

## EDITORIAL

### Psychotherapy in the market-place<sup>1</sup>

The starting point for this editorial is the latest in a series of meta-analyses of psychotherapy outcome studies (Smith & Glass, 1977; Smith *et al.* 1980; Andrews & Harvey, 1981; Landman & Dawes, 1982; Shapiro & Shapiro, 1982). The authors of this study (Prioleau *et al.* 1983) reach the conclusion that for 'real' patients (as opposed to subjects solicited specifically to take part in research) there is no evidence to suggest that the benefits of psychotherapy are greater than those of placebo treatment. It is already apparent that, for a variety of reasons, the implications of this conclusion are unlikely to be assessed dispassionately, as may be seen from the twenty-three open peer commentaries appended to the article by Prioleau *et al.* (1983), and elsewhere (see, for example, Spitzer & Klein, 1976; *Journal of Consulting and Clinical Psychology*, 1983).

Probably the most helpful strategy for approaching the issues was suggested by Ellenberger (1970), who not only elucidated the dramatic contrast between the historical evolution of dynamic psychiatry and that of the physical sciences, but also closely linked the many metamorphoses of 'dynamic' psychiatry to prevailing cultural and secular trends. Such an approach is also exemplified, in part, by contributions to a recent issue of *American Psychologist* (1983). In Britain it was demonstrated clearly by the Medical Research Council feasibility study for a controlled trial of formal psychotherapy (Candy *et al.* 1972), a trial which failed and whose real significance was to reveal our substantial ignorance of the epidemiological and social context of psychotherapy. To appreciate the pertinence of this point and the potential value of enquiries addressed to this problem, which is essential to a consideration of the place occupied by the various psychotherapies in medicine (Cawley, 1971), it is instructive to look at the findings, albeit incomplete, of a timely North American survey (Beitman, 1983).

In reality, however, it has been political and economic factors which have proved to be the stimulus for most of the recent interest in psychotherapy outcome research, especially that which produces positive findings. This was anticipated by Parloff (1979), among others, when it was appreciated that in times of economic austerity US policy decisions affecting the third-party reimbursement of psychotherapists would be based on research evidence; and, further, that research reports were likely to be interpreted not by 'research-wise' individuals but by lay policy-makers, a prospect which was not greeted with universal acclaim. The cat was finally put among the pigeons when Congress decided (Omnibus Budget Reconciliation Act, 1981) to consolidate funding for Alcohol and Drug Abuse and Mental Health Services in a block grant, to make cuts in allocations agreed by the previous Administration, and to place the responsibility for mental health care explicitly in the hands of individual states. Moreover, funds (\$511 million for 1983, and \$532 million for 1984) were to be allocated only if the individual states undertook to establish reasonable criteria to evaluate the effective performance of recipient entities. Since the annual reimbursement costs of psychotherapy and pharmacotherapy are each estimated to be in excess of a billion dollars the stakes are high and the potential conflicts manifold. Some of the resulting oppositions, differences of emphasis, divergence and inconsistencies on the subject of payment for psychotherapy are well illustrated by two contrasting attitudes. On the one hand, in a sanguine article colourfully entitled, 'Psychotherapy research evidence and reimbursement decisions: Bambi meets Godzilla', Parloff (1982) begins by asserting that 'Research evidence on psychotherapy outcome is both extensive and positive', and continues, 'By the criterion of popularity in the market-place, the field of psychotherapy is ostentatiously successful; it flourishes and prospers. Practitioners multiply and consumers increase. Indeed, psychotherapy appears to have everything going for it except one – namely, credibility'. On

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the other hand, there is the (belated) recognition that 'With large financial support from government agencies, especially the National Institute of Mental Health, an enormous private market has been generated since World War II for psychotherapeutic services that have never been fully defined or comprehensively described, let alone thoroughly evaluated in a scientific manner', accompanied by a call for a standing national group to assess the efficacy and safety of the psychotherapies (London & Klerman, 1982).

