# PSYCHOANALYTIC THERAPY as HEALTH CARE

## *Effectiveness and Economics in the 21st Century*

edited by
Harriette Kaley
Morris N. Eagle
David L. Wolitzky

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# Editors' Introduction

Health care in general has come under siege in an era of managed care and preoccupation with cutting health costs and maximizing profits. Mental health care has become a special target; and, of the various approaches to mental health care, psychoanalytically oriented treatment has been particularly threatened. The reason is that it is associated with long-term treatment and is not limited to symptom reduction. We as editors join with our contributors, all mental health professionals with a focus on psychoanalysis, in our concern with a variety of questions raised by the current storm raging about our services. Are they health care? Is psychoanalysis a health care profession? Is there a legitimate role for psychoanalytically oriented treatment in the delivery of health care?

It is important to note at the outset that it is not just traditional psychoanalysis that concerns us, but all therapeutic interventions guided by psychoanalytic principles and psychoanalytic understanding. As we understand it, that includes all psychoanalytically informed psychotherapies and most forms of psychodynamic psychotherapy. We conceive of them all as variants of psychoanalytic approaches, and thus all of them are our objects of concern. Questions about their status have great salience in the present climate of flux and uncertainty about how health care in the United States will be provided over the long run.

That psychoanalytic treatment has come in for special scrutiny is not difficult to understand. Psychoanalytic treatment, with the obvious exception of brief psychodynamic psychotherapy, tends to be long-term treatment (but see Bernay, chapter 2) and is therefore anathema to the profit-making and cost-cutting concerns of managed care. In addition, there is a direct clash between psychotherapeutic values, such as the vital importance of privacy and confidentiality and the emphasis on an ongoing, trusting relationship developed over a period of time (see Sundelson, Cummings, and Newman, chapters 8 through 10), versus the demands, intrusions, and interventions of managed health care, which are almost

always linked to controlling costs and thereby maximizing profits.[1] In addition, as Barron points out (chapter 3), managed care fails to appreciate the significance of unconscious processes in psychopathology. So serious is this clash of values that at least one of our contributors (Hyman, chapter 5) believes that there is no alternative for psychoanalysis but to remain outside the framework of managed care; however, see Moldawsky (chapter 4) for an opposing point of view. There is little doubt, then, that psychoanalytic treatment, along with other long-term treatment, is seriously threatened. This would be a matter of limited interest—limited, that is, to those practitioners who find it difficult to carry on with their work—were it not for the fact that the threat to psychoanalytic treatments is also a threat to the basic principle that patients should get the treatment they need for as long as they need it. Indeed, as Lionells (chapter 6) points out, managed care represents a challenge to all health care practices, whether generally medical or explicitly psychotherapeutic in nature.

If psychoanalysis and its offshoots are health professions and can contribute to health care, then ways must be found to do what has not hitherto been done: provide effective ways for such forms of health care to be available to those who need it, whether or not they are affluent, as psychoanalytic patients in the past have been reputed to be. But how can we as a nation provide such health care for people without the attendant evils that seem to accompany the currently evolving systems for providing health care: lack of privacy and confidentiality, escalation of administrative bureaucracies and the unintended but inevitable consequent increases in costs, the removal of care-making decisions from the patient–therapist dyad, unending (and unpaid) paperwork, and so on? (See Welch, chapter 1; Barron, chapter 3; Hyman, chapter 5; Sundelson, chapter 8; Cummings, chapter 9; and Newman, chapter 10).

These are the questions that mental health professionals have been struggling with as we as a nation confront and attempt to deal with America's health care needs. Furthermore, as more of us are covered by managed care companies, we come increasingly to experience directly the fact that they are planned as commercial enterprises, as profit-making organizations, whose top officials frequently command staggering compensation packages and whose stockholders demand capital appreciation and

[1] It is worth noting that psychoanalytic forms of mental health care are not alone in being questionable treatments in the eyes of managed care. Other forms of extended treatment and potentially life-saving but still experimental treatments, such as bone-marrow transplants, have also been questioned. Some managed care plans still make it difficult for infertility treatments to be covered. The problem, as we see it, is that the concerns of managed care for issues of cost create scotomas that make it hard to see that expensive or extended treatment (or both) is in fact often the treatment best designed to alleviate a patient's problem.

dividends (see Cantor, chapter 7). It has also become clear that political ideologies about the role of government in private life, the value of rugged individualism, and the relative virtues of social welfare and entrepreneurial approaches, color the systems that we develop for delivering—or limiting the delivering of—health care (see Bernay, chapter 2).

