The Place for Psychodynamic Therapy and Obstacles to Its Provision

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Psychodynamic treatment has been shown to provide specific benefits for patients with **personality disorders, chronic depressive** and **anxiety disorders**, and **chronic complex disorders** and its intensity and duration have independent positive effects. An obstacle to its provision includes a bias privileging brief treatments, especially cognitive behavior therapy, seen as a "gold standard" of treatment, despite difficulties with the design, validity and generalizability of its supporting research and the diagnostic nosology of the illnesses studied. Another obstacle to the provision of psychodynamic psychotherapy lies in **insurance company protocols** that **violate the mandate for mental health parity** and focus on conserving insurers' costs over the provision of optimum treatment to patients.

Those valuing short-term cost saving objectives over optimum treatment might prefer to provide lower cost medication treatment. Nonetheless, psychotherapy is preferred over medication by 75% of patients[1], often provides a higher effect size than medication alone, augments the effect of medication (although the reverse of medication augmenting psychotherapy is not established), has lower dropout rates than medication alone protocols, and obviously lacks the side effects of medication treatments.[2]

While psychotherapy of different approaches is effective for many patients, there is a common assumption that cognitive-behavioral therapy is the superior and preferred approach. However, a recent study[3] has shown psychodynamic therapy to be equivalent to other treatments established as efficacious. In addition, Leichsenring and Steinert, 2017[4], challenge the "gold standard" status of CBT with their findings of publication bias, its frequent small effect size, the influence of researcher allegiance, several meta-analyses revealing its limited efficacy, and response and remission rates of 50% or less for depression and anxiety leaving a large percentage of patients with insufficient improvement.

Length and Intensity of Psychotherapy

With respect to treatment "dosage", recent studies identify several diagnostic groups of patients who need an intensive and longer duration of psychotherapy including those with **chronic, debilitating personality disorders, chronic, complex disorders** such as **severe longstanding depression and anxiety**, and **multiple chronic psychiatric disorders.** Among the most seriously ill, these patients are frequently

not adequately treated with psychotherapy due to arbitrary limits on reimbursement for psychotherapy by insurance companies.[5] Patients with personality disorders are very costly to society, are among the most chronically impaired groups in psychiatric populations, are unemployed for longer periods, have more drug problems, suicide attempts, interpersonal difficulties ,[6,7,8,9] criminal behavior, divorce, child abuse, and heavy use of mental and general health care.[10] The lifetime prevalence of personality disorders is between 10% and 13.5%, [11,12,9,13,14] affecting 30 million Americans of all social classes, races and ethnicities.

For these patients who need more psychotherapy, both longer duration and higher frequency of psychotherapy have independent positive effects and contribute to the most positive treatment outcomes.[15,16,17,18,19] The cost-effectiveness and cost-offset of extended intensive psychotherapy for those patients who need it include savings from decreased sick leave, and decreased medical costs and decreased hospital costs.[20,21,22,23,24.25,26,27,28,29,30]

Patients with **borderline personality disorder** (BPD) take significantly longer to improve. [31,32,33,34,35,36] In fact, the British Health Service National Institute for Health and Care Excellence cautions against brief psychological interventions for borderline personality disorder 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.) [37]

Depression has a lifetime prevalence in the U.S. of 19.3% with **major depression** being a common diagnosis affecting 16.6% of adults,[38] occurring in one of every 10 to 20 primary care patients,[39] and is the most common diagnosis made in primary care.[40] Depression is experienced by one-fifth of all Americans at some point during their lifetimes,[41] is extremely costly to society in increased medical costs, suicide-related mortality costs, and disability. A World Health Organization study [42] found unipolar depressive disorders to be the greatest cause of worldwide disability. The 20% of **depressed patients who are treatment resistant** fare better with longer psychotherapy. Compared to other depressed patients, the treatment resistant have greater health care costs**,** are twice as likely to be hospitalized both for depression and general medical admissions, have 12% more outpatient visits, 1.4 to 3 times more psychotropic medications, over six times the mean total medical costs, and 19 times greater total depression-related costs.[43]

