Psychotherapy Faces Test of Worth

Therapists may become eligible for direct federal reimbursement if they prove psychotherapy works

Healers of the human psyche have never been able to create an orthodoxy governing the practice of psychiatry, psychology, and psychoanalysis. But since October, they have come under very strong pressure from the federal government to do just that.

This fall and winter the Senate Finance Committee, to name the most influential of several critics, has begun to lean on these professions to put their house in better order. The staff of the health subcommittee, led by chief of staff Jay Constantine, has said that it would like to see better proof of the usefulness of various psychotherapies before expanding reimbursement for them under Medicare.

The leaders of the professions involved face a poignant dilemma: Should they continue to push for broad federal reimbursement and accept the added federal quality controls that will come with it, or should they leave well enough alone and accept the less than satisfactory support they receive now?

Although some of the professional spokesmen were at first taken aback by the plans being developed by the finance committee staff, they now seem to have settled on a satisfactory response. They hope to turn the demands for proof of efficacy into an expanded, federally funded program of research on psychotherapy. They would like to do this at the same time (not before) they win federal reimbursement for practicing the therapies being studied. At least one leader in the community—Nicholas Cummings, president of the American Psychological Association—says 10 to 20 years of this research may be needed before any conclusive answers begin to come in.

The finance committee did not launch this adventure on its own; it was responding to political pressure. Congress is being asked to expand the mental health benefits in several federal health programs; in particular, it is being asked to allow clinical psychologists to bill the government directly—as psychiatrists already do—for serving clients covered by Medicare (old age) insurance. The key distinction is that psychiatrists are physicians and psychologists are not. The former have some training in the practice of psychology, though not always enough, in the latter's view. Psychoanalysts are the least physiologically inclined of the three major groups, and for this reason they are the least likely to win federal reimbursement. The government's health insurance programs were designed with physical ills in mind, and thus they tend to pay physicians for whatever they do. Other professions are expected to follow the medical model if they wish to partake of federal largess.

Expanding Medicare to allow direct billing by psychologists would set an important precedent, for the entire insurance industry now follows Medicare's lead. Once the psychologists have won recognition, social workers and nurses in the field will be better armed to argue for their own inclusion. Partly to keep these demands in check and partly out of a sense of accountability to the taxpayer, the finance committee staff is asking for hard data on various types of psychotherapy showing that they are (i) safe and (ii) genuinely efficacious in improving the patient's mental health.

Spokesmen for the professions do not attack the proposal broadside, for it is difficult to argue in principle against a plan to guarantee efficacy. On the contrary, most say they welcome it wholeheartedly. They do find fault, however, with the fine print. They suspect they may be asked to meet medical criteria for efficacy, which are said to be inappropriate for many kinds of psychotherapy.

The test proposed in October by Constantine offended the psychologists because it seemed to reinforce the medical model. He suggested that therapies be tested over the next 5 years as drugs are now tested by the Food and Drug Administration (FDA) before being released to the market. That suggestion is being revised, largely because of the furor it created among the lobbies when it leaked out.

In its original form, the proposal surfaced as a draft of an amendment to a bill recently reported out of the finance committee, now awaiting a vote on the floor of the Senate. It is the Child Health Assessment Program bill (S.1204), the counterpart of which (H.R.4962) awaits a vote in the House. The amendment in question would have affected not just this bill, but other federal programs already in operation.

Some senators led by Jacob Javits (R-N.Y.) were pushing to expand mental health care for children under this legislation—an effort, according to one professional newsletter, being carried out "on behalf of the major mental health organizations." The committee staff, led by Constantine, drafted a counterproposal to temper Javits' drive, an amendment making the mental health benefits available only for 5 years (until 1984), and after that, limiting federal reimbursement only to those therapies that have been given a federal seal of approval. The proposed amendment said that federal reimbursement after 1984 would be given only for services found to be "safe and effective on the basis of controlled clinical studies which are conducted and evaluated under generally accepted principles of scientific research."

Once the plan had leaked out, the psychologists and other mental health professionals were furious. The nonphysicians were angry with Constantine, of course. But they had long considered him an adversary. They were angrier with Gerald Klerman, chief of the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA), and the federal government's leading mental health official. Klerman was in touch with Constantine before the amendment was drafted and was suspected of endorsing it. He is seen as an advocate of hard, medically based research, and the psychologists' lobby has accused him of conspiring to exclude humanistic therapies from the federal system.

Clarence Martin, executive director of the Association for the Advancement of Psychology (AAP) was quoted in *Behavior Today* as saying, "There is now a Klerman strategy of American psychiatry. What the psychiatrists are doing is to develop a base in the legislation in which 'efficacy of treatment' is a major concern. What we'll be hearing shortly is that no treatment is efficacious unless it

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has a medical as well as a psychological component. And Klerman is playing ball with them."

Klerman naturally denies that there was any conspiracy. In the hallway outside a recent meeting of the National Mental Health Advisory Council, he cornered the executive director of the American Psychological Association—parent of AAP—to give him a thorough scolding for letting a private dispute get into the press. Relations between the psychologists and Klerman are sorely strained.