Such considerations probably did not go unheeded when the Sub-committee on Health of the House of Representatives Committee on Ways and Means recently dealt with a bill to amend the Social Security Act to authorize direct medicare and medicaid reimbursement for mental health services rendered by clinical psychologists, social workers, and psychiatric nurse specialists (H.R. 6092, 1982). This delicate matter, the outcome of which will be of more than passing interest, introduced an even more piquant flavour to the general dispute, for during the above hearings evidence was produced, in the form of detailed costings, to support the notion that the recognition of psychologists, and other accredited non-medical health professionals, would clearly benefit efforts to decrease health care costs by increasing the competitive pool of practitioners available for the delivery of care. It was argued to the nearest cent that, for nearly every item of psychotherapeutic service, psychologists charged less on average than psychiatrists, and similar claims were made for the other two groups. In this hornets' nest, and cost-benefit and cost-effectiveness calculations and options notwithstanding, the clinical psychologists, who have everything to gain in this context, seem set to turn the screw on the American medical profession. One indication of the scope of their goal and the antagonism involved is communicated by a passage which arose in a different, but relevant and related context (Wiggins *et al.* 1983; see also Pertschuk & Correia, 1983):

The professional and economic challenges to psychologists posed by organised medicine have been stymied in the past by the Federal Trade Commission and by strict enforcement of the anti-trust laws. Now that professional competition and consumer choice are being supported in the courts, the American Medical Association is redoubling its efforts to retain a monopolistic hold on health care, hospital practice, and health insurance throughout the nation. Organised psychology, with the help of its friends in other professions and in the Congress, has barely held the line against politically and economically stronger forces. Now, therefore, psychologists should study the issues involved, consider the ramifications for the public good and for their professional existence, and act on their conclusions while their future is still their own to shape.

A comprehensive account of the direction towards which this kind of thinking might lead health services planners has been given by Havighurst (1982).

The other side of the coin for psychologists has been underlined by Maher (1981) in the course of arguing strongly against proposals for *mandatory* insurance coverage for psychotherapy on the grounds that the main beneficiary of this practice is the private practitioner. Some American states, it should be noted, already have laws that forbid health insurance companies from offering health insurance unless the cover includes a sum of several hundred dollars per annum in reimbursement for out-patient psychotherapy. Maher (1981) comments:

The production of doctorates has fallen off since 1975 in all fields of behaviour and life sciences except one. That one is clinical psychology. Not only has the rate of production increased in that field, but it has begun to increase exponentially with the rapid growth of the professional schools, the re-training into clinical psychology of many who hold doctoral degrees in other branches of psychology and so forth. Employment opportunities for these psychologists are not increasing significantly in academic or salaried clinical posts. Consequently the most likely source of income is the fee-earning private practice. All of the indications are that there will be intense pressure on the clinical psychologist to support policies designed to increase the client pool.

Perhaps this would matter less if no more than the recreational and experiential uses of psychotherapy were at issue, but in the medical setting investments in such activities are bound to divert resources from more needy groups. For meanwhile, far behind the scenes it appears, the pressure within the United States has been building up to determine which mental health services are expendable; and fears of a return to the economics of scarcity are causing concern to those who

believe that the Community Mental Health Centres programme, that 'leading edge of psychotherapeutic populism' (Beitman, 1983), may soon cease altogether to serve the chronically and seriously mentally disordered who most need it and are least able to pay (Wickenden, 1981).

