technology Assessment in Health Care
Disability	
Presenteeism	
Absenteeism	
Effectiveness	Difference in pre-treatment and post-treatment utility scores: Psychoanalytic Psychotherapy (PP): 0.054; Psychoanalysis (PA): 0.089. Both exceed 0.033, thus both treatments had a clinically relevant effect on health-related quality of life.
Cost Effectiveness	PA compared with PP showed that the cost of one QALY gained was just over \$65,241. More QALYs were achieved after PA as compared with PP (6.4 vs. 4.5, respectively)
Medical Care Costs	PA treatment costs: \$129,865; PP treatment costs: \$28,325

Article Beutel (2004), Assessing impact of psychoanalysis and psychoanalytic therapies on health care utilization and cost, *Psychotherapy Research*

Disability

Presenteeism

Absenteeism Mean days of sick leave Psychoanalytic treatment: 1 yr before treatment: 8.2 days; 1 yr post treatment: 5.1 days; 1 yr post treatment: 5.2 days

Effectiveness 75.9% of the patients were satisfied with their psychoanalyses or long-term psychotherapeutic treatments. 70–80% of patients achieved good and stable psychic changes (average 6.5 yrs after ending tx)

Cost Effectiveness Savings almost equaled the treatment costs (estimates range of savings: 80–97% of total cost). This is not considering the substantial improvements in quality of life and well-being attained by the tx.

Medical Care Costs Mean number medical consultation/yr: 1 yr pre-treatment: 5.8 First yr of treatment: 3.3 1 yr follow up: 3.5 Reduced regular use of psychotropic medication (13% initially, 3% at the end of treatment).

Article birnbaum (2010), Assessing the relationship between compliance with antidepressant therapy and employer costs among employees in the United States, *Journal of Occupational & Environmental Medicine*

Disability

Presenteeism Presenteeism costs: Depressed Compliant patients: \$19,170; Depressed Non-compliant: \$15,829

Absenteeism Absenteeism costs: Compliant patients w/ anti-depressant: \$3857; Non-compliant w/ anti-depressant: \$4,907; Depressed patients compliant: \$3976; Depressed non-compliant: \$5899

Effectiveness Increased compliance with antidepressants is significantly associated with reduced absenteeism costs.

Cost Effectiveness

Medical Care Costs Direct Medical costs (minus drug costs): Compliant patients w/ anti-depressant: \$4,879; Non-compliant w/ anti-depressant: \$5,461; Depressed patients compliant: \$5,654; Depressed non-compliant: \$6,519

Article Blonk (2006), Return to work: A comparison of two cognitive behavioural interventions in cases of work-related psychological complaints among the self-employed, *Work & Stress*

Disability

Presenteeism

Absenteeism

Effectiveness

Cost Effectiveness

Medical Care Costs

Partial return occurred 17 and 30 days earlier in this group than in the CBT group and the control group, respectively. Full return to work, the difference was approx. 200 days

Scores for depression, anxiety, and stress had decreased after 4 and 10 months of follow up in all 3 groups including the control group.

Workers with the combined intervention returned after 122 days, while those in the control group returned after 320 days.

Article

Disability

Presenteeism

Absenteeism

Effectiveness

Cost Effectiveness

Medical Care Costs

Blum & Roman (1995), Cost-effectiveness & preventive implications of EAPs, *SAMHSA*

After 4 yrs, EAP clients treated for AOD dependency had a turn-over rate of 7.5% as compared to 40% for employees using other routes.

50 companies credited their EAPs a 14% increase in productivity.

50 companies credited their EAPs with a 21% absenteeism reduction. One study of employees receiving alcohol/other drug (AOD) treatment through an EAP missed 44% fewer days of work as compared to employees who sought treatment through other routes.

Gillette Company saw a 75% drop in inpatient substance abuse treatment costs after implementing an EAP.

Companies with EAPs report dollar cost savings of anywhere from \$5 to \$15 for every \$1 spent on EAP services. The McDonnell Douglas EAP estimated saving \$5.1 M due to fewer days missed from work, lower turnover, and lower medical claims of employees, spouses, and dependents.

50 companies credited their EAPs with a 17% reduction in on-the-job accidents.

Article Burnand (2002), Psychodynamic psychotherapy and clomipramine in the treatment of major depression, Psychiatric Services

Disability

Presenteeism

Absenteeism Duration of sick leave: Combined treatment: 46.1 days (\$7,211); Clomipramine alone: 57.9 days (\$9,057); Number of hospitalizations: Combined: 2; Clomipramine alone: 9

Effectiveness Combined treatment Hamilton Depression Rating Scale scores: Baseline: 24.3 Post-treatment: 8.9; Clomipramine alone HSDR scores: Baseline: 24 Post-treatment: 9.7; Combined treatment Global Assessment Scale scores: Baseline: 43.3; Post-treatment: 62.8; Clomipramine alone GAS scores: Baseline: 43.1 Post-treatment: 58.3

Cost Effectiveness The total costs/patient: Combined group: \$10,187; Clomipramine alone: \$2,311/patient in the combined treatment group

Medical Care Costs The total direct costs: Combined treatment: \$2,976; Clomipramine alone: \$3,441; Direct cost savings: \$465/patient in the combined treatment

Article Currendall (2010), Productivity losses among treated depressed patients relative to healthy controls, Journal of Occupational & Environmental Medicine

Disability Patients with depression had STD costs that were \$356 higher/ patient and those with severe depression had costs that were \$861 higher.

Presenteeism

Absenteeism Those with severe depression incurred significantly higher absenteeism costs compared with the matched controls. Controlling for covariates, the marginal effect was \$338

Effectiveness

Cost Effectiveness

Medical Care Costs

Article De Maat (2007), Costs and benefits of long-term psychoanalytic therapy: Changes in health care use and work impairment, Harvard Review of Psychiatry

Disability

The reduction in work impairment appears to be the main factor (65% to 75%) in these positive results.

Presenteeism

Sick leave: The average pre-/post-treatment reduction was 61%, and the mean pretreatment/ follow-up reduction was 67%. Sick-leave days/yr: Pre-treatment: 20.8; Post-treatment: 6.9; Reduction: 13.9

Effectiveness

The mean cost of LPT/patient was \$25,829. The mean costs of health care use and sick leave pre-treatment were \$10,398/person. Post-treatment were \$3,494/person. The break-even point for benefits and treatment costs was approximately 3 yrs after treatment termination

Cost Effectiveness

Medical Care Costs Days in the hospital: The mean pre-/post-treatment reduction was 85%, and the mean pre-treatment/ follow-up reduction was 59%. Medical Consultations: mean pre-/post-treatment reduction: 54%; mean pre-treatment/follow-up reduction: 56%.

Article

Della-Posta & Drummond (2006), Cognitive behavioural therapy increases re-employment of job seeking worker's compensation clients, Journal of Occupational Rehabilitation

Disability

Mean time (\pm S.D.) taken to secure employment: CBT group: 6.6 \pm 2.2 wks after the onset of treatment. Standard Job Search group: 8.3 \pm 1.3 wks

Presenteeism

Absenteeism

After treatment, depression, anxiety and stress scores decreased in the CBT group but did not change in the Job Search group

Cost Effectiveness

Medical Care Costs

Article Doumas & Hannah (2008), Preventing high-risk drinking in youth in the workplace: A web-based normative feedback program, *Journal of Substance Abuse Treatment*

Disability

Presenteeism Alcohol use and alcohol-related impairment impact 15% of the U.S. workforce (19.2 million workers)

Absenteeism

Effectiveness Decreases in the intervention group were significantly greater than those in the control group for weekend drinking, frequency of drinking to intoxication, and peak consumption

Cost Effectiveness

Medical Care Costs

Article Druss (2000), Health and disability costs of depressive illness in a major US corporation, *American Journal of Psychiatry*

Disability Employees treated for depression incurred annual per capita health and disability costs of \$5,415. Almost one-fifth of the costs of depressive illness in this company were related to disability pay.