When we look at the issues from these points of view, it becomes evident that the fundamental problem may be a basic clash of values. What, really, is important in health care delivery? Is it cost effectiveness in some form or other, or is it optimal patient care? For those engaged in managing health care, the former plays a very large role; for those who care for patients, the latter is the primary concern. Neither group comes to its position without a long and mostly honorable tradition, a philosophy that supports it, and probably, for some, at least, considerable soul-searching. The managed care contingent warns that national resources must be allocated rationally or else the entire system will escalate out of control and ultimately collapse, serving well neither the people in need of services nor the national economy. It presents itself as having to make difficult decisions in an unsentimental manner and claims that its opponents are at best fiscally uninformed and unwise and at worst self-serving and tender-minded (in the least flattering sense of that Jamesian term). For those who treat patients, the managed care position is transparently in basic conflict with the obligation to provide the best possible care, in keeping with a sense of the dignity of the individual and the value of life; to them, the managed care position is a vaguely intellectualized excuse for rationing health care for the ultimate purpose of producing greater corporate profits. They do not accept the notion that this wealthy country, with its expensive advances in medical technology, cannot afford to use its wealth and technology to make life happier, healthier, longer.

Nowhere is this clash of values seen more clearly than when managed care and psychoanalysis meet. The goal of managed care is to return the patient as quickly as possible to a state that we may call serviceability. This is done in the name of a nebulous criterion described as medical necessity. The idea is to get the patient functional in some way, whether or not the underlying problems have been treated and the suffering ameliorated, and to do it with dispatch; if it cannot be done with dispatch, then the patient risks being consigned to some sort of limbo, because his or her problems run more deeply than the concept of medical necessity can contain. Psychoanalytically informed psychotherapy has a different goal; it is to enable the patient to be at his or her best, to be not merely symptom free but internally comfortable and relatively unconflicted, and to live in a fulfilling way. Psychoanalytic treatment seeks not merely symptom relief, but alterations in defense, improved self-esteem, and more gratifying object relations. When corporate values meet the psychoanalytic set of values, there

is a clash of cultures wherein politics, power, and money are more likely to be decisive in the outcome than is concern for quality of patient care (Messer and Wachtel, 1997).

At least two considerations have weakened the case that can be made in defense of psychoanalytic treatment. One is the lack of well-designed outcome studies clearly demonstrating the relative effectiveness of long-term psychoanalytic treatment. The other consideration is the equation, in the minds of many, of psychoanalytic and psychodynamic treatment with traditional psychoanalysis (i.e., frequent sessions each week, use of the couch, etc.) and the accompanying, perhaps understandable, assumption that such treatment tends to be limited to relatively well-to-do patients and is not especially relevant to current health care concerns.

The first concern—lack of well-designed outcome studies—is a legitimate and warranted one, and there is no question that the broad psychoanalytic community needs to deal with this concern more fully and effectively than it has up to this point. One should note, however, that attempts have been made within the psychoanalytic community to address this issue (see Doidge, 1997, for an extensive review of studies dealing with the efficacy of psychoanalytic psychotherapies). A brief review is appropriate here of three linked issues associated with studies of psychotherapy outcomes: studies of the efficacy of psychotherapy, of the growing controversy over empirically validated treatments, and of the value of pharmacotherapy.

