

# Making Therapy Widely Available: Clinical Research Triumph or Existential Catastrophe?

A. John Rush, M.D.

You don't need a weatherman to know which way the wind blows.

—Bob Dylan, “Subterranean Homesick Blues”

Based on two decades of data, Tadmon and Olfson (1) have identified clear and growing trends that fewer psychiatrists are providing less psychotherapy to fewer patients, regardless of the disorder being treated, sociodemographic features, or prescribed medication. There were only two exceptions: patients over age 65, who continued to receive psychotherapy by psychiatrists in about 30% of the visits, and patients with schizophrenia, who continued to receive psychotherapy by psychiatrists about 10% of the time (1).

The causes also seem clear. Without evidence that more costly therapists produce better overall outcomes, public mental health care system administrators and private payors are making economically driven role reassignments (in care systems) or implementing reimbursement schemes (private payors) that incentivize diagnosis and medication management over the direct provision of psychotherapy by psychiatrists. Taken together, these decisions explain the reported inverse relationship between medication prescription and provision of therapy in psychiatric practice.

While psychiatrists are doing less and less therapy (50% of the psychiatrists reported doing no psychotherapy at all), other less expensive therapists—*sans* medical training and the associated debt—are being used as replacements. However, about 10% of the sampled psychiatrists still do regularly provide therapy along with medications—a practice that is most typical for self-pay patients—and it seems to be holding. This suggests that if more patients had a voice, the receiving of both therapy and medication from the same provider might be more the norm. What are the implications of these findings for mental health care delivery and psychiatric training?

## Psychiatrists as psychotherapists

Psychiatrists are being (or have been) economically dealt out of providing psychotherapy, at least as defined by Tadmon and Olfson. They are not alone. Ph.D.-level clinical psychologists who have as much or more psychotherapy training are being replaced by counselors with master's degrees to further reduce costs (2). Peer counseling may be

the road to inexpensive therapy for a wide number of people (3, 4).

Several forces likely account for this shift. The first is economics: the public sector needs to stretch finite budgets, and the private sector needs to compete for mental health care contracts. Absent evidence that psychotherapy provided by psychiatrists provides superior efficacy or cost-effectiveness in the real world, paying psychiatrists higher fees for delivering what seems to be the same product supplied by “less expensive” providers cannot be justified. Our patients' desire for a more convenient, quicker fix in the form of medications and the commercialization of the medical model are two mutually reinforcing forces.

Another force is the development of psychotherapy models (e.g., interpersonal, cognitive-behavioral, psychodynamic, and supportive therapies) and the specification of the related methods and procedures derived from their facilitated dissemination.

The creation of therapy “manuals” (5–7) that explain each model and illustrate its application with case vignettes began in the late 1970s.

Subsequently, comparative efficacy trials provided an empirical basis for incorporating time-limited, evidence-based therapies into psychiatric, psychological, social work, and other training programs, which increased the number and legitimacy of “less expensive” nonpsychiatric mental health clinicians.

Regardless of the causes, when clinical outcomes are unmeasured in practice, it cannot be known whether these changes actually affect patient outcomes. On the one hand, it is reassuring that virtually every trial that has demonstrated efficacy in these evidence-based, manualized therapies have relied on non-MD therapists (with master's degrees or Ph.D.s). Typically, these therapists are trained to a prespecified level of skill/competence, and some quality control/supervision is provided. These therapies are effective, at least for research-eligible patients treated in research study settings under these conditions. Indeed, several studies have shown that competency matters in terms of therapy outcomes (8). It is not known whether these positive results generalize to real-world patients who have comorbid,

**Do the Tadmon and Olfson findings suggest that we abandon therapy training in residency? The answer is a resounding “NO.”**

complex, or chronic conditions with substantial general medical and psychiatric comorbidities treated by therapists who have varying degrees of experience, skill, and competency and are practicing in a range of clinical contexts.

### Challenges in delivering psychotherapy

Broadly speaking, the psychotherapies aim to optimize symptom control, daily function, quality of life, and relapse prevention (9). Symptom improvement, whether achieved with therapy or medication, often precedes functional improvement, sometimes by months (10, 11). In many patients, however, residual interpersonal, familial, occupational, or other deficiencies in daily function persist (9, 12), which may require different therapeutic approaches such as family counseling, resilience training, or the addition of therapy to medication or vice versa.

Identifying those clinicians who are best suited to deliver psychotherapy to accomplish these goals is just one challenge. Others include 1) matching the type of therapy with a particular patient/condition; 2) matching therapist skill/training with patient difficulty/need; 3) ensuring high-quality therapy; and 4) knowing when to stop therapy.