Presenteeism Depressive illness was associated with a mean of 9.86 annual sick days

Absenteeism

Effectiveness

Cost Effectiveness

Medical Care Costs The cost of non-mental-health care for depressed patients during that time period was \$3,032. Employees with comorbid general medical and depressive illness cost \$7,906, or 1.7 times more than those with either condition alone.

Article	Druss (2001), Comparing the national economic burden of five chronic conditions, Health Affairs (Millwood)
Disability	
Presenteeism	Cost of work loss: People treated for depression: \$11.5 billion
Absenteeism	Employees w/ Mood Disorder: 18% missed 1 or more work days annually due to their condition. Lost Wages: people w/ 1 or more of the 5 chronic conditions: \$36.2 billion in wages
Effectiveness	The impact of lack of insurance on access to and intensity of treatment was greatest for mood disorders. % treated: Mood Disorders: 67; Diabetes: 95.3; Heart Disease: 92.6; Hypertension: 95.3; Asthma: 83.4
Cost Effectiveness	
Medical Care Costs	Mood Disorders was ranked 2nd out of 5 chronic conditions in total health and work-loss costs.
<hr/>	
Article	Eaton (2008), The burden of mental disorders, Epidemiologic Reviews
Disability	Global Burden of Disease (GBD) Schizophrenia (highest): 0.53; Bipolar disorder (highest): 0.40; Drug abuse /dependence: 0.25; Major depressive disorder: 0.35
Presenteeism	
Absenteeism	
Effectiveness	
Cost Effectiveness	
Medical Care Costs	Cost estimates/yr (billions): Panic Disorder: \$30.4; Schizophrenia: \$70.0; Bipolar Disorder: \$78.6; Major Depressive Disorder: \$97.3; Drug abuse: \$201.6; Alcohol abuse/dependence: \$226.0. Estimates are composed of direct (medical care) and indirect costs.

Article Fleming (2000), Benefit-Cost analysis of brief physician advice with problem drinkers in primary care settings, *Medical Care*

Disability

Presenteeism

Absenteeism Costs due to lost worktime: \$29.67/patient

Effectiveness The mean number of binge drinking episodes reported by the intervention group decreased by 49.1% at the 6-month point and by 45.7% at the 12-month point.

Cost Effectiveness Benefit-cost ratio was 5.6:1 (\$56,263 in total benefit for every \$10,000 invested.)

Medical Care Costs The intervention caused: \$195,448 in savings in emergency department and hospital use; \$523/patient in medical care savings.

Article Goetzel (2002), The business case for quality mental health services: Why employers should care about the mental health and well-being of their employees, *Journal of Occupational & Environmental Medicine*

Disability Workers with depression experienced 1.5 to 2.3 more STD days than workers w/out depression over a 30-day period (Kessler, 1999).

Presenteeism The number of lost workdays declined from 1.31 to 0.25/patient in the 6 months after antidepressant treatment (Katzelnick, 1997). Persons with depression had 1.09 days more/month of work cutback than those w/out psychiatric problems (Kessler, 2001).

Absenteeism Persons w/depression were absent 1/4 day more/month than those w/out psychiatric problems (Kessler, 2001).

Effectiveness Patients in clinics that emphasized psychotherapy suffered 47 fewer days of depression over the 2-yr period, and patients in clinics that emphasized medication suffered 25 fewer such days (Wells, 2000).

Cost Effectiveness Medical costs for 20 patients averaged \$13.28/ day (6-month pre-treatment for depression) and \$12.55/day (in the 6 months post treatment) Post treatment costs included costs of depression treatment (Katzelnick, 1997).

Medical Care Costs Depressed and stressed individuals were 70% and 46%, respectively, more costly than those lacking these risks. Individuals who reported being both depressed and highly stressed: 147% more costly than their counterparts w/out those risks.

Article Greenberg (2003). The economic burden of depression in the United States: How did it change between 1990 and 2000, Journal of Clinical Psychiatry

Disability

Presenteeism Workplace costs: \$51.9 billion in 1990 and \$51.5 billion in 2000. Presenteeism accounted for 16.1% of the 1990 total, and 18.4% of the 2000 total.

Absenteeism Workplace costs: \$51.9 billion in 1990 and \$51.5 billion in 2000. Absenteeism accounted for 51% of the 1990 total, and 43.6% of the 2000 total.

Effectiveness

Cost Effectiveness

Medical Care Costs Of the 1990 total, \$19.1 billion (26%) were direct medical costs. Of the 2000 total, \$26.1 billion (31%) were direct medical costs

Article Hargrave (2008), EAP treatment impact on presenteeism and absenteeism: Implications for return on investment, Journal of Workplace Behavioral Health

Disability

Presenteeism Reduced productivity: Pre-treatment: 9.22 hrs/wk; Post-treatment: 2.70 hrs/wk; 2.60 days/employee (403 days total)

Absenteeism %age of Employees Improved: Number of sick days: 32.0; Tardiness: 32.7

Effectiveness %age of Employees Improved: Concentration: 72.7; Energy level: 68.9; Quality/quantity of work: 68.2/64.7; Relationships w/ supervisors and coworkers: 45.6

Cost Effectiveness ROI: in a typical EAP for every dollar spent for the program- expected return of between \$5.17 and \$6.47.

Medical Care Costs The overall cost of the EAP program is \$24,000.

Article Harwood (2000), Updating the economic costs of alcohol abuse in the US: Estimates, update methods, and data, Prepared by The Lewin Group for The National Institute on Alcohol Abuse and Alcoholism

Disability

Presenteeism Costs due to alcohol related reduced productivity: \$134 billion in 1998 (mostly absenteeism and poor work performance)

Absenteeism Costs due to alcohol related reduced productivity: \$134 billion in 1998 (mostly absenteeism and poor work performance). Overall economic cost of alcohol abuse was \$185 billion in 1998

Effectiveness

Cost Effectiveness

Medical Care Costs Excess Healthcare Costs due to Alcohol Problems in 1998 were \$26.3 Billion.

Article Hilton (2009), The association between mental disorders and productivity in treated and untreated employees, Journal of Occupational & Environmental Medicine

Disability

Presenteeism As psychological distress levels decrease, the productivity of the in treatment group rises from 5.6% (high K6)* to 15.9% (moderate K6) to 16.7% (low K6). Productivity of untreated group as they move from high K6 (18.6%), medium K6 (19.5%), and low K6 (20.3%) levels of distress

Absenteeism In treatment employees with a high K6 have 6.2% less extensionism than high K6 not in treatment group.

Effectiveness The investigators found the productivity of employees w/out psychological distress and who have not been in treatment for a mental disorder was 20% (SE _ 0.3%). The productivity of a successfully treated employee (low K6) for a mental disorder was 17% (SE 0.6%).