In the early 1950s, Eysenck's (1955) challenge that the results of therapy were no better than those attributable to spontaneous remission stimulated what has become by now a great number of psychotherapy process and outcome studies. These have been subjected to numerous meta-analyses with frequently similar results. Two main conclusions have emerged from this work: a) psychotherapy is effective, compared with several different kinds of control procedures, and b) no single school of therapy produces consistently superior outcomes (Smith, Glass, and Miller, 1980). These findings are a source of solace to many clinicians, despite the fact that they forced proponents and adherents of rival schools to take a more modest stance. It must be noted, however, that the bulk of the studies used in the various meta-analyses were behavioral or cognitive-behavioral studies. It is therefore not possible at this point to draw conclusions about the relative efficacy of psychoanalytically oriented approaches compared with others. Such uncertainty is especially important when we note that psychotherapy research studies typically use criteria (e.g., elimination of subjects showing comorbidity) and procedures (e.g., random assignment of patients and use of treatment manuals) that are very different from those characterizing routine clinical practice. These considerations limit the generalizability of many psychotherapy outcome studies.

The overall thrust of these findings is, of course, central to the controversy over empirically validated treatments. The conclusions of a Task Force of the American Psychological Association (Task Force on Promotion and Dissemination of Psychological Procedures, 1995), presenting a list of treatments shown on the basis of empirical research to be efficacious for particular clinical syndromes, have been rightly questioned because of the failure to distinguish efficacy in research settings from effectiveness in clinical practice. As Messer and Wachtel (1997) note, different approaches to therapy have different outcome criteria, and in real-life conditions adherence to a treatment manual in dealing with complex, multiproblem patients might retard rather than enhance effective treatment. Even those who are sympathetic to and have been active in efforts to identify empirically validated treatments have expressed concern regarding the possible misuse of the studies and their limited generalizability. For example, Borkovec and Castonguay (1998) write, "Our concern about the empirically supported therapy movement is . . . that we may draw erroneous conclusions from outcome results when applying them to applied questions. . . ." (p. 139). And Goldfried and Wolfe (1998), who explicitly refer to the possible misuse to which insurance companies can put these studies, are gravely concerned that the methodological and other constraints of research designs might translate into clinical constraints for the practicing therapist, to the detriment of practitioners and patients alike.

Additional pertinent data come from pharmacotherapy-and-psychotherapy studies. In the treatment of depression, medication is not more effective than either is alone (Antonuccio, Danton, and DeNelsky, 1995). Nor are the two together more effective than psychotherapy alone is (Greenberg et al., 1994). Medication for depression is only modestly more effective than are placebos, and earlier work (Evans et al., 1992; Hollon, 1990) has shown that antidepressant medication can lead to more rapid improvement than can psychotherapy alone, but the durability of changes is greater if psychotherapy is also part of the treatment plan.

The state of intervention research ought to give committees and managed care companies pause in asserting prescribed forms of treatment for particular psychiatric syndromes. In their search for profits, these companies focus on efficiency and symptom relief, not on the kinds of long-lasting, pervasive, and revitalizing kinds of changes that psychoanalysts emphasize. The practical and economic issue here is whether more liberal mental health benefits would make patients more resilient in the face of future stress and conflict and therefore be more cost effective in the long run (Cummings, 1996; Lazar and Gabbard, 1997). There are, for example, some data to suggest that decreased use of medical services is a consequence of psychotherapy (e.g., Mumford and Schlesinger, 1987), although this is not a uniform finding (Fraser, 1996).

Although there is much room for improvement in the design of such studies and much more to be done (in this volume, see Blatt and Ford, chapter 15, as exemplar), there is enough evidence to suggest that failure to support long-term psychodynamic or psychoanalytic treatment might well deprive many patients of the help they need and from which they can benefit. It seems to us that, given our current state of seriously incomplete knowledge, it is premature to speak about "empirically validated treatments" with any degree of confidence—certainly not with the degree of confidence necessary for the determination of which treatments should or should not be eligible for reimbursement.

We hold that, at this point in our knowledge, it is wiser to provide a broader rather than a narrower range of treatments. If we provide treatments that turn out to be not as economically sound and not as uniformly effective as they could be, we are not cutting costs as well as we might have. If, however, we fail to provide treatments that may be genuinely helpful, at least to some patients, we are putting people's health, well-being, and lives at risk.