Specific Effects of Psychodynamic Psychotherapy

Psychodynamic therapy provides a specific advantage for patients with **personality disorders** and other **chronic complex disorders** who often have ingrained, inflexible, maladaptive ways of thinking and behaving leading to impaired relationships that constitute a highly significant risk factor for increased mortality exceeding smoking, alcoholism, obesity and hypertension.[44] While psychotherapy of different approaches improves symptoms, studies demonstrate that long-term psychodynamic treatments are significantly superior in improving maladaptive interpersonal relationships.[45,46,2,18,19,47] Compared to patients treated with other psychotherapies, patients treated with psychodynamic psychotherapy maintain therapeutic gains better and continue to improve after treatment ends, the "sleeper effect." [47]

For patients with **borderline personality disorder (BPD),** one study[48] found no evidence that the core pathology of patients with BPD (unstable relationships, primitive defenses, identity disorder and boredom) is affected by one year of Dialectical Behavior Therapy (DBT.) Several studies have found that

dynamic psychotherapy leads to broader personality changes than supportive psychotherapy or DBT for borderline personality disorder.[46,29]

Perfectionistic depressed patients also need more than a brief course of psychotherapy and do better with intensive extended psychodynamic therapy.[49,50] For **depressed patients with residual symptoms** after treatment, a literature review of unsatisfactory degrees of remission found that subsyndromal residual depressive symptoms can progress to prodromal symptoms of recurrence and may be the most consistent predictors of relapse.[51] Judging a patient successfully treated because of no longer meeting syndromal criteria of illness does not connote full recovery; residual symptoms may indicate the need for more extended treatment. Dysfunctional social and interpersonal patterns are also correlated with persistent depression, relapse and poor long-term prognosis. Psychodynamic treatment is more effective for these traits that put patients at risk for recurring illness.[29,45,18,46,47]

Both a psychodynamic approach and the greater intensity of a psychoanalytic schedule add benefit for patients with unipolar depression. Long-term cognitive-behavioral, psychoanalytic and psychodynamic therapies yield similar improvements in depressive symptoms for all three approaches immediately post treatment. CBT and psychodynamic therapy patients have similar levels of depressive symptoms at three-year follow-up. However, patients treated with the more intensive psychoanalytic treatment sustain greater improvement both 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.[45] Demonstrating the impact on the brain of the improvement in depression after long-term psychodynamic psychotherapy, Buchheim, Viviani, Kessler, et al, (2012)[52] published the first study documenting its treatment-specific changes in the limbic system and regulatory regions in the prefrontal cortex.

Comorbidity is a frequent serious complication for depressive illness. **Depressed patients with comorbid personality disorders** have more treatment resistant, persistent and recurrent depression, role limitations, impaired social functioning and health perceptions than patients with major depressive disorder alone. Depressed patients whose personality disorders remit improve in social functioning and have a likelier remittance of depression than those with persisting personality disorders -- the group that functions the poorest. Depressed patients with comorbid personality disorders also have a longer time to achieve remission than depressed patients without personality disorders. Borderline and obsessive-compulsive personality disorders at baseline are robust predictors of accelerated relapse after remission from an episode of major depressive disorder, even controlling for other negative prognostic predictors. Borderline personality disorder is a robust independent predictor of chronicity (accounting for approximately 57% of persistent cases) and is 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.[53,54] Patients with major depression and a comorbid personality disorder need both illnesses treated to avoid recurrent and persistent depressive illness even when a longer and more intensive treatment is required.[55,56] As noted, psychodynamic treatments have a greater potential to ameliorate the perfectionism of many depressed patients, the disturbed interpersonal relations for those with personality disorders and other chronic conditions, and the core psychopathology of patients with borderline personality disorder.

