

Resource Document on Psychotherapy as an Essential Skill of Psychiatrists

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- *APA Operations Manual*.

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Issue

Psychiatrists are uniquely positioned to provide comprehensive, integrated treatment either by providing medication alone, psychotherapy alone, or combined treatment. Importantly, psychotherapy and prescribing medication flourish on the same foundation—confidentiality, trust, and active patient participation—which readily allows psychiatrists to change or add treatment modalities e.g., switch from psychotherapy to medications or add medication to psychotherapy, while keeping a clear focus on the complex interplay of patient, practitioner, pharmacotherapy, and psychotherapy. Even when a psychiatrist provides “only” medication, psychotherapeutic elements in the therapeutic alliance enhance the effectiveness of any medication. Indeed, although cost per session is higher for psychiatrists, integrated psychiatric care (as compared to split treatment by a psychiatrist and non-MD therapist) may lead to lower total costs and decreased patient suffering.

Patient-centered, evidence-based, holistic care demands that clinicians constantly evaluate and employ one or all of the evidence-based treatments that would most benefit a particular patient at a particular time. Of all mental health practitioners, only psychiatrists are privileged—and able—to provide all therapeutic modalities (e.g., medications, electroconvulsive therapy, and psychotherapy with individuals, couples, groups, families, brief or long term, supportive or disorder specific) and integrated, comprehensive treatment.

Scientific Evidence

Psychotherapy alone is effective for the acute treatment of mild-to moderately ill patients with a wide range of disorders, and for severely ill patients with a more limited range of disorders e.g., borderline personality

disorders (1,2). Combined treatment (medications and therapy) is particularly effective for more severely impaired patients e.g., those suffering from bipolar disorder, schizophrenia, chronic depression (2,3). Psychotherapy is also effective for increasing adherence to medication (4-8), as maintenance therapy and for prevention of relapse. Therefore, psychotherapy should be the universal treatment base for all patients and may be the treatment that is helpful to the largest percentage of patients across the entire range of disorders.

Clinical relevance and financial models: Psychiatrists are uniquely positioned to provide medication alone, psychotherapy alone, or combined treatment. Importantly, psychotherapy and prescribing medication flourish on the same foundation—confidentiality, trust, and active patient participation—which readily allows psychiatrists to change or add treatment modalities e.g., switch from psychotherapy to medications or add medication to psychotherapy, while keeping a clear focus on the complex interplay of patient, practitioner, pharmacotherapy, and psychotherapy (9,11).

Even when a psychiatrist provides “only” medication, psychotherapeutic elements in the therapeutic alliance enhance the effectiveness of any medication (12-14). Therefore, even 20-minute medication management visits can be optimized by integrating psychotherapeutic elements at no additional cost since it is covered in the cost of the medication visit (9, 11).

Psychotherapy alone provided by a psychiatrist is effective for a significant number of patients. However, optimal care—particularly for those with moderate-to-severe symptoms—often requires the addition of medication during the course of psychotherapy. Psychiatrists evaluate the need for medication at every visit and start medication promptly when needed. In contrast, some studies find that non-MD psychotherapists often delay referral for medication, leading to prolonged patient distress and increased cost for ineffective therapy sessions. Indeed, although cost per session is higher for psychiatrists, integrated psychiatric care (as compared to split treatment by a psychiatrist and non-MD therapist) may lead to lower total costs (9, 15, 16) and decreased patient suffering.

When *psychotherapy and medications* are needed, integrated treatment can be provided by one person (only a psychiatrist or a nurse practitioner can do this) or via treatment “split” between a therapist, e.g., social worker or psychologist, and a psychiatrist. Integrated treatment provided by a psychiatrist has many advantages: patients

PSYCHOTHERAPY AS AN ESSENTIAL SKILL OF PSYCHIATRISTS

have the convenience and privacy of working with only one clinician (17), both psychological and medication factors, e.g., effectiveness and side effects are addressed at each visit, and a dyadic relationship is easier to manage than a triadic relationship.

“Split treatment” becomes “collaborative treatment” when two clinicians purposefully coordinate care (17). Despite a greater number of total visits and total cost, this is the preferred model for some patients e.g., those suffering from schizophrenia. However, although widely practiced, studies find that clinicians routinely fail to collaborate (18, 19), exposing them to many pitfalls, e.g., miscommunications between patient and clinician or between clinicians, defensive splitting by the patient and increased liability exposure for the psychiatrist (10, 15, 16, 17, 20, 21, 22).

Role of Organized Psychiatry

Psychiatrists are uniquely positioned to provide comprehensive, integrated treatment. Although definitive data are not available, studies suggest that psychiatrists provide treatment (psychotherapy, medication, either alone or in combination) in a clinically beneficial, time-efficient and cost-effective manner. The cost of medical psychotherapy is a modest and predictable segment in a large-scale system, and utilization is self-limiting even when benefits are generous (23). Therefore, the APA advocates for psychotherapy to remain a central treatment option for all patients and for psychotherapy (alone or as part of combined treatment) by psychiatrists to be reimbursed by payers in a manner that does not distort practice or favor medication management. Such distortions deprive patients of optimal, integrated care by contributing to increasingly fewer psychiatrists providing essential psychotherapy to their patients (24).

The APA also advocates for all residents to receive excellent training in psychotherapy as well as collaborative treatment. It collaborates with the American Association of Directors of Psychiatric Residency Training (AADPRT) and the American Association of Chairs of Departments of Psychiatry (AACDP) to address the increasing difficulty programs face in supporting the extensive time and money required for teaching and supervising psychotherapy.

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