The second consideration that may have undermined the case for psychoanalytic or psychodynamic psychotherapy as health care is the view of it as an esoteric treatment suitable only for a limited and highly select group of patients. While this description may conceivably be accurate for traditional or classical psychoanalysis, it is not accurate with regard to psychoanalytically or psychodynamically oriented or informed treatment. It is this second consideration on which the book mainly focuses. The different chapters of this book, taken together, indicate clearly and forcefully the wide range of contexts and populations to which psychoanalytically oriented and psychoanalytically informed treatments are relevant and applicable.

The Division of Psychoanalysis (Division 39)[2] of the American Psychological Association (APA) has been addressing these issues concerning psychoanalytic treatment and health care in an intensive way for several years. In 1994, the Division's meetings at the annual Convention of the APA was devoted to the theme "Psychoanalysis as Health Care." Those meetings, organized by the senior editor of this volume, Harriette Kaley, as part of her responsibilities as president-elect of the Division, helped all

[2] In 1994, Division 39 had a membership of about 4200. Because members had to belong to the American Psychological Association (APA), itself a nationwide organization with over 120,000 members, it was, obviously, an organization almost exclusively of psychologists (there were also graduate psychology students and a few people from allied professions whose professional contributions had earned them membership in the APA); the additional requirement was an interest in psychoanalysis. As it turned out, most Division members were clinicians who described themselves as practicing psychoanalysis or psychoanalytic psychotherapy.

of us focus more clearly on the potential opportunities and dangers for psychoanalysis and its related therapies in the emerging health-care delivery systems. Since then, more and more of us in the Division, often in collaboration with our colleagues in psychology and in related mental health professions, have considered the topic in depth. This volume, with the assistance of the two invited coeditors, Morris N. Eagle and David L. Wolitzky, collects some of the most relevant thinking by significant workers in the field. Some of the papers were presented at the 1994 meetings and thus helped define the issues in a focused way; others were invited contributions that the editors believed would help convey a fuller picture of the present state of affairs and the prospects for the future.

The organization of this book reflects our sense of the major topics that must be included in any attempt to view the subject comprehensively. Part I opens the discussion with an overview of the present problems and suggestions for the future. All the chapters in Part 1, except for Cantor's (chapter 7), were presented at the 1994 meetings and were revised for this volume.[3] The chapters in the section pose the question of where psychoanalytic treatments currently stand in relation to health care, offer some ideas about why matters have developed as they have, and consider possible directions for the future.

The second part addresses some of the most critical matters in the attempt to fuse psychotherapy and managed health care: the ethical, legal, and professional issues of confidentiality, privacy, and reporting to third parties. The breach of the "confessional," as Sundelson tellingly terms it, that begins with any kind of reporting to a third party—even so much as whether or not a particular person is in treatment—turns out to have wide-reaching implications that tend to undermine, if not destroy, the basic enterprise. These chapters ask whether it is in principle possible to have managed mental health care, especially when the treatment modality is of the psychoanalytically-informed variety.

Part III takes a larger perspective on the matter. It considers the experiences of psychoanalysts under health care systems in other parts of the world. Willock et al. (chapter 11), in a summary of several presentations at the original meetings, surveys the world scene; in a companion piece written for this volume, Speilman (chapter 12) reviews the history and effects of Australia's very recent adoption of governmental controls over mental health care. These comparative approaches provide much food for thought for America.

The final section, Part IV, brings psychoanalytic approaches to bear

[3] Cantor's chapter is taken from a talk originally given to the New Jersey Psychological Association while she was president of the American Psychological Association in 1996 and is published here in virtually its original form to retain its freshness.

on the treatment of a variety of contemporary problems, populations, and questions. The entire section consists of articles written specifically for this volume, and it speaks of the application of psychoanalytic work to such varied and significant populations as AIDS patients (Blechner, chapter 14), seriously disturbed adults (Blatt and Ford, chapter 15), and inner-city populations (Altman, chapter 17). In addition, it considers who the people are today who are analytic patients (Doidge, chapter 13) and describes the encounter between a psychoanalytically run hospital and the constraints of managed care (Plakun, chapter 16). These chapters should, once and for all, dispel the idea that psychoanalytic treatment is only or primarily for the "worried well." The populations to whom psychoanalytically oriented treatment is relevant and applicable are, indeed, worried, but they are in great distress and in that sense are certainly not well. The editors believe that this section, by showing real-life clinical applications of psychoanalytic approaches, puts skin and bones on the skeleton of the arguments rolling around managed care and at the same time demonstrates the continued salience of psychoanalytic thinking to our troubled world.