Other studies have examined outcome and cost-effectiveness for over 5000 outpatients with a variety of common DSM4 Axis 1 and 2 diagnoses treated with either long-term psychodynamic psychotherapy

(LTPP) or psychoanalytic treatment. Both LTPP and psychoanalysis yield large effect sizes for symptom reduction, personality change, improvement in moderate pathology both at termination and follow-up as well as reduced health care use and sick leave.[57,58] Psychoanalysis, with its greater frequency, is more costly but more cost-effective than LTPP from a health-related quality perspective[59,60] and both treatments yield significantly reduced work absenteeism and lowered hospitalization at seven-year follow-up.[61]

Pychodynamic psychotherapies have also been found to be effective for anxiety disorders, eating disorders, substance abuse, somatic symptoms and marital discord.[2]

The Obstacles

Shortcomings in Nosology and Research Generalizability

Evidence supported psychotherapy is based on research studies of specific groups of patients generally with one DSM diagnosis. Since DSM 3 in 1980, psychiatric diagnosis has been based on observable symptoms not reflecting underlying chronic vulnerabilities that lead to recurrent symptoms and subjective distress. Much of this research focuses on brief, highly-scripted forms of psychotherapy, studied in randomized controlled trials with subjects bearing a single DSM diagnosis without comorbidities. Brief therapies yielding statistically significant effects are promoted as the approaches of choice for the diagnoses studied. They do not identify efficacious therapies for most psychiatric patients since the vast majority have more complex conditions and comorbidity than those accepted into research cohorts, as, for example, the large population of patients with major depression (MDD), of whom 78.5% have additional psychiatric comorbidity with MDD not even their primary diagnosis.[41]

A finding of "statistically significant" reduction in symptoms does not necessarily signify meaningful, lasting improvement or recovery from illness. An extensive review of manualized brief treatments for depressive and anxiety disorders found that treatment benefits were short-lived; over half of the patients in their sample sought treatment again within six to twelve months.[62] In addition, examinations of the research literature on RCTs for anxiety and depression[63] and on CBT for depression[64] found study design flaws and publication bias that undermined ostensible findings of efficacy. The findings of much academic research are often neither relevant to the actual clinical needs of patients nor appropriate information to shape health care policy or insurance company medical necessity protocols.

Underlying their acute symptoms, most psychiatric patients have chronic illnesses that often lead to repeated episodes of treatment. To be treated more definitively with psychotherapy, most will need more than brief treatment with a primary focus on an acute presenting symptom. Many patients need ongoing psychotherapy or remain at risk of substance abuse, physical illness, and destructive behavior costly to themselves and to society. According to Shedler (2015 p. 48) brief, " 'evidence-based' therapies are ineffective for most people most of the time."[65] Shedler also quotes Driessen et al, (2013, p. 1047) with regard to a study of depressed patients treated with brief CBT or psychodynamic therapy: "Our findings indicate that a substantial proportion of patients….require more than time-limited therapy to achieve remission"[66] In sum, 75% of patients did not get well.

If our diagnostic schemes are descriptive of different superficial observable symptoms and overlooking more salient commonalities between them, what more accurate and nuanced concepts would identify and focus treatment on the actual underlying drivers of illness? In examining patterns of comorbidity among common mental disorders, Krueger (1999)[67] conceives of them not as "discrete, dichotomous entities, but rather as "extreme points on continua that span a range of emotional and behavioral functioning" (p. 922.) Superficial nosology accounts in no small measure for the frequent finding of "comorbidity."

Brown, Chorpita and Barlow (1998)[68] noted that "the expansion of our nosologies has come at the expense of less empirical consideration of shared or overlapping features of emotional disorders that…….may have far greater significance in the understanding of the prevention, etiology, and course of disorders, and in predicting their response to treatment……Our classification systems have become overly precise to the point that they are now erroneously distinguishing symptoms and disorders that actually reflect inconsequential variations of broader, underlying syndromes" (p. 179.)

A number of researchers have focused on delineating common variables shared by certain diagnostic categories. Watson and Clark (1984)[69] and Brown, Chorpita, and Barlow (1998)[68] note ***negative affect*** as a construct connecting patients with symptoms of anxiety and depression. Barlow et al (2014)[70] postulate ***neuroticism*** as a common factor among anxiety and related disorders and their high rate of comorbidity. Kruger et al (2001)[71] link dimensions of mental disorder with ***Dimensions of Personality***, with, for example, **internalization** (linked with higher negative emotionality) and **externalization** (linked with lower constraint.)