With regard to matching therapy type with patient/condition, most practitioners learn one model (e.g., cognitive behavioral therapy [CBT], psychodynamic, etc.) and then adapt and apply it to various situations, conditions, and goals. This practice has spawned the adaptation of the above psychotherapeutic models to a wide range of patients and conditions. For example, CBT has been adapted to bipolar disorder (13), adolescent depression (14), and eating disorders (15). Similarly, interpersonal psychotherapy (IPT) has been adapted to anxiety disorders (16), personality disorders (17), and preadolescent depression (18).

As an alternative approach to matching therapy type and patient, the Personalized Advantage Index (PAI) (19, 20) uses randomized trial data to identify specific baseline features that 1) predict outcome regardless of treatment (*prognostic predictors*), or 2) differentiate patients who do better or worse with one or another treatment (*prescriptive predictors* or treatment moderators). The PAI was shown to have a moderate, clinically meaningful effect size (0.51) in differentiating depressed patients better served by IPT or CBT (20) in the Treatment of Depression Collaborative Research Project (21). These findings suggest that types of therapies are not interchangeable and that evidence-based matching is feasible.

The second challenge is to match therapist skill and experience (which is highly variable) with patient difficulty, which can range from the relatively easily addressed to the therapeutically very challenging and complex. For example, major depression ranges from those who achieve sustained remission with placebo or watchful surveillance to others who are unable to ever achieve sustained remission (22, 23). Advanced therapy training or extensive clinical experience is likely only needed for the more challenging and complex cases. The more effective matching of therapists and

patients could improve the cost efficiency of psychotherapeutic care and provide an evidence-based approach to deciding when to persist, revise, or discontinue therapy. Research is needed to personalize psychotherapist, psychotherapy, and patient matching.

Another challenge in matching treatments and conditions entails medication and psychotherapy (when aimed at symptom reduction or relapse mitigation). In certain conditions (e.g., psychotic disorders, severe obsessive-compulsive disorder, bipolar disorder, etc.), medication is initiated and therapy added; the type and goals of the chosen therapy are informed by the outcomes of the initial medication. However, for many patients (e.g., those with depressive, anxiety conditions), evidence indicates that therapy alone is comparable to medications acutely (24, 25) and that it has an enduring effect (25, 26), which is a clinical and economic advantage. Others argue for beginning medication and adding therapy for relapse mitigation and to address residual problems that remain unresolved by the medication (27). Research to address these sequencing issues in real-world patients would be very useful.

### Psychiatric training

Psychiatric residents are expected to achieve competency in “cognitive-behavioral therapy (CBT), psychodynamic psychotherapy, and supportive psychotherapy—in brief and long-term formats—with optional experiences in group and couples/family therapy” (28). Do the Tadmon and Olfson findings suggest that we abandon therapy training in residency? The answer is a resounding “NO.” Here’s why.

First, “medication visits” often entail education, support, cognitive restructuring, life and self-management, problem solving, etc.—typically in less than 30 minutes. Medication and patient management together are essential and uniquely suited for those who have mental illnesses that require medications, and they are highly valued by patients (29). Effective medication visits require substantial general psychotherapeutic skill and experience, especially since many of our patients have executive function, impulse control, and interpersonal difficulties as well as environmental challenges.

Second, by doing psychotherapy, residents develop more effective relationship and listening skills, as well as greater empathy for and equanimity in the management of their patients who can display irrational, unpredictable, and occasionally threatening behavior. Their experiences as therapists combined with supervision helps them to understand what is required to conduct effective therapy sessions and to learn how to develop and strengthen the therapeutic alliance. The experience of being a therapist who works intensively with patients helps residents to recognize, experience, and learn to deal with their personal reactions that, if unrecognized, can become obstacles in relating to various kinds of patients. These experiences as therapist are also invaluable in many subsequent roles as mentors, supervisors, and administrative leaders. I wonder, however, whether one or at most two

forms of therapy would better serve residents' needs and provide them a deeper understanding and experience than perhaps attempting proficiency with three models.

Residents are uniquely trained and qualified as medical and neuropsychiatric diagnosticians; as providers or overseers of psychopharmacology, brain stimulation, and other complex treatments; as clinicians in emergent situations; and in the clinical and medical management of persons with difficult-to-treat major mental disorders. Perhaps a 4th-year scholar track to provide greater experience in neuropsychiatry including neurostimulation, neuroimaging, neuropsychology, neuropsychopharmacology, and biomedical interventions and another focused on psychotherapeutic/psychosocial/brain training/learning interventions are worthy of discussion. This specialization may become even more important with the development of psychedelic agents (30) and brain training interventions (31) for addressing mental habits and disorders.

## Conclusions

The question is not what is best for psychiatry, but rather, what is best for our patients. There is a need for more well-trained, less expensive therapists. This workforce challenge is being addressed in part by the American Psychological Association, which is developing a process to accredit master's programs in health service psychology (Personal communication: L.F. Bufka, Ph.D., Senior Director, Practice Transformation and Quality, American Psychological Association). Could these trainees help psychiatrists with the delivery of biomedical interventions as well? Is it time for a collaboration?