As editors, we come away from our task of shepherding this volume to completion with a renewed sense of the vigor and applicability of psychoanalytic treatments. We trust that reading this volume will create the same experience in the reader.

## REFERENCES

Antonuccio D. O., Danton, W. G. & DeNelsky G. Y. (1995), Psychotherapy versus medication for depression: Challenging the conventional wisdom with data. *Profess. Psychol.,* 26:574–585.

Borkovec, T. D. & Castonguay, L. G. (1998), What is the scientific meaning of empirically supported therapy? *J. Consul. Clin. Psychol.,* 66:136–142.

Cummings, N. A. (1996), Does managed health care offset costs related to medical treatment? In: *Controversies in Managed Health Care,* ed. A. Lazarus. Washington, DC: American Psychiatric Press, pp. 213–227.

Doidge, N. (1997), Empirical evidence for the efficiacy of psychoanalytic psychotherapies and psychoanalysis: An overview. *Psychoanal. Inq.,* Suppl:102–150.

Evans, M. D., Hollon, S. D., DeRubeis, R. J., Pasecki, J. M., Grove, W. M., Garvey, M. J. & Tuason, V. B. (1992), Differential relapse following cognitive therapy and pharmacotherapy for depression. *Arch. Gen. Psychiat.,* 49:802–808.

Eysenck, H. (1955), The effects of psychotherapy: A reply. *J. Abn. Psychol.,* 50:147–148.

Fraser, J. S. (1996), All that glitters is not always gold: Medical offset effects and managed behavioral health care. *Profess. Psychol.,* 27:335–344.

Goldfried, M. R. & Wolfe, B. E. (1998), Toward a more clinically valid approach to therapy research. *J. Consult. Clin. Psychol.,* 66:143–150.

Greenberg, R. P., Bornstein, R. F., Zborowski, M. J., Fisher, S. & Greenberg, M. D. (1994), A meta-analysis of fluoxetine outcome in the treatment of depression. *J. Nerv. Ment. Dis.,* 182:547–551.

Hollon, S. D. (1990) Cognitive therapy and pharmacotherapy for depression. *Psychiat. Annals,* 20:249–258.

Lazar, S. G. & Gabbard, G. O. (1997), The cost-effectiveness of psychotherapy. *J. Psychother. Prac. & Res.,* 6:307–314.

Messer, S. B. & Wachtel, P. L. (1997), The contemporary psychotherapeutic landscape: Issues and prospects. In: *Theories of Psychotherapy,* ed. P. L. Wachtel & S. B. Messer. Washington, DC: American Psychological Association, pp. 1–38.

Mumford, E. & Schlesinger, H. J. (1987), Assessing consumer benefit: Cost offset as an incidental effect of psychotherapy. *Gen. Hosp. Psychiat.,* 9:360–363.

Smith, M. L., Glass, G. V. & Miller, T. L. (1980), *The Benefits of Psychotherapy.* Baltimore, MD: Johns Hopkins University Press.

Task force on promotion and dissemination of psychological procedures (1995), Training and dissemination of empirically validated psychological treatments. Report and recommendations. *Clin. Psychol.,* 48:3–23.

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PART I

# Psychoanalysis and Health Care: Present Problems and Future Prospects

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ONE

# Psychoanalysis In the Political Arena

## *The Reality Principle*

BRYANT L. WELCH

### THE LAWSUIT

In 1985 psychologists took what seemed at the time a very radical approach to the problem psychologists were having obtaining psychoanalytic training. They filed a class action antitrust suit against the American Psychoanalytic Association, the International Psychoanalytic Association, and two of their component institutes.

Psychologists did not take these steps precipitously. In 1983, psychologists felt that at long last the American Psychoanalytic Association was going to change its policy barring psychologists from training in their institutes, from hiring their teachers to set up their own institute, and from admission to the International Psychoanalytic Association.