None of this interprofessional jostling has addressed the problem raised by the

Nicholas Cummings

congressional staff. If the government is to finance mental health care strictly as a medical benefit (and not as a means of conveying solace as well), then how should it identify the types of therapy that have proved efficacious?

The answer given by the mental health lobbies is that virtually everything in the mainstream today is worth supporting. They would use clinical trials to eliminate unwanted practices, not to validate the useful ones. They have lobbied the finance committee staff to drop the 1984 deadline for proof of efficacy.

While generous, this approach fails to include any decision-forcing mechanism that might serve later on to weed out the less promising therapies. It is arguable that even funding the mainstream therapies for 5 years will so entrench them that there will never be any weeding out. With no deadline at all, there might be no pressure for selectivity. And, as Nicholas Cummings has said, there are perhaps 100 types of therapy in the mainstream. Each field of expertise, when pressed to select the most efficacious, will nominate itself.

On 15 November Constantine wrote a strongly worded letter to Klerman in which he dropped the 1984 deadline but expressed his doubts about the usefulness of previous attempts to review psychotherapy. He thanked Klerman for consulting with him and then made this point: "Based upon evaluations of the literature and the testimony* it appears clear to us that there are virtually no controlled clinical studies, conducted and evaluated in accordance with generally accepted scientific principles, which confirm the efficacy, safety and appropriateness of psychotherapy as it is conducted today. Against that background, there is strong pressure from the psychological and psychiatric professions and related organizations to extend and expand Medicare and Medicaid payment for their services." Because of the "almost infinite" potential demand, "we could be confronted with tremendous costs, confusion, and inappropriate care."

Constantine suggested that it might be possible to use FDA-type trials over the next 10 years to sort therapies according to safety and efficacy. In the interim, he thought it would be a good idea to set up several panels of experts to pass judgment on current practices and certify the useful ones for reimbursement pending the final ruling by clinical trials.

Constantine did not mention it in his letter, but he suggested privately that the experts might be assembled under the aegis of the Institute of Medicine (IOM). This idea will not go over well among the mental health professionals. They may prefer to steer clear of the IOM and have the existing bureaucracy—ADAMHA—make the evaluations through contract research. That, at least, was the wish expressed by the psychologists' leader, Nicholas Cummings.

Cummings told *Science* that he thought it would be a "dreadful mistake" to ask the IOM to oversee the review process because the institute is "already biased in one direction—the drug side." Cummings thinks the government should ask for contract research proposals and then allow panels of experts to choose the best qualified proposals. "It's got to be done scientifically; it can't be done on political grounds." How do you keep politics out of psychotherapy? "I'm not sure," Cummings said. But he wanted the review panels to be chosen carefully, for "the whole thing is going to rest not on who looks at the final outcome but on who looks at the research that's being set up."

Testing psychotherapies will be much more difficult than testing drugs, and Cummings predicts that Constantine will soon realize that this project will take two decades: 10 years testing for safety and another 10 years for efficacy. The reason it will be difficult is that no one has yet found an acceptable way to study the techniques of therapy in isolation from the therapist. As in teaching, success seems to depend as much on the personality and the talent of the individual practitioner as on methodology. Some argue that it is futile to try to separate the two. Cummings thinks it will be possible at least to identify practices that do not work—something he was able to do as chief psychologist at the Kaiser-Permanente Health Plan in northern California. He said it would be "premature," however, to apply the standards that he developed in California to the federal system.

The medical director of the American Psychiatric Association, Melvin Sabshin, said that the psychiatrists support the concept of clinical trials. Like Cummings, he thinks it would be fine to support more qualified research on psychotherapy. Unlike Cummings, he thought the IOM might be one of the qualified managers of research. He added that his own association planned to offer a proposal.

Klerman has not yet replied to Constantine. But he did bring the issue before the annual policy meeting of the National Mental Health Advisory Council on 6 December. There he pointed out that ADAMHA was being pressed by Congress and the Executive Branch to begin specific evaluative studies, and he raised the possibility that the agency might be called on to serve as the Food and Drug Administration of psychotherapy—a certifier of safety and efficacy. He said that he saw "the shadow of the future" in requests received from the new National Center for Health Care Technology this year. The latter has asked ADAMHA to study three techniques (aversion therapy for alcoholism, transsexual surgery, and megavitamin therapy for schizophrenia) and pass judgment on their usefulness. Although these cases may be of marginal interest, Klerman said, they will set precedents: "The same procedures that are used today to evaluate aversion therapy for alcoholism may be used tomorrow to assess family therapy for schizophrenia or behavior modification for phobias." Until now, he said, ADAMHA has been in a "reactive" posture regarding these demands; it must become "proactive" and turn the situation to its advantage.

The professional associations have reached no consensus on these issues. But they seem ready to endorse government-funded trials of psychotherapy, provided that they themselves have a hand in shaping the trials. This qualification will be the subject of many hours of negotiation.

Another article will examine current efforts to screen therapies for safety and efficacy.—ELIOT MARSHALL

*Hearings before the health subcommittee of the Senate Finance Committee, 18 August 1978.