Cost Effectiveness

Medical Care Costs

Article	IBI Quick Study (2009), The impact of chronic conditions and co-morbidity on lost work time, IBI Quick Study
Disability	
Presenteeism	Socioemotional conditions result in the most presenteeism lost time. Individuals w/both socio-emotional conditions and additional cluster co-morbidities: Average 12 (12.1) annual presenteeism lost days. Only socio-emotional conditions: average 10 (9.6) annual presenteeism lost days
Absenteeism	Absenteeism (2.5 days) are added to presenteeism (10.8 days) social and emotional disorders account for 13.3 days of lost productivity/yr, by far the highest lost productivity in this group of chronic illnesses and their relationship to each other.
Effectiveness	
Cost Effectiveness	
Medical Care Costs	
Article	Kessler (2006), Prevalence, comorbidity, and service utilization for mood disorders in the United States at the beginning of the twenty-first century, Annual Review of Clinical Psychology
Disability	
Presenteeism	Presenteeism: for people with bipolar disorder (average of 35.3 days/yr.); for people with major depressive disorder (average 18.2 days/yr)
Absenteeism	Absenteeism: for people with bipolar disorder (average 27.7 days/yr) and people with major depressive disorder (average 8.7 days/yr)
Effectiveness	
Cost Effectiveness	
Medical Care Costs	

Article Lam (2013), Effects of combined pharmacotherapy and psychotherapy for improving work functioning in major depressive disorder, *British Journal of Psychiatry*

Disability

Presenteeism Telephone CBT vs. Escitalopram alone: Lam Employment Absence and Productivity Scale (LEAPS) productivity subscale scores 3.9 vs. 2.6. The Health and Work Performance Questionnaire (HPQ) Overall Performance change scores: The telephone-CBT group showed significantly greater improvement than the escitalopram-alone condition

Absenteeism Escitalopram-alone group had numerically higher reduction in hrs of work missed than the telephone-CBT group; Telephone CBT vs. Escitalopram alone: LEAPS total score 9.7 vs. 6.9

Effectiveness Results: After 12 wks, there were no significant between-group differences in change in Montgomery-Åsberg Depression Rating Scale (MADRS) score or in response/remission rates. There was significant improvement in change scores on the MADRS w/in each treatment condition, w/large baseline-to-end-point effect sizes ($d = 1.78$ and $d = 1.72$, respectively).

Cost Effectiveness

Medical Care Costs

Article Lerner (2012), Impact of a work-focused intervention on the productivity and symptoms of employees with depression, *Journal of Occupational & Environmental Medicine*

Disability

Presenteeism \$6,041.70 would be saved annually for each depressed employee who participated in the program. \$979 of the total is attributable to reduced at-work productivity.

Absenteeism \$5,062 of the total is attributable to reduced absence costs.

Effectiveness At follow-up, PHQ-9 depression severity scores significantly improved in the WHI group. Pre-treatment: 13.1; Post-treatment: 7.7. The change in usual care group mean scores was not significant.

Cost Effectiveness

Medical Care Costs

Article Loeppke (2009), Health and productivity as a business strategy: A multi-employer study, *Journal of Occupational & Environmental Medicine*

Disability

Presenteeism Average monetized lost productivity/yr due to depression is highest for Executives (\$15,889 compared with \$3,903–\$11,646 for other occupation groups). Employees' health-related productivity costs are, on average, 230% greater than medical and pharmacy costs.

Absenteeism For every dollar of medical and pharmacy costs, there is on average \$2.30 of health-related productivity loss. 70% of the full cost of poor employee health is caused by absenteeism and presenteeism.

Effectiveness

Cost Effectiveness

Medical Care Costs Of the top five conditions driving overall health care costs (work related productivity + medical + pharmacy cost), depression is ranked number one; 30% of the full cost of poor employee health is attributable to medical care costs and pharmaceutical costs.

Article Mangione (1999), Employee drinking practices and work performance, *Journal of Studies on Alcohol and Drugs*

Disability

Presenteeism Mean score for doing less work: Abstainer: 0.93; Heavy: 1.55

Absenteeism Mean number of missed days: (lowest level of drinking to highest level of drinking) Abstainer: 1.24; Heavy: 1.52

Effectiveness The overall number of work performance problems increased as a function of increasing drinking level category. All problems (lowest level of drinking to highest level of drinking): Abstainer: 4.88; Heavy: 7.43

Cost Effectiveness

Medical Care Costs

Article Merikangas (2007), The impact of co-morbidity of mental and physical conditions on role disability in the US adult household population, Archives of General Psychiatry

Disability U.S. adults with 1 or more of the mental or physical conditions report an average 32.1 more role disability days/yr than matched controls (total: 3.6 billion days)

Presenteeism

Absenteeism The classes with the 2nd and 3rd highest estimated days are: anxiety disorders (706.6 million days); mood disorders (489.7 million days)

Effectiveness

Cost Effectiveness Annual medical expenses-chronic medical & behavioral health conditions combined cost 46% more than those with only a chronic medical condition

Medical Care Costs

Article Miller & Flaherty (1999), Effectiveness of coerced addiction treatment (alternative consequences): A review of the clinical research, Journal of Substance Abuse Treatment

Disability A 60% reduction in turnover rate of employment for psychiatric clients and 81% for alcohol and other drug use clients (Normand, 1994).

Presenteeism

Absenteeism EAP clients who received treatment for psychiatric and alcohol/drug use had lower absenteeism: 34% and 44% fewer days lost than those with psychiatric/alcohol/drug problems who did not receive treatment (Normand, 1994).

Effectiveness Findings showed that treatment was effective, in that alcohol and drug use was reduced by about two-fifths (Gerstein, 1994).

Cost Effectiveness On average, \$1.00 of treatment costs saved at least \$7.00 in other medical and social costs (Gerstein, 1994).

Medical Care Costs A Fortune 100 company's EAP: annual medical costs for workers with addictive illness fell from \$2,068/yr to \$165/yr after the employees received treatment. Even when treatment costs were added, the total health care cost savings was approximately \$500/employee.

Article	Miranda (2008), The societal promise of improving care for depression: Nine years out, RAND Research Brief, RAND Research Briefs
Disability	
Presenteeism	The programs increased the amount of time patients were working by about 1 month.
Absenteeism	The programs increased the amount of time patients were working by about 1 month.
Effectiveness	12 months after study enrollment, patients in the programs were 10 %age points less likely to be clinically depressed than were patients in usual care. A full 57 months after enrolling in the study, patients in the QI programs were 7 %age points less likely to be depressed.
Cost Effectiveness	The programs modestly increased health care costs but, compared with other accepted interventions, were cost-effective
Medical Care Costs	
Article	Proudfoot (1997), Effect of cognitive-behavioural training on job-finding among long-term unemployed people, Lancet
Disability	
Presenteeism	
Absenteeism	Success in finding full-time work four months post-training: Cognitive Behavioral Therapy (CBT) group: 34%; Control Group: 13%
Effectiveness	General Health Questionnaire (GHQ) mean scores after treatment: significantly greater in the CBT group than in the control group.
Cost Effectiveness	
Medical Care Costs	