A simple extrapolation of the foregoing difficulties leads directly to the thorny question of the future for psychotherapeutic practices in other countries, particularly within the medical orbit. In the United Kingdom, Shepherd (1979) plainly charted this minefield five years ago, but the predictable response was for the warning signs to be ignored despite the overriding consideration that unhappy and at times desperate people, who seek no more than relief from suffering, continue to be at risk and are in need of protection from unscrupulous practitioners of psychotherapy. An illustration of the widespread tendency of psychotherapists to avoid the therapeutic foreground in favour of the middle distance is demonstrated by the sorry confusion and fudging which affects thinking on the vexatious topic of the statutory registration of psychotherapists. In an assessment of this sorry saga, after mention of representations dealing with, for example, the avoidance of value-added tax by lay psychotherapists in private practice and the possible employment of lay therapists within the National Health Service, a recent report raises a more significant issue (Royal College of Psychiatrists, 1983): namely, that since 1981 the British Psychological Society has made the registration of psychologists and not the registration of psychotherapists their primary goal (British Psychological Society: Steering Committee on Registration, 1982). The inferences from, and the likely widespread effects of, their aims, even in the present sphere, have yet to be fully appreciated by those outside the psychological domain, but events in North America provide plenty of food for thought.

In addition, one more disturbing piece of information needs to be digested. Psychotherapy as a sub-specialty was introduced into the National Health Service in 1975, when there were about ten practising consultants. Since then, there has been roughly a 350% increase in the number of consultant psychotherapists (from 18 to 79) in England and Wales (DHSS, 1977, 1983), and an unknown but probably enormous hidden increase in the number of non-medical 'therapists' and 'counsellors'. This fact is not easily reconciled with the results of personal enquiries which show that pitifully little investigation into the process or outcome of psychotherapy is currently being supported by the major bodies responsible for medical research. The determinants of and the relationships between these factors in the overall equation continue to be puzzling in view of the lack of scientific knowledge concerning the need for and the uses of psychotherapy.

Without doubt, the time has come to re-examine all the 'stinging administrative, ethical, and scientific questions' (Shepherd, 1979) concerning the use of psychotherapy in the National Health Service. By now, this should be more than apparent to responsible decision-makers in the Department of Health and Social Security. Value for money is a basic governmental shibboleth. By that inadequate single criterion the efficacy of psychotherapy has still to be rigorously tested and, in consequence, the data justifying the extensive and increasing psychotherapeutic activity in the Health Service are alarmingly weak. Unequivocal evidence bearing on this topic seems unlikely to appear in the near future. Meanwhile, however, the conclusion reached by Prioleau *et al.* (1983) is clear enough and brief enough to concentrate the governmental mind:

Thirty years after Eysenck (1952) first raised the issue of the effectiveness of psychotherapy, twenty-eight years after Meehl (1955) called for the use of placebo controls in psychotherapy, eighteen years after Brill *et al.* (1964) demonstrated in a reasonably well-done study that the psychotherapy effect may be equivalent to the placebo effect, and after about 500 outcome studies have been reviewed – we are still not aware of a single convincing demonstration that the benefits of psychotherapy exceed those of placebos for real patients.