Two other promising approaches aim to provide a more indepth and accurate assessment and guide to treatment of mental disorders. The Psychodynamic Diagnostic Manual, which assesses the **Level of *Personality Organization, Quality of Mental Functioning, and Subjective Experience of Symptoms*** [72] is a comprehensive psychodynamic diagnostic tool that provides a detailed assessment of psychological strengths and vulnerabilities. The resultant profile yields a more nuanced and specific diagnosis of a patient's psychiatric illness than designations of superficial and observable symptoms. Another is the study of patients' level and quality of ***Mentalization***,[73] which are assessed along a number of axes to examine the maturity of a patient's capacity to make sense of his/her own subjective states and mental processes as well as those of others. The maturity of a patient's mentalization is seen as a driving factor in psychiatric illness, as the appropriate focus of psychotherapy, and its improvement is seen as the signal indicator of a treatment's success.

Insurance Company Obstacles to Provision of Adequate Psychotherapy

Insurance Protocols, Medical Necessity and Utilization Review

Given decades of stigma and lack of appropriate support for psychotherapy and all mental health care, most psychiatric illness is still undiagnosed and untreated or inadequately treated.[74,75,76] The lack of sufficient treatment is a hidden multiplier of morbidity, disability and greatly expanded overall health care expenses for patients with psychiatric illness compared to those without psychiatric illness. The

increased medical expenses of the psychiatrically ill go beyond the costs of their psychiatric care and include more primary care visits, higher outpatient charges, and longer hospital stays.[75,77,78]

If inadequately treated, large patient groups are very costly to society and often need more intensive and/or extended psychotherapy than most insurance companies are willing to support, despite research documenting the cost-effectiveness of an appropriate level of care to achieve recovery and savings that often result from their decreased medical expenses and improved productivity. Insurance companies focus on controlling their short-term costs and not on thorough treatment that leads to better health outcomes and savings over time in the budgets of other parties. According to the U.S. Department of Labor Bureau of Labor Statistics 2016 report,[79] the median number of years that wage and salary workers had been with their current employer declined to 4.2 years in January 2016, down from 4.6 years in January 2014. Thus, subscribers who obtain medical insurance through their employer change their insurance providers every few years. The cost savings by under-reimbursing mental health care is of greater interest to an insurer; a cost offset in overall medical expenses down the line by virtue of the adequate coverage of mental health services would not be a consideration to a current insurer focused on its own immediate expenses. An insurer's preferential support for very brief courses of psychotherapy undermines the provision of extended and intensive psychodynamic therapy for the patients who need it for optimum recovery.

Insurers also perpetuate stigma against psychotherapy in their concern that readily available outpatient psychotherapy would be overused. However, a RAND study demonstrated that when weekly outpatient psychotherapy is fully covered, only 4.3% of the insured population uses it and the average length of treatment is 11 sessions.[80] With respect to those patients who need more, a long history of higher copayments for mental health services reduces both initial access to and treatment intensity of mental health visits, and this reduction of care affects patients at all levels of clinical need.[81,82] A more recent study found that increasing costs to patients for mental health care leads to a significant decrease in new mental health visits in equal measure for both severe and mild disorders but a larger decrease in low compared to high-income neighborhoods. Furthermore, the costs of an associated increase in involuntary commitment and acute mental health care exceed the cost savings from the decline in new mental health visits. Increasing costs to patients reduces access to mental health care and increases costs and morbidity particularly among high-need, vulnerable populations.[83,84] Poor and very ill psychiatric patients are disproportionately affected by discriminatory copayments and financial disincentives designed to screen out a hypothetical group of patients who it is feared would capriciously abuse covered mental health services.[85]

Medical Necessity

The concept of medical necessity is central to managed care and used routinely by insurers to evaluate medical claims eligible for reimbursement.[86] Although The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health insurers to use equivalent standards to authorize and provide the same levels of coverage for mental health care as for other medical conditions ("parity"), health insurers use much more limited definitions of "medical necessity" for mental health treatment than for other medical care. *A* 2003 report by the Substance Abuse and Mental Health Services Administration ("SAMHSA" [87]) found that medical necessity criteria are generally designed by insurers – not treating clinicians – and are used to limit reimbursement for treatments deemed inconsistent with insurers' interpretations of relative cost and efficiency -- even when care is demonstrably consistent with

professional standards. The SAMHSA report found that neither state nor federal regulatory processes universally controlled medical necessity standards promulgated by insurers. [88]