Article	Quayle (1983), American productivity: The devastating effect of alcoholism and drug abuse, American Psychologist
Disability	Employees with a drinking or drug problem use a third more sickness benefits, and have five times more compensation claims while on the job than the average employee.
Presenteeism	\$30.1 billion of the \$70 billion is related to lost productivity due to employee alcohol and drug abuse
Absenteeism	Employees with a drinking or drug problem are absent 16 times more than the average employee
Effectiveness	Reported recovery rates for employees referred to EAPs range as high as 90%, and in most programs are around 50%
Cost Effectiveness	For every dollar invested in EAPs, employers realize returns ranging from \$2 to \$20. Treatment has also resulted in sharp reductions in the use of health care services by members of the treated employee's family, another savings often overlooked.
Medical Care Costs	The price of health care, days away from work, and lost productivity as the result of addiction and alcoholism is \$70 billion.
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Article	Roche (2008), Workers' drinking patterns: The impact on absenteeism in the Australian work-place, Addiction
Disability	
Presenteeism	
Absenteeism	High-risk drinkers were up to 22 times more likely to be absent from work due to their alcohol use compared to low-risk drinkers. Alcohol-related absenteeism in 2001: 2.7 million days lost at a cost of about \$845 million
Effectiveness	
Cost Effectiveness	
Medical Care Costs	Workers who regularly drank at risky or high-risk levels were significantly more likely than low-risk drinkers to take a day off of work due to illness/injury (odd ratio 0.87 vs. 1.53)

Article	Rosenheck (1999), Effect of declining mental health service use on employees of a large corporation, Health Affairs
Disability	
Presenteeism	
Absenteeism	Sick-day use for previous mental health users increased 22% when access to mental health benefits was restricted
Effectiveness	
Cost Effectiveness	Savings in mental health services were fully offset by increased use of other services and lost workdays by a ratio of roughly 3:1. Managed behavioral health practices reduced behavioral health service costs by 37.7% in 21,000 employees over 3 yrs, there was an associated 36.6% increase in nonbehavioral health expenses with a net annual increase in total health care costs of \$130/enrollee.
Medical Care Costs	Restrictions in mental health visits lowered specialty care costs but increased primary care costs. 36.6% increase in nonbehavioral health expenses.
Article	Rost (2004), The effect of improving primary care depression management on employee absenteeism and productivity a randomized trial, Medical Care
Disability	
Presenteeism	The intervention significantly improved productivity by 6.1% ($p < 0.05$) in all employees, and by 8.2% over 2 yrs.
Absenteeism	The intervention significantly tended to improve absenteeism by 22.8% ($p = 0.06$), and by 28.4% or 12.3 days over 2 yrs.
Effectiveness	
Cost Effectiveness	The gain translated into \$1491 for decreased presenteeism and into \$539 for decreased absenteeism/one depressed employee/annum
Medical Care Costs	

Article Selvik (2004), EAP impact on work, relationship, and health outcomes, *Journal of Employee Assistance*

Disability

Presenteeism "Quite a bit of difficulty" performing work due to: Physical Health: reduced from 15% to 5% of cases; Mental Health: reduced from 30% to 8% of cases

Absenteeism Absenteeism and tardiness: Before use of the EAP: 2.37 days of unscheduled absences or tardy days in the prior 30-day period. After completing EAP sessions: average of 0.91 days.

Effectiveness The clients' General Health Status scores improved from 2.55 (pre) to 2.37 (post). Work and Social Relationship scores also improved from 2.75 (pre) to 1.89 (post).

Cost Effectiveness

Medical Care Costs Clients experienced a 31% reduction in possible health-related job loss costs

Article Sharar (2012), Evaluating the workplace effects of EAP counseling, *Journal of Health and Productivity*

Disability

Presenteeism Presenteeism Workplace Outcomes Suite (WOS) scores: Pre-test: 13.99; Post-test: 10.15

Absenteeism Absenteeism WOS scores: Pre-test: 8.39; Post-test: 5.87

Effectiveness Life Satisfaction WOS scores: Pre-test: 14.13; Post-test: 15.45; Workplace Distress WOS scores: Pre-test: 12.37; Post-test: 11.71

Cost Effectiveness

Medical Care Costs

Article	Shepard (2003), The ADSS cost study: Costs of substance abuse treatment in the specialty sector, Department of Health and Human Services
Disability	
Presenteeism	
Absenteeism	
Effectiveness	
Cost Effectiveness	Mean cost of admission: nonmethadone outpatient admission was 1/3 of a nonhospital residential admission (\$1,169 vs. \$3,132).
Medical Care Costs	Cost/enrolled client day: nonmethadone outpatient care was 1/7 of a nonhospital residential day (\$9.17 vs. \$62.10). The cost/enrolled client day in outpatient methadone care (\$10.32) was only marginally higher than the cost/enrolled client day in non-methadone outpatient care (\$9.17).
Article	Smit (2006), Cost-effectiveness of preventing depression in primary care patients: Randomised trial, British Journal of Psychiatry
Disability	
Presenteeism	Work cut-back costs: Control Group: \$2,855; Experimental Group: \$2,007
Absenteeism	Work loss costs: Control Group: \$2,134; Experimental Group: \$2,948. The mean cost of the production losses was \$4170 in the intervention condition vs. \$5,827 in the usual care condition, resulting in an average savings of \$1,657.
Effectiveness	Rate of depressive disorder: 12 months: 11.9% in the psychotherapy group s. 18.3% in the TAU group. Results suggest that adjunctive minimal contact psychotherapy is more successful than usual care alone in reducing the incidence of depressive disorder
Cost Effectiveness	The incremental cost-effectiveness ratio= -288.75, meaning for each case of depression that can be avoided by offering the experimental treatment (vs. TAU), a saving is made of \$259.62
Medical Care Costs	The mean difference of the direct medical costs was \$54 (s.e. = 555) in favor of care as usual, but this was not statistically significant ($P = 0.914$).

Article Stewart (2003), Cost of lost productive work time among US workers with depression, JAMA

Disability

Presenteeism Lost hrs/wk due to presenteeism: Depressed employees: 4.6 (\$35.75 billion); Non-depressed: 1.1 (\$9.17 billion)

Absenteeism Lost hrs/wk due to absenteeism: Depressed employees: 1.0 (\$8.27 billion); Non-depressed: 0.4 (\$3.90 billion)

Effectiveness

Cost Effectiveness

Medical Care Costs U.S. workers with depression cost employers: \$44 billion/yr in LPT (an excess of \$31 billion for workers w/out depression). This does not include labor costs associated w/disability.

Article Sturm (1999), How expensive are unlimited substance abuse benefits under managed care, Journal of Behavioral Health Services & Research

Disability

Presenteeism

Absenteeism

Effectiveness

Cost Effectiveness Providing comprehensive unlimited substance abuse health benefits costs just \$.06 more/member than imposing a \$10,000 limit on those benefits

Medical Care Costs

<p>Article Disability Presenteeism Absenteeism Effectiveness Cost Effectiveness Medical Care Costs</p>	<p>Walsh (1991), A randomized trial of treatment options for alcohol-abusing workers, <i>New England Journal of Medicine</i></p> <p>Subjects in all three groups showed substantial improvement in all aspects of job functioning. 76% of supervisors rated subjects' performance as "Good" or "Excellent."</p> <p>Number of hrs recorded by the company as missed from work dropped by more than 1/3 in all groups.</p> <p>At 24 months outcome measures: Report of any drinking: Hospitalization group: 41%; AA group: 80%; Choice of treatment group: 62%; Hospitalization (for drinking): Hospitalization group: 18%; AA group: 63%; Choice of treatment group: 27%</p> <p>Costs for the AA group: \$1,200 less/person than hospitalization group (a savings of just 10%)</p>
<p>Article</p>	<p>Wang (2007), Telephone screening, outreach, and care management for depressed workers and impact on clinical and work productivity outcomes: A randomized controlled trial, <i>Journal of the American Medical Association</i></p>
<p>Disability</p>	<p>Intervention group showed significant improvements in job retention (92.6% vs. 88.0% by 12-month; OR, 1.7; 95% CI, 1.0–3.3)</p>
<p>Presenteeism</p>	<p>The intervention increased effective hrs worked ($p = 0.002$, 3.3 increased hrs worked)</p>
<p>Absenteeism</p>	<p>Scores on the summary effective hrs worked measure were significantly higher in the intervention than usual care group at 6 (= 3.0) and 12 (= 3.3) months.</p>
<p>Effectiveness</p>	<p>Intervention group had a higher %age of people with improved symptoms (30.9% vs. Control 21.6%). Intervention had a higher recovery rate (26.2% vs. Control 17.7%)</p>
<p>Cost Effectiveness Medical Care Costs</p>	<p>The gain translated into 2.6 more hrs/wk, or 2 more wks</p>