Clinical research support is sorely needed to address the many aforementioned challenges in the delivery of therapy (e.g., quality, matching, targeting, sequencing). At the system level, the choice is budget-based or evidence-based care management. We need evidence. At the patient level, it is essential that clinical research support the development of more cost-efficient delivery methods such as computer-assisted CBT (32), the development and testing of innovative therapies such as circuit-based brain training (31) based on a newfound understanding of brain function, and the targeting of treatments. The last half century of research support has produced a wealth of effective and teachable psychotherapeutic approaches. Clinical and services research in this arena needs a major resource commitment. "Funding neuroscience should not mean eliminating research our patients need today" (33).

## AUTHOR AND ARTICLE INFORMATION

Duke-NUS Medical School, Singapore, Duke University, Durham, N.C., Texas Tech University, Permian Basin, Tex.

Send correspondence to Dr. Rush (curbstoneconsultant@gmail.com).

Dr. Rush has received consulting fees from Compass Inc., Curbstone Consultant LLC, Emmes Corp., Evecia Therapeutics, Inc., Holmusk

Technologies, Inc., USA, Johnson and Johnson (Janssen), Liva-Nova, Neurocrine Biosciences Inc., and Otsuka-US; speaking fees from Johnson and Johnson (Janssen) and Liva-Nova; and royalties from Guilford Press, the University of Texas Southwestern Medical Center (for the Inventory of Depressive Symptoms and its derivatives), and Wolters Kluwer Health. He is also named co-inventor on two patents: U.S. Patent No. 7,795,033: Methods to Predict the Outcome of Treatment with Antidepressant Medication [Inventors: McMahon FJ, Laje G, Manji H, Rush AJ, Paddock S, Wilson AS]; and U.S. Patent No. 7,906,283: Methods to Identify Patients at Risk of Developing Adverse Events During Treatment with Antidepressant Medication [Inventors: McMahon FJ, Laje G, Manji H, Rush AJ, Paddock SJ].

The author acknowledges the editorial support of Jon Kilner, M.S., M.A. (Pittsburgh).

*Am J Psychiatry* 2022; 179:79–82; doi: 10.1176/appi.ajp.2021.21121201

## REFERENCES

1. Tadmor D, Olfson M: Trends in outpatient psychotherapy provision by US psychiatrists: 1996–2016. *Am J Psychiatry* 2022; 179: 110–121
2. Humphreys K: Clinical psychologists as psychotherapists: history, future, and alternatives. *Am Psychol* 1996; 51:190–197. Available at doi: 10.1037/0003-066X.51.3.190
3. Patel V, Weobong B, Weiss HA, et al: The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: a randomised controlled trial. *Lancet* 2017; 389:176–185, (Epub, Dec 15, 2016). Available at doi: 10.1016/S0140-6736(16)31589-6
4. Bernecker SL, Williams JJ, Caporale-Berkowitz NA, et al: Non-professional peer support to improve mental health: Randomized trial of a scalable web-based peer counseling course. *J Med Internet Res* 2020; 22:e17164. Available at doi: 10.2196/17164
5. Beck AT, Rush AJ, Shaw BF, et al: *Cognitive therapy of depression*. New York, Guilford Press, 1979
6. Klerman GL, Weissman MM, Rounsaville BJ, et al: *Interpersonal psychotherapy of depression*. New York, Basic Books, 1984
7. Rush AJ (ed): *Short-term psychotherapies for depression*. New York, Guilford Press, 1982
8. DeRubeis RJ, Hollon SD, Amsterdam JD, et al: Cognitive therapy vs medications in the treatment of moderate to severe depression. *Arch Gen Psychiatry* 2005; 62:409–416
9. Rush AJ, Thase ME: Improving depression outcome by patient-centered medical management. *Am J Psychiatry* 2018; 175: 1187–1198. Available at doi: 10.1176/appi.ajp.2018.18040398
10. van der Voort TYG, Seldenrijk A, van Meijel B, et al: Functional versus syndromal recovery in patients with major depressive disorder and bipolar disorder. *J Clin Psychiatry* 2015; 76:e809–e814. Available at doi: 10.4088/JCP.14m09548
11. Rush AJ: Distinguishing functional from syndromal recovery: implications for clinical care and research. *J Clin Psychiatry* 2015; 76:e832–e834
12. Miller IW, Keitner GI, Schatzberg AF, et al: The treatment of chronic depression, part 3: psychosocial functioning before and after treatment with sertraline or imipramine. *J Clin Psychiatry* 1998; 59:608–619
13. Basco MR, Rush AJ: *Cognitive-behavioral therapy for bipolar disorder*, 2nd ed. New York, Guilford Press, 2005
14. Wilkes TCR, Belsher G, Rush AJ, et al: *Cognitive therapy for depressed adolescents*. New York, Guilford Press, 1994
15. Murphy R, Straebl S, Cooper Z, et al: Cognitive behavioral therapy for eating disorders. *Psychiatr Clin North Am* 2010; 33: 611–627. Available at doi: 10.1016/j.psc.2010.04.004
16. Markowitz JC, Lipsitz J, Milrod BL: Critical review of outcome research on interpersonal psychotherapy for anxiety disorders. *Depress Anxiety* 2014; 31:316–325. Available at doi: 10.1002/da.22238