While the Mental Health Parity Act did not alter insurers' control of criteria for medical necessity, it mandated public disclosure of their clinical standards,[89] an action consistent with the recommendations of the Institute of Medicine ("IOM").[90] In 2011, subsequent to the passage of the Affordable Care Act ("ACA") and its mandate of essential health benefits (which includes mental health care and psychotherapy as one of its components), the American Medical Association ("AMA") issued a public statement to the IOM Committee on Determination of Essential Health Benefits[91] defining "medical necessity" as:

> **Health care services or products that a prudent physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate in terms of type, frequency, extent, site and duration; and (c) not primarily for the economic benefit of the health plans and purchases or for the convenience of the patients, treating physician, or other health care provider.**

The AMA statement reiterated the mandate for parity of coverage for all essential health benefits (which include mental health care.) This AMA definition was endorsed in a 2015 Official Position Statement by the American Psychiatric Association.[92]

While most insurance plans ostensibly incorporate these AMA and APA position statements on medical necessity, many managed behavioral healthcare organizations create medical necessity criteria grossly at odds with them. This disturbing, frequently unchallenged practice often takes the form of proprietary medical necessity criteria claiming consistency with generally accepted standards of medical practice, but categorically failing to address the chronicity and pervasiveness of mental illnesses and substance use disorders. They also apportion inadequate care based on a false premise that the generally accepted standard for psychiatric care is to focus solely on time-limited treatment for acute symptoms until their resolution to the condition prior to their onset. For example, a number of national managed behavioral healthcare organizations have used proprietary medical necessity criteria that expressly define outpatient treatment as "acute" and require acute symptoms to justify its provision. Their standards also ignore data in professional guidelines (cited as references for their own guidelines) about the need for extended and intensive psychotherapy for chronic conditions.

Contrary to both generally accepted standards of medical practice and mental health parity laws, proprietary guidelines all too commonly require "objective" proof that psychiatric illness will deteriorate in the absence of proposed care or that less expensive, potentially inferior treatments have not or will not work. To demand a less intensive treatment to "fail first" devalues the clinical judgment of treating providers and imposes unacceptable risks on mental healthcare not tolerated in the medical/surgical context. As noted by the American Society of Addiction Medicine in The ASAM Criteria,[93] a "treatment failure" approach puts the patient at risk by delaying a more definitive level of treatment and potentially increasing health care costs by allowing the addictive disorder to progress. "Fail-First" policies are also demoralizing to patients who are made to feel untreatable when they are being inadequately treated.

Utilization review is an insurance company's monitoring process to pre-authorize reimbursement for recommended treatment and to assess with "clinical reviews" ongoing treatments for continuing

eligibility for reimbursement. In violation of mental health parity, utilization review is used more restrictively for mental health treatment than for other medical care for both pre-authorization of new care and "clinical review" of ongoing treatment. Clinical review protocols often stop coverage for a course of mental health treatment when acute symptoms have improved to a patient's baseline condition without resolving chronic underlying vulnerabilities to repeated episodes of acute illness.[94]

Utilization review has been found to lack reliability and validity, to impose a needless administrative burden, and to cause a "sentinel effect" in which providers experience a distortion in their practice style from the expectation of intrusive insurance company review. Very brief psychotherapy is often authorized for a broad spectrum of diagnoses regardless of severity.[95]

Medical necessity and utilization review protocols are too often designed to conserve insurance company costs in the short term without consideration of the sequelae from undertreated illness -- its increased associated costs in other medical services, in increased morbidity and mortality and the enormous costs to society in increased disability.[94,93,95]

Given appropriate medical necessity guidelines at parity with other medical care, consistent with provider expertise and a broad range of psychotherapy research, there would be no need or place for utilization review protocols. The national goal should be actual mental health parity without the interference of insurers' cost and profit concerns undermining the provision of appropriate care. Frequency and duration of psychotherapy as prescribed by the clinician should be supported without arbitrary limitations.

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