Article	World Health Organization (2001), Mental health: A call for action by World Health Ministers
Disability	In the Medical Outcomes Study: Depression was the most disabling condition of all those investigated.
Presenteeism	In all countries mental illness was among the five leading factors contributing to low productivity and absenteeism.
Absenteeism	In all countries mental illness was among the five leading factors contributing to low productivity and absenteeism.
Effectiveness	
Cost Effectiveness	
Medical Care Costs	Studies from countries with established economies have shown that mental disorders consume more than 20% of all health service costs. The aggregate yearly cost of mental disorders in 1990 for the U.S. was estimated at \$148,000 M USD

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Current State of Psychotherapy Training: Preparing for the Future

Jerald Kay and Michael F. Myers

Abstract: This article provides an overview of what is currently being taught in psychiatry residency programs about psychotherapy in general, and to evolving changes in the field related to mental health parity and the Affordable Care Act (ACA) in particular. Future psychiatrists must have a firm grasp of not only the principles of psychotherapy but also the development of increasingly effective and evidence-based psychotherapies if they are to be effective health care leaders. We review what attracts medical students to psychiatry and how much their decision to train in psychiatry is rooted in a desire to learn both dynamic psychiatry and psychotherapy in its various modalities. It is no secret that the quality of teaching and learning psychotherapy is variable in our training programs. One reason for this can be attributed to trainees who ascribe more to the biological dimensions of our field and have less interest and commitment to more than basic skills in psychotherapy. In addition, in some settings there is a dearth of teachers trained in the various forms of psychotherapy who are committed to this pedagogical imperative. We conclude with several recommendations to residency training programs and to residents themselves regarding what we deem essential in both the curricular and clinical exposure to the challenges and shortcomings of the mental health parity and Affordable Care Act. Tomorrow's psychiatrists have a fiduciary responsibility of advocating for their complex and chronically ill patients that must include providing psychotherapy.

WHY DO MEDICAL STUDENTS CHOOSE PSYCHIATRY?

Only 685 graduates of allopathic (M.D. granting) U.S. medical schools matched into psychiatry in 2014 (National Resident Matching Program [NRMP], 2014). This represents about half of the positions offered. The remaining slots were filled by international medical gradu-

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ates (U.S. and non-U.S. citizens), Canadian medical students, graduates from osteopathic schools, and students who graduated the previous year. Internal medicine and family medicine have similar fill rates but are on the upswing. Additionally, the NRMP has increased in competitiveness. Fourteen allopathic schools increased class size by more than 10% and four new schools opened in the recent past. Applications from medical students graduating from osteopathic schools, including 20 new ones, and from Caribbean medical schools, have increased the pool of applicants to psychiatry.

Psychiatry is one of the top “aging” specialties defined by the number of practitioners 55 years and older—only preventive medicine and clinical pathology rank higher. Given the large number of psychiatrists retiring and the small and stagnant number of U.S. seniors and graduates selecting psychiatry residencies, the field is poised to have difficulty meeting the challenges of increased mental health needs as supported by both parity and ACA legislation (Association of American Medical Colleges [AAMC], 2014). Indeed from 2000 to 2008, the number of psychiatrists decreased by 14%.

REQUIREMENTS FOR PSYCHOTHERAPY TRAINING

In 2001 the Accreditation Council for Graduate Medical Education (ACGME) established six core mandated areas of competency for residents including: Patient Care; Medical Knowledge; Interpersonal and Communication Skills; Practice-Based Learning and Improvement; Professionalism; and Systems-Based Care, and added psychotherapy competencies for psychiatry residents (Mellman & Beresin, 2003). At the time, this was considered a boon to the preservation of psychotherapy training in psychiatric education. There have been some modifications in competencies since then. Currently the ACGME’s competencies for psychiatry (2007) require that all graduating residents will be proficient in:

- Using pharmacological regimens, including concurrent use of medications and psychotherapy (IV.A.5.a).(3).(c)
- Applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as to assuring exposure to family, couples, group and other individual evidence-based psychotherapies (IV.A.5.a).(3).(e)

- Providing care and treatment for the chronically mentally ill with appropriate psychopharmacologic, psychotherapeutic, and social rehabilitative interventions (IV.A.5.a).(3).(g)
- Evaluation and treatment of ongoing individual psychotherapy patients, some of whom should be seen weekly under supervision (IV.A.5.a).(5).(c).(i)
- All U.S. residency programs in psychiatry are expected to provide training in psychotherapy competency, and when or if these above parameters are not met, they traditionally would have received one or more citations by the Resident Review Committee (RRC) in psychiatry when the program is site visited for accreditation. Although site visits are now to take place only every ten years, new processes have been implemented to monitor compliance.

THE MILESTONES INITIATIVE

Recently the ACGME has developed a new accreditation system that focuses on specialty-specific competencies called Milestones (Bernstein, 2013). Milestones are knowledge, skills, attitudes, and other attributes for each of the ACGME competencies organized in a developmental framework from less to more advanced. They are descriptors and targets for resident performance as he or she progresses in the training experience. Residents will be rated as “proficient” as these educational milestones are met throughout training according to five levels based on expectations for beginning advanced and graduating residents.

Current evaluation tools include, but are not limited to peer-evaluations, in-service examinations, direct observation, and simulation (Bernstein, 2013). Nevertheless, monitoring adherence to the milestones will present a challenge moving forward. For psychiatry, the Milestones are a product of the *Psychiatry Milestone Project* (2013), a joint initiative of the ACGME and the American Board of Psychiatry and Neurology (ABPN).

The Milestones support the place of psychotherapies as central to the practice of psychiatry. Regarding residents’ training in psychotherapy, what follows are two facets of the milestones.

PC4 (Patient Care 4): Psychotherapy

Refers to (1) the practice and delivery of psychotherapies, including psychodynamic, cognitive-behavioral, and supportive psychothera-

pies; (2) exposure to couples, family and group therapies; and (3) integrating psychotherapy with psychopharmacology

- Empathy and process
- Boundaries
- The alliance and provision of psychotherapies
- Seeking and providing psychotherapy supervision.

MK4 (Medical Knowledge 4): Psychotherapy

Refers to knowledge regarding: (1) individual psychotherapies, including but not limited to psychodynamic, cognitive-behavioral, and supportive therapies; (2) couples, family and group therapies; and (3) integrating psychotherapy and psychopharmacology

- Knowledge of psychotherapy: theories
- Knowledge of psychotherapy: practice
- Knowledge of psychotherapy: evidence base.

Regarding residents' training in systems-based care and the importance of psychotherapy in the treatment of complex, chronically ill patients, here are other dimensions of the milestones that prepare them for a "real world" career after graduation:

PC3: Treatment Planning and Management

- A. Creates treatment plan
- B. Manages patient crises, recognizing need for supervision when indicated
- C. Monitors and revises treatment when indicated.