Unfortunately, in late 1983 the Medical Director of the American Psychiatric Association addressed the American Psychoanalytic Association and strongly cautioned them not to admit psychologists, but, instead, to move closer to their "medical roots." And, in May of 1984, the American Psychoanalytic Association Board of Directors voted to table all proposals to train psychologists.

In the summer of 1984, in the newsletter of the American Psychoanalytic Association, the newly elected president, Ed Joseph, expressed relief that the proposals had been defeated and that during his tenure institutional attention could be directed to other areas. For those psychologists who had been following this issue for 15 years, not only was

defeat of the proposals disheartening, but it seemed to them very unlikely that, barring a more radical intervention, psychologists would be able to obtain psychoanalytic training.

While the lawsuit effort was arduous for all, there is little dispute now, even within the American Psychoanalytic Association, that training psychologists has had a wonderful and rejuvenating impact on psychoanalysis in this country. And psychoanalysis is now one of the fastest growing areas of interest within the American Psychological Association, something one would not have imagined just a few decades ago.

The lawsuit's challenge to the long-standing autocratic structure of the American Psychoanalytic Association has at least arguably had a positive impact within the American Psychoanalytic Association. One can now see hope for a reduction in the American's rigidity, as a number of younger analysts realize that one can politically challenge its rules and procedures just as they can with any organization. That one may have a problem with authority does not mean that one has an "authority problem." Indeed, the change has had a salutary effect on freedom of thought within the American Psychoanalytic Association.

It is true that in the early days after the lawsuit many members of the American Psychoanalytic Association responded with a defensive historical revisionism—claiming "We were going to do it anyway." They overlooked the voluminous documents and public statements that were very much to the contrary, not to mention the direct statements made to the lawsuit organizers in presuit meetings between the two groups.

But it is noteworthy that, just a few years later, as psychologists and medical analysts began a perilous reformation period in the nation's health care system, psychology's closest ally was the American Psychoanalytic Association. As both groups confronted the multiple issues that the crisis had raised for them, the analytic community appreciated more fully that, in fighting over psychoanalytic training opportunities, psychologists were testifying to its importance, a value shared by analytically oriented psychologists and psychiatrists but not by many other large segments of society.

It became increasingly important for Division 39 psychologist/psychoanalysts and the American Psychoanalytic Association to articulate their shared values, which often were lost in the health care debate. Psychotherapy is one of the few therapeutic sanctuaries that we provide in our culture. It is founded on a deeply held belief in the importance of the subjective realm of human experience and human emotion. And it inherently depends on a close and intimate relationship that can unfold only over sufficient time and with a degree of intensity sufficient to allow meaningful events to take place.

In 1992, the American Psychoanalytic Association took what were, for it, radical steps—it hired its own lobbying firm and began to participate in the political dialogue in Washington. Psychologist lobbyists were in regular contact with them, and, combined, they added energy geared toward securing a place for intensive psychotherapy and psychoanalysis in the health care reform.

## THE HEALTH CARE SYSTEM

While the psychoanalytic community was waging its legal civil war, other major changes were confronting the overall health care system. Costs were escalating exponentially. The percentage of our Gross National Product spent on health care rose from 6% to 15%, and health care became a major political issue in this country. Simply put, we suffered from a system of health care in which patient and provider decided how much of the insurance company's money they wanted to spend. Not surprisingly, their decisions were inflationary. And so we shifted to a system where a fourth private party was given both the money and the power to determine how much of the money to spend on patients and how much to retain for their own corporate profits. (They would like to retain a lot in corporate profits!) This new system became known as managed health care.

By the mid-1990s, the *Wall Street Journal* reported that the CEO of one of the largest managed care companies made a salary of ten million dollars, money that could probably have provided inoculations for most of the nation's children who were not inoculated at the time.

Not surprisingly, long-term psychotherapy was extremely vulnerable in this new system. Therapy's inherent subjectivity, people's fear of and antipathy toward the subjective realm, and the prejudice that exists against mental illness all contributed to the problem and made it very difficult for people to protest when their psychotherapy benefits were removed.