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## REFERENCES

- American Psychologist* (1983). Psychology in the public forum; **38**, 907–955.
- Andrews, G. & Harvey, R. (1981). Does psychotherapy benefit neurotic patients? A reanalysis of the Smith, Glass, and Miller data. *Archives of General Psychiatry* **38**, 1203–1208.
- Beitman, B. D. (1983). The demographics of American psychotherapists: a pilot study. *American Journal of Psychotherapy* **37**, 37–48.
- Brill, N. Q., Koegler, R. R., Epstein, L. J. & Forgy, E. W. (1964). Controlled study of psychiatric outpatient treatment. *Archives of General Psychiatry* **10**, 581–595.
- British Psychological Society: Steering Committee on Registration. (1982). A consultative paper on the form of a registration Act. *Bulletin of the British Psychological Society* **35**, 109–114.
- Candy, J., Balfour, E. H. G., Cawley, R. H., Hildebrand, H. P., Malan, D. H., Marks, I. M. & Wilson, J. (1972). A feasibility study for a controlled trial of formal psychotherapy. *Psychological Medicine* **2**, 345–362.
- Cawley, R. H. (1971). Evaluation of psychotherapy. *Psychological Medicine* **1**, 101–103.
- Department of Health and Social Security: Medical Manpower Division (1977). Medical staffing and prospects in the NHS in England and Wales, 1976. *Health Trends* **9**, 45–47.
- Department of Health and Social Security: Medical Manpower Division (1983). Medical and dental staffing prospects in the NHS in England and Wales, 1982. *Health Trends* **15**, 35–39.
- Ellenberger, H. F. (1970). *The Discovery of the Unconscious. The History and Evolution of Dynamic Psychiatry*. Allen Lane: London.
- Eysenck, H. J. (1952). The effects of psychotherapy: an evaluation. *Journal of Consulting Psychology* **16**, 319–324.
- Havighurst, C. C. (1982). *Deregulating the Health Care Industry. Planning for Competition*. Ballinger Publishing Company: Cambridge, Mass.
- H.R. 6092 (1982). To authorize direct medicare and medicaid reimbursement for mental health services rendered by clinical psychologists, social workers, and psychiatric nurse specialists. Ways and Means Committee, House of Representatives, 14 December.
- Journal of Consulting and Clinical Psychology* (1983). Special section: Meta-analysis and psychotherapy; **51**, 3–75.
- Landman, J. T. & Dawes, R. M. (1982). Psychotherapy outcome. Smith and Glass' conclusions stand up under scrutiny. *American Psychologist* **37**, 504–516.
- London, P. & Klerman, G. L. (1982). Evaluating psychotherapy. *American Journal of Psychiatry* **139**, 709–717.
- Maher, B. (1981). Mandatory insurance coverage for psychotherapy. A tax on the subscriber and a subsidy to the practitioner. *The Clinical Psychologist* **35**, 9–12.
- Meehl, P. E. (1955). Psychotherapy. *Annual Review of Psychology* **6**, 357–379.
- Omnibus Budget Reconciliation Act (1981). Public Law 97-35 of the 97th Congress of the United States of America.
- Parloff, M. B. (1979). Can psychotherapy research guide the policymaker? A little knowledge may be a dangerous thing. *American Psychologist* **34**, 296–306.
- Parloff, M. B. (1982). Psychotherapy research evidence and reimbursement decisions: Bambi meets Godzilla. *American Journal of Psychiatry* **139**, 718–726.
- Pertschuk, M. & Correia, E. (1983). The AMA versus competition. *American Psychologist* **38**, 607–610.
- Prioleau, L., Murdock, M. & Brody, N. (1983). An analysis of psychotherapy versus placebo studies. *Behavioural and Brain Sciences* **6**, 275–310.
- Royal College of Psychiatrists (1983). Statutory registration of psychotherapists. *Bulletin of the Royal College of Psychiatrists* **7**, 190–195.
- Shapiro, D. A. & Shapiro, D. (1982). Meta-analysis of comparative therapy outcome studies: a replication and refinement. *Psychological Bulletin* **92**, 581–604.
- Shepherd, M. (1979). Psychoanalysis, psychotherapy, and health services. *British Medical Journal* **ii**, 1557–1559.
- Smith, M. L. & Glass, G. V. (1977). Meta-analysis of psychotherapy outcome studies. *American Psychologist* **32**, 752–760.
- Smith, M. L., Glass, G. V. & Miller, T. I. (1980). *The Benefits of Psychotherapy*. Johns Hopkins University Press: Baltimore.
- Spitzer, R. L. & Klein, D. F. (eds.) (1976). *Evaluation of Psychological Therapies. Psychotherapies, Behaviour Therapies, Drug Therapies and Their Interactions*. Johns Hopkins University Press: Baltimore.
- Wickenden, D. (1981). Mental health's malady. From the snakepits to the streets, via the 'community'. *The New Republic* **185**, 19–23.
- Wiggins, J. G., Bennett, B. E., Batchelor, W. F. & West, P. R. (1983). Psychologists in defence of the Federal Trade Commission. *American Psychologist* **38**, 602–606.