(Level 3 notes incorporating manualized psychotherapies when appropriately indicated and Level 5 notes supervising treatment planning of other learners and multidisciplinary providers.)

MK6: Practice of Psychiatry

- A. Ethics
- B. Regulatory compliance
- C. Professional development and frameworks.

It is important to note that Level 4 refers to the significance of advocacy, not just on behalf of one's specific patient but advocacy on broader systems issues, including working with policy makers like state and federal legislators and both peer and professional organizations. This expands the scope and mandate of medical training.

With the cessation of the live patient interview within Part II of the ABPN examinations, residency training programs have been assigned the responsibility of evaluating those Milestones relevant to establishing a therapeutic alliance such as the capacity to elicit a comprehensive and empathic interview, establishing a safe, non-judgmental relationship that respects boundaries, and demonstrating an ability to formulate a patient's psychiatric problems by integrating what has traditionally been termed the biopsychosocial approach. Essentially, what will now become Part I of the ABPN examination is to occur within the residency. Those trainees unable to demonstrate Milestone accomplishments will not be certified to sit for the successive parts of the board examination.

WHAT DO RESIDENTS HAVE TO SAY ABOUT THEIR TRAINING IN PSYCHOTHERAPY?

In an anonymous electronic questionnaire survey of 15 U.S. residency programs in 2006-2007 ($n = 249$ residents), Calabrese et al. (2010) concluded that their data gave a mixed picture of how residents experience their training in psychotherapy. Over one-half agreed that their program provided high-quality psychotherapy training. Concerns about the adequacy of the time and resources provided by their programs were expressed by 28%. Further, although most residents generally believed that their training directors supported psychotherapy training, approximately one-third of the respondents did not believe that other key department leaders were supportive. This perception raises concern and suggests the need to insure the implementation of the competencies and milestones discussed above.

WHAT DO TRAINING DIRECTORS HAVE TO SAY ABOUT PSYCHOTHERAPY TRAINING TODAY?

Sudak and Goldberg (2012) surveyed U.S. general psychiatry training directors in 2009 about the current state of teaching psychotherapy in their respective programs. They received 82 valid returned sur-

veys representing a response rate of 45% of U.S. programs. The largest amount of didactic training and supervision is in psychodynamic psychotherapy. Less time was devoted to cognitive behavioral therapy (CBT) didactics and supervision but there was an increase from an earlier survey in 2001. Interestingly, although supportive psychotherapy is the most widely practiced, it receives the least amount of didactic time and supervision. There are no clear guidelines as to what the optimal didactic and supervised clinical experiences are to produce “competent” residents. In an attempt to address this, the Executive Council of the American Association of Directors of Psychiatric Residency Training (AADPRT) has initiated the charge to its Psychotherapy Committee.

OBSTACLES TO TRAINING IN PSYCHOTHERAPY

As alluded to earlier, if trainees get mixed messages from their supervisors about the usefulness of psychotherapy versus psychopharmacology, they will not feel unequivocally supported in meeting basic competencies in this modality—nor in pursuing additional training while in residency or after graduation. Further, if the majority of their supervisors are themselves practicing mostly split treatment and little or no psychotherapy, their primary role models will be psychiatrists who largely prescribe medication and apply only basic supportive psychotherapy principles or strategies. Despite robust psychotherapy efficacy research, residents training in ambulatory psychiatry may be influenced by “quick fix” psychopharmacology results (which may not be sustained) in providing symptom relief without the exposure to patients who improve over time with a variety of psychotherapy modalities that take longer. This is especially true in the treatment of personality-disordered patients. Moreover, it has been demonstrated that dynamic psychotherapy provides mechanisms for increased personal and social development after treatment termination (Bateman & Fonagy, 2001). Lack of exposure of trainees and early career psychiatrists to these very important aspects of psychiatric care will lead to a diminishing of what the field has to offer patients.

Watson and Michels (2014) have recently argued for the retention of the psychodynamic perspective within the neuroscience curriculum in the residency contending that many of the central questions facing neuroscience research revolve around the understanding of the human internal experience. These include topics such as attachment, motivation, cognition, and emotional processing.

Despite ACGME regulations that residents have a two-year experience (spanning the PGY3 and PGY4 years) treating ambulatory patients with long-term psychodynamic psychotherapy (with or without adjunctive medication), residents' experiences often fall far short of this goal (Clemens & Notman, 2012). In addition to a shortage of appropriate faculty and supervisors and the challenge of finding appropriate cases at the point when residents need to begin this experience, most residents choosing to specialize in child and adolescent psychiatry begin this training after the third year of general residency. Still other general psychiatry residents use significant chunks of their fourth year to remediate incomplete blocks from earlier years or make up for missed rotations because of maternity/paternity leave or complete research projects, thus interrupting the process of learning long-term therapy. The psychotherapy experience and supervision are therefore likely to get short shrift. We argue that training in psychotherapy, with the richness of learning about interpersonal interactions that it involves, be made a higher priority in residency training in fact as well as on paper.

ENHANCING THE APPEAL OF PSYCHOTHERAPY TRAINING

Residency training accreditation is evolving rapidly and therefore for those faculty practitioners who endorse psychotherapy as a core clinical skill and find psychotherapy attractive for many reasons, paying close attention to the process of establishing curricular content and evaluation policies by the ACGME is vital. The same is true for attending to the goals of organized psychiatry as represented chiefly through the American Psychiatric Association (APA). Within the formal APA structure support for psychotherapy is conspicuous by its absence. At this year's annual meeting approximately 40 members attended the initial session of a psychotherapy caucus, however, there was no longer a formal committee on the practice of psychotherapy, and the APA journal devoted to this topic, the *Journal of Psychotherapy Practice and Research*, was discontinued more than a decade ago. A recent article entitled "Training the Psychiatrist of the Future" by a residency educator and the president of the APA noted five areas requiring the field's attention: (1) doctor-patient relationship; (2) diversity and broad range of treatments/roles; (3) integrated care; (4) neuroscience education; and (5) systems of care and quality improvement (Summers & Lieberman, 2013). Although noting the centrality of rapidly establishing a therapeutic alliance, the authors expressed the opinion that the psychiatrist of the future is likely to have less regular face-to-face time with pa-

tients. Moreover, while acknowledging the need for a broad range of treatments, they recognized this has always been a challenge for preparing residents. The implications for training programs, especially as they relate to the teaching of psychotherapy, are of great consequence. Instead of demonstrating competency in the delivery of long-term dynamic psychotherapy, for example, the focus will shift to evaluating competency in establishing a therapeutic relationship and treatment frame (Bernstein, 2013) and greater emphasis on brief treatments. Ironically, the latter is often more challenging to teach without sufficient long-term psychotherapy experience. Many of these issues are significant areas of concern for the future of psychotherapy but beyond the scope of this article. The remainder of this article, therefore, will focus on direct teaching initiatives.

For psychotherapy provided by psychiatrists to remain a core clinical skill and to be intellectually attractive to residents, concerted and simultaneous efforts must be made on four levels: continuing medical education (CME), faculty, resident, and medical students.