## AMERICAN PSYCHOLOGICAL ASSOCIATION PRACTICE DIRECTORATE

Managed care was clearly a political problem that was going to require a massive federal and state lobbying effort. And yet, when psychologists looked to their national trade organization, they found an organization that had been established by research academics, had very little to do with advocacy, and had even less to do with advocacy on behalf of psychoanalytic practitioners. Thus, in 1985, spurred by an insurgent group of young

practitioners drawn largely from state psychological associations, the APA established a special tax on its practitioners to raise the three million dollars annually needed to establish an advocacy structure that could begin to tackle the problems that these young psychologists anticipated were going to confront psychology in the not too distant future.

In building the structure, psychologists had to focus on a number of areas. First psychology's scope-of-practice issues, under assault by medical interests, were fought at the state level. Psychologists' state political structures were extraordinarily primitive and ill equipped to meet the major tasks that lay ahead. At the federal level, our health care system appeared to be spiraling out of control and deteriorating so rapidly with managed care that eventually it seemed likely to collapse, forcing the federal government to intervene with some type of quasinational health insurance system. The United States was one of just two countries that did not have a national health insurance system. (The other was South Africa.)

In response, psychologists did two things. First, they built an infrastructure. Substantial resources were spent building state associations and helping them hire professional staff and equipment. At the federal level, psychologists set up a grass roots network so that psychologists would be able to contact elected officials in their home district. They established a database of information about the value of psychotherapy and psychological services in general. They set up an aggressive political action committee so that psychologists could make contributions to candidates' campaigns and form relationships with elected officials who would support them in legislative chambers. Psychologists set up a public relations arm to advocate their issues in public forums, and they developed a cadre of lobbyists to make their case on Capitol Hill.

The second thing psychologists did while building the infrastructure was to shape emerging legislation to have an impact on inevitable health care reform legislation. When Senator Edward Kennedy (D-MA) and Congressman Henry Waxman (D-CA) proposed the first national health insurance plan, it contained no mention of mental health and no mention of psychology. Psychologists responded aggressively to the proposed legislation and were successful in having both psychology and other mental health care included, albeit with a very limited outpatient benefit.

Psychologists also looked at the Medicare program. Many were predicting that Medicare would be the logical vehicle to extend for national health insurance. Clearly, if psychological treatment were not included in Medicare soon, psychologists would not be eligible for participation in that program in the future, and jockeying for position at a time of expansion to national health insurance would be even more problematic.

## HEALTH CARE REFORM

The managed care marketplace continued to deteriorate. We had the worst of all possible worlds: a health care system under which costs of care were escalating dramatically and the number of people not covered by health insurance was also growing rapidly. In his first presidential campaign, President Clinton made health care a major campaign issue, and psychologists knew that with his election would come a major push toward national health insurance. Several questions, of course, then arose. What role would psychoanalysis and psychotherapy play? What could psychologists do to influence the outcome?

One immediate problem that had to be overcome by psychology's leadership was the attitude many of their colleagues had about participation in the political process. Psychologists' traditional passive political postures can be easily fit into personality profiles.

### *Deniers*

Some simply denied that there was any problem. "Health care reform. What's that?" At one Division 39 meeting, a psychologist in the audience raised her hand and said to the speaker, "You seem to be saying that this health care reform issue is something that could affect my practice." The denier!

### *Narcissists*

The narcissist responds to political tension in many ways: "It won't affect me because I'm special," or "Yes, but that's politics and politics is dirty. I'm above that." As Plato said over 2,000 years ago, "The price that wise people pay for not participating in politics is to be governed by the decisions of unwise people."

### *Infantiles*

The third group is the "blatantly infantile." These are the people who look at the health care climate and, in effect, say, "This isn't right," their tone suggesting they have just implemented an action plan.

### *Escapists*

The fourth group—soon to be an extinct species—is the "escapist." "I don't like health care reform. I think I'll fight to get out of it. Then I

can survive and prosper." In short, the position suggests that psychologists can simply step "outside" the reimbursement system and do well by their patients and themselves.