17. Dimaggio G, Montano A, Popolo R, et al: Metacognitive interpersonal therapy for personality disorders: A treatment manual, 1st ed. New York, Routledge, 2015., 10.4324/9781315744124
18. Weinberg R, Dietz LJ, Weinberg RB, et al: Family-based interpersonal psychotherapy for depressed preadolescents. New York, Oxford University Press, 2018
19. DeRubeis RJ, Cohen ZD, Forand NR, et al: The Personalized Advantage Index: translating research on prediction into individualized treatment recommendations. A demonstration. *PLoS One* 2014; 9:e83875. Available at doi: 10.1371/journal.pone.0083875
20. Huijbers MJH, Cohen ZD, Lemmens LHJM, et al: Predicting optimal outcomes in cognitive therapy or interpersonal psychotherapy for depressed individuals using the Personalized Advantage Index approach. *PLoS One* 2015; 10:e0140771. Available at doi: 10.1371/journal.pone.0140771
21. Elkin I, Shea MT, Watkins JT, et al: NIMH Treatment of Depression Collaborative Research Program. General effectiveness of treatments. *Arch Gen Psychiatry* 1989; 46:971-982. Available at doi: 10.1001/archpsyc.1989.01810110013002
22. Rush AJ, Aaronson ST, Demyttenaere K: Difficult-to-treat depression: A clinical and research roadmap for when remission is elusive. *Aust N Z J Psychiatry* 2019; 53:109-118, (Epub, Oct 31, 2018). Available at doi: 10.1177/0004867418808585
23. McAllister-Williams RH, Arango C, Blier P, et al: The identification, assessment and management of difficult-to-treat depression: An international consensus statement. *J Affect Disord* 2020; 267:264-282. ISSN 0165-0327, <https://doi.org/10.1016/j.jad.2020.02.023>
24. DeRubeis RJ, Crits-Christoph P: Empirically supported individual and group psychological treatments for adult mental disorders. *J Consult Clin Psychol* 1998; 66:37-52
25. Hollon SD, Thase ME, Markowitz JC: Treatment and prevention of depression. *Psychol Sci Public Interest* 2002; 3:39-77
26. Hollon SD, Stewart MO, Strunk D: Cognitive behavior therapy has enduring effects in the treatment of depression and anxiety. *Annu Rev Psychol* 2006; 57:285-315
27. Guidi J, Tomba E, Fava GA: The sequential integration of pharmacotherapy and psychotherapy in the treatment of major depressive disorder: A meta-analysis of the sequential model and a critical review of the literature. *Am J Psychiatry* 2016; 173:128-137. Available at doi: 10.1176/appi.ajp.2015.15040476
28. Feinstein RE, Yager J: Advanced psychotherapy training: psychotherapy scholars' track, and the apprenticeship model. *Acad Psychiatry* 2013; 37:248-253
29. Cruz AM, Cruz RF, Pincus HA: Patients' perspective on the value of medication management appointments. *Healthcare (Basel)* 2015; 3:284-295. doi: 10.3390/healthcare 3020284 [www.mdpi.com/journal/healthcare](http://www.mdpi.com/journal/healthcare)
30. Davis AK, Barrett FS, May DG, et al: Effects of psilocybin-assisted therapy on major depressive disorder: A randomized clinical trial. *JAMA Psychiatry* 2021; 78:481-489. Available at doi: 10.1001/jamapsychiatry.2020.3285
31. Iacoviello BM, Murrough JW, Hoch MM, et al: A randomized, controlled pilot trial of the Emotional Faces Memory Task: a digital therapeutic for depression. *NPJ Digit Med* 2018; 1:21. Available at doi: 10.1038/s41746-018-0025-5
32. Wright JH, Mishkind M: Computer-assisted CBT and mobile apps for depression: Assessment and integration into clinical care. *Focus Am Psychiatr Publ* 2020; 18:162-168. Available at doi: 10.1176/appi.focus.20190044
33. Markowitz JC, Friedman RA: NIMH's straight and neural path: The road to killing clinical research. *Psychiatr Serv* 2020; 71:1096-1097