CONTINUING MEDICAL EDUCATION

CME opportunities in psychotherapy have been limited. The APA annual scientific program offers case conferences, workshops, symposia, and courses on psychotherapy topics but because of time constraints, these activities can rarely provide the extended experience needed to master psychotherapy. CME activities do not provide effective vehicles to teach skills and attitudes that were missed during the formal training period. It is challenging to integrate into daily practice what was so briefly encountered without attention to reinforcement and guided follow-through. It is true that many psychoanalytic institutes are devoting more resources to advanced psychodynamic psychotherapy programs for continuing education; however, these tend to be expensive and, if the clinician is geographically removed from a sponsoring organization, it is unlikely to be an attractive possibility. The increasing growth of telepsychiatry and educational technology should provide an impetus and the opportunity for the development of new models of postgraduate education in dynamic therapy and other sophisticated therapies. Finally, requirement for maintenance of certification by the ABPN was established to promote lifelong learning and competence. However, it is unclear how improving psychotherapy skills will be addressed within this initiative given its heavy reliance on CME products from professional organizations.

EXPOSURE TO PSYCHOTHERAPY IN THE MEDICAL STUDENT EDUCATION PROGRAM

Despite the push for greater ambulatory care experiences by the Liaison Committee on Medical Education (the accreditation body for American medical schools), many students receive most of their clinical psychiatry training on traditional inpatient units. Thirty years ago it was possible to observe individual, family, and group therapies in such settings; this is no longer the case since length of stay has dramatically decreased and patient acuity has significantly increased. Most students focus on three dimensions of their patient care: diagnosis, drugs, and disposition. Nearly all students hear of psychotherapy in lectures but few ever see it conducted. Innovative educational programs about psychotherapy are desperately needed within the junior clerkship yet the demands of a four to six week experience rarely permit much beyond a passing discussion about psychotherapy. However, on a positive note, this may be more likely to occur in those limited residency programs that support chief residency positions in medical student teaching (Roman, Khavari, & Hart, 2010). The necessity therefore for providing opportunities almost always falls to the senior year elective in psychiatry most often, but not always, subscribed to by those students with a stronger interest in psychiatry. While it is also possible to provide preclinical experiences integrating exposure to psychotherapy, these require substantial faculty and/or resident input and have mostly been pilot projects not easily sustained.

MAINTAINING WELL-TRAINED FULL-TIME AND VOLUNTEER FACULTY PSYCHOTHERAPISTS

Over the last 15 to 20 years, fundamental changes have altered the roles of faculty (Greenberg, 2013). First, for many years, academic departments across all clinical specialties have been comprised of an increasingly larger junior faculty who are more likely to be clinician-educators (AAMC, 2014). Their heavy clinical and teaching duties, the former often supplying the larger part of these faculty salaries and contributing to financial well-being of an academic department, have made for large workloads that impinge not only on scholarly development but the ability to teach residents and students. As a result, residents account for greater portions of the teaching responsibilities for students and often for their junior resident peers. Yet residents now struggle

more intensely with challenges between the provision of clinical service versus acquiring clinical education, a situation that is complicated by their growing role as consumers of education with its increasing program evaluation activities and that of ACGME (Greenberg, 2013). Yet economic pressures for those in private practice have resulted in decreased availability of volunteer teachers across all clinical specialties. In psychiatry, the voluntary faculty for many years provided the bulk of outpatient clinical supervision, especially in psychotherapy. In larger urban areas, psychoanalysts made substantial contributions to the teaching of psychotherapy. However, this group is no longer as large nor are they able to escape the economic pressures faced by their non-analytic colleagues, leading to a threat to the continuation of this source of educators. In a recent survey of the 16 Canadian residency programs, seven program directors responded and all of them indicated a need for more psychotherapy supervisors (Stovel & Felstrom, 2013).

There is a crisis on two fronts: how to retain voluntary faculty and how to ensure that newer fulltime faculty are competent to teach psychotherapy courses and provide supervision of resident clinical work in ambulatory, consultation, and inpatient experiences. We have described the demands of new accreditation requirements that will focus on milestones and more precise methods of evaluation of resident competency. Departments of psychiatry therefore must provide instruction to volunteer faculty in the new evaluation methods and ensure that they are sensitive to new training requirements. With increased paperwork in the absence of remuneration, a concerted effort must be made to reward the volunteer teachers appropriately. This might include offering a clinical appointment, timely promotion to the next level of advancement, being nominated for teaching awards, and exclusive conferences that permit discussion of supervisory challenges.

Outside of a small number of prominent academic psychiatry departments, there are a decreasing number of faculty members with psychoanalytic training or advanced training in dynamic therapy. There is a very real question as to where the next generation of dynamic, CBT, dialectical behavioral therapy (DBT), brief therapy, supportive, family and group therapy teachers and supervisors will come from. Departments must step forward to support young faculty who choose to attend advanced psychotherapy courses often sponsored by analytic institutes. One of us (JK) has over the years sent full-time faculty to CBT or interpersonal therapy (IPT) training programs to ensure an adequate number of faculty proficient to teach these approaches. It may be that this strategy will be adopted to ensure competent faculty in psychotherapeutic treatments. Formal mentoring programs by knowledgeable senior faculty therapists may require departmental support. Case

reports are excellent vehicles for learning about psychotherapy and, when written well for peer-reviewed journals, can support requirements for academic advancement. A number of national psychiatric organizations provide visiting professorships in psychodynamic psychotherapy for residency programs. This model is readily adaptable to faculty development as well. As a means of becoming aware of key issues in psychotherapy practice and research, junior faculty should be encouraged to review manuscripts for psychotherapy journals.

RESIDENTS

Training directors and senior faculty have a significant role in promoting the benefits of treatment experiences for their residents, especially in light of the recent decline in the number of residents pursuing personal psychotherapy. Proficiency in supportive psychotherapy is an RRC requirement for graduation from a residency. It is often a missed opportunity that dynamically informed supportive therapy is not emphasized. It tends to provide a broad-based perspective in the treatment of more marginally functioning patients and in those with recent circumscribed trauma. Those educators that continue to provide grand rounds presentations on psychotherapy are impressed by the lack of faculty and resident knowledge about research in the psychotherapies. They more readily follow the psychopharmacology literature and have greater confidence in this area. Some may follow the CBT literature but few are aware of the efficacy studies in mentalization-based treatment (MBT), transference-focused psychotherapy (TFP), and psychodynamic psychotherapy for panic disorder, to mention but a few. These visiting professors have also been struck with the dramatic change of outpatient experiences for residents. Some residency clinics now resemble community mental health centers with respect to their patient acuity and triage focus. Many residents struggle to find the opportunity to treat patients that are higher functioning. Fewer have the experience of successful treatment of depression without utilizing medication in spite of research evidence of the efficacy of psychotherapy in this domain (see article on the efficacy of psychotherapy in this issue). Moreover, the literature indicates that a substantial portion of psychiatric patients require long treatment experiences. This group is comprised of personality disordered patients as well as those suffering from severe chronic mental illnesses and those with chronic comorbid mental and medical illnesses. It is vital that residents have opportunities to care for these patient populations. Medicare-mandated faculty clinical presence aside, training programs must ensure a patient base that will provide

the requisite psychotherapy experiences for residents. Referral sources must be developed for the resident clinic. Special programs for graduate students, many of whom are not eligible for their student mental health services, should be encouraged.

There is a need to incorporate new technological approaches within the residency curriculum. One online model is the Psychotherapy Training e-Resources (PTeR). This McMaster University Web-based learning program is intended to supplement traditional psychotherapy instruction (Weerasekera, 2013). It contains 11 separate modules covering a broad range of treatments including, but not limited to, CBT, psychodynamic, interpersonal, dialectical behavioral, group, and family therapies as well as motivational interviewing. The program reviews the evidence-based psychotherapy literature and includes quizzes, reading materials, vignettes, and simulations (“the Virtual Therapists”) to assess content mastery.

Another innovative approach to provide more in-depth psychotherapy experience is exemplified by the University of Colorado’s “Psychotherapy Scholars’ Track and Apprenticeship Model” that is provided to two residents in each of the four years of training with explicit learning goals and objectives in each of the postgraduate years (Feinstein & Yager, 2013). The apprenticeship portion of this initiative involves intense faculty participation in this first of three phases of treatment followed by increasing assumption of leadership and teaching responsibilities among the residents. Patients and residents appear to enjoy this treatment approach and thorough clinical and educational evaluation of this program is anticipated.

Residents deserve the opportunity to conduct long-term dynamic psychotherapy beyond limited rotations. The capacity to tolerate strong patient affect, to be able to ensure a safe environment for traumatized patients, to allow immersion into a patient’s inner world, to appreciate the course of mental disorders, and to appreciate how much of human behavior is outside of awareness are issues best expressed within longer and in-depth treatment. These are precisely the issues that must be taught by a psychiatrist team leader to other team members in the new models of treatment and therapy delivery that are likely to evolve as a result of the ACA and parity expansion of clinical services. Therefore, the short outpatient rotations that mandate premature endings with patients and are ubiquitous among training programs must be supplemented with the possibility of creative learning experiences such as the Colorado program. Few residents have the experience of terminations with patients that are not forced or premature nor do they receive much teaching about this topic.

It will require considerable diligence in monitoring the impact of the new ACGME Milestones lest too much emphasis gets placed on interviewing skills and patient engagement and little concern with the actual conduct of psychotherapy. It is appropriate that in light of resident recruitment problems, novel accreditation requirements, and economic challenges to healthcare, that more organized efforts be undertaken to preserve the importance of achieving psychotherapy competency for psychiatry to return to its mandate of providing the most comprehensive treatments for our patients. Research has consistently demonstrated that, even in the most disordered of our patients, the addition of psychotherapy to the treatment regimen provides more successful treatment outcomes (see article on the efficacy of psychotherapy in this issue).

RECOMMENDATIONS TO RESIDENCY TRAINING PROGRAMS AND TO RESIDENTS

If, as predicted by many, both the ACA and parity coverage increase the demand for psychiatric services, thoughtful discussion and planning to meet these needs must begin immediately. We should be clear, however, that beyond knowing that 35% of those enrolled under the ACA are 35 years or younger and that there is a significant increase in Medicaid enrollment, we know little about the particulars. This, in conjunction with the recent change in how the national Current Population Survey (CPS) inquires about insurance coverage, leaves us somewhat in the dark concerning demographic specifics (Wilensky, 2014). During the advent of managed mental health care in the 1980s, we recall that many program directors articulated that it is shortsighted to train exclusively for a narrow clinical setting or populations (Kay, 1996). However, it appears that the ACA will require new clinical settings if costs currently attributed to inpatient and emergency room services are to be reduced. For example, one alternative to caring for patients in these two settings might involve contracting to community agencies to provide short-term residential placement with comprehensive psychiatric services and integrated primary care that would replace observation beds in expensive emergency rooms. With sophisticated clinical services, it is hoped that many patients, after they have been stabilized, could be directly referred to community agencies thereby bypassing hospitalization that would be reserved for only the most severely disturbed. This will require that residents have clinical exposure in these alternative settings and have in-depth supervised administrative exper-

rience to lead healthcare teams in non-traditional sites. Public health approaches that develop the least expensive mechanism for providing services to the largest number of patients undoubtedly will become more prominent. A knee-jerk response to this reality might be to expect that medication and brief treatments will take a more central role. However, as elaborated in the article on the efficacy of psychotherapy in this issue, evidence supports investment in training and provision of psychotherapy services. Other elements of extending the reach of services might include increased utilization of telepsychiatry and reliance on telephone or Web-based treatments.

In short, we must be honest about what we do not know in order to plan timely graduate medical education changes. However, in addition to paying greater attention to psychiatric education in medical school, it is likely that psychiatrists of the future will require some additional types of clinical and administrative experiences to be competent in new healthcare roles. As noted, the ACA requires a multidisciplinary team approach to care delivery. The psychiatrist is likely to be in the leadership position of this model of mental health care. The ACA also mandates a new method of reimbursement for care whose focus will be on "value-based purchasing" to determine the best quality of care for the money. This is likely to be filtered down to graduate medical education (GME) funding for residency slots and undoubtedly entail increased paperwork for program directors and faculty (Magen, Richards, & Ley, 2013). It follows that there must be greater time devoted in residency training to more sophisticated teaching that prepares tomorrow's psychiatrist for leadership positions and roles. Johnson and Stern (2013) reviewed the characteristics of exceptional leadership that merit consideration in training residents for new health care roles. It may be that this type of leadership has more to do with achieving emotional intelligence than with traditionally defined cognitive and technical skills and abilities. Emotional intelligence is defined by attributes in five domains: self-awareness; self (affective) regulation; passionate motivation; social awareness; and social skills (Freshman & Rubino, 2002; Goleman, 1998). It is questionable that emotional intelligence can be taught to future psychiatric leaders for newer roles in healthcare through lectures and/or traditional didactic approaches. Closely supervised administrative experiences for advanced residents will be vital to build emotional intelligence. In this respect, the educational goals are quite similar to those of labor-intensive psychotherapy supervision. For program directors this will likely entail work above the current overburdened curricular requirements (Greenberg, 2013).

There are as well substantial anticipated changes in the prevalence of some disorders, especially in the areas of geriatric psychiatry. These

include not only the dementias but also mood disorders and substance abuse that are magnified by the very small numbers of residents selecting geropsychiatry fellowships. Graduating psychiatrists therefore will need much more sophisticated clinical and administrative experiences to function in leadership positions especially since they will be working more frequently alongside primary care physicians and nurse practitioners, social workers, psychologists, and pharmacists in new clinical settings such as medical homes (Federally Qualified Health Centers) and assisted living and nursing homes. Comfort with psychotherapy in elderly patients as well as appreciation for the pharmacologic treatment challenges in this patient group will be vital. Some have called for reducing the psychiatry residency to 36 months and thereby allow entry into fellowships in what now would be the fourth year of training. This makes psychiatry similar to family medicine, which appears to attract like-minded graduating medical students, and permit earlier payback on student indebtedness (Magen et al., 2013). Such a proposal would likely decrease the opportunity for residents to develop adequate psychotherapy skills beyond the treatment of a very limited number of patients in each of the required modalities.

CONCLUSION

Although it is challenging to assess the impact of the ACA and parity initiatives, it will once again force educators to provide more with less: more administrative and leadership experiences and less time for broad-based learning during the residency. In light of the decreasing provision of psychotherapy by psychiatrists (Mojtabi & Olfson, 2008), it is imperative that the core clinical skills consolidated through psychotherapy not be jettisoned from residency training. After all, this is where trainees develop the capacity to tolerate ambiguity, develop humility, understand the intricacies of the doctor-patient relationship, work with strong patient and staff affect, and appreciate in a systematic fashion that the reason for maladaptive behavior is very often outside of patient awareness. If psychiatrists are to assume team leadership roles and psychotherapy will be provided increasingly by other mental health clinicians with the expected expansion of services under the ACA and parity legislation, psychiatrists must be able to teach and supervise the delivery of these treatments. One cannot teach what one does not know.

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