That is true for some. But for most psychologists the simple fact is that, if the federal government is going to pour 80 to 100 billion dollars into mental health care, but nothing for intensive psychotherapy or psychoanalysis, psychoanalysis, psychotherapy, patients, and most psychologists will suffer drastically. One can talk about stepping outside the system all they want. Certainly, there are "Gold Coasts" in this country where a few people will maintain practices with the wealthy and the elite. But for most people on a very practical basis it is not a viable option. In reimbursement circles, it was never hard to "get out" of the system. Everybody would let you out. There was no enemy to be met on that battleground. The real battleground was over two issues: benefits structure and managed care.

As for the legislative struggle itself, it was very clear that psychologists wanted to make certain that they had the right to participate in the system. Thanks to the Medicare battle, inclusion of psychologists was not controversial, nor has psychology's scope of practice been threatened in any proposed new systems. The controversy was *all* in the two areas of benefits and managed care.

The health care battle that ensued was remarkable. The psychologists' case was very simple: we can afford good mental health care if we do not waste mental health resources. The areas in which mental health resources were being wasted were inpatient adolescent care and inpatient alcohol and substance abuse. Watch the hospital door carefully, but recognize that it is very cost effective to let people gain access to intensive outpatient treatment. The psychologists also pointed out that the then-current managed care systems' allocation of up to 20 visits for psychotherapy was not sufficient for people who are multiple trauma victims or who have serious personality disorders or severe chronic depression.

Unfortunately, White House staff included one person who espoused a very antipsychotherapy viewpoint and another with an exclusively biological psychiatric perspective. This skew produced a bill with unlimited inpatient care, an unlimited drug benefit at 80% reimbursement, and 30 outpatient visits reimbursed at 50% coverage.

Of course, a major struggle ensued. Thanks to long-time psychologist advocates Senator Inouye (D-HI) and Congressman Ted Strickland (D-OH), psychologists received audiences with Hillary Clinton and with various staff for the Administration's health care reform initiative. Thus, before a more objective tribunal, psychologists were able to present their case for a better outpatient benefit.

One might think that all mental health professionals would be de-

lighted if a better outpatient benefit was obtained. This was not the case. Overlooking the fact that it was private-sector hospitalizations that had deflected money from the states and dominated and misled by the private psychiatric hospitals and later by the duplicitous managed care companies, a vociferous minority of the community argued that outpatient care would block access to treatment for the seriously mentally ill.

As a result of the split in the mental health community, psychologists obtained more limited improvement in the outpatient benefits with the Clinton administration than they would have otherwise. Therefore, they went to the Hill with two objectives: one was to remove from the bill the limits on outpatient care, and the other was to explain the managed care problem to Congress.

By this time psychologists had been through a number of battles. Medicare and other advocacy struggles had seasoned them in the political arena. The psychologists had formed ongoing relationships with key people who would be influential in the health care debate and who psychologists felt would be sympathetic to mental health. The psychologists hired full-time field organizers to go to the states and help organize for political activity. In one week alone, the psychologists sent out 350,000 pieces of mail, including letters to all the members of the American Psychological Association asking them to write and phone their elected officials. The psychologists also sent 35,000 telegrams on critical issues. The psychologists brought in conservative actuaries who said that the benefit model psychologists developed would work and made actuarial sense for health care systems.

Although the overall health reform legislative train stalled, the outcome for psychotherapy was dazzling. Every major bill reported out of committee had an unlimited outpatient psychotherapy benefit. There was no question that psychologists and psychotherapy had made tremendous headway on Capitol Hill. Maybe even more important, there was also a demonstrative attitudinal change in Congress about mental health care. Where once one heard about "the worried well" and the "Woody Allen Syndrome," elected officials now realized that Woody Allen was a far cry from the typical psychotherapy patient.

That was the good news. The second issue, though, managed care reform, was not successful. One can have any size "benefit" one wants, but, if the managed care company will not "authorize" it, patients do not get it.

While psychologists were extremely aggressive with regard to the managed care provisions, there was no question that provisions supporting managed care dominated the legislative proposal brought forth by the Administration. The provisions that the psychologists advocated did not receive serious consideration in the managed care reform effort.

For a period of time, psychologists had succeeded in having a "point

of service" option included in the legislation. (A point of service option stipulates that patients who are willing to pay a little higher co-pay are allowed to go outside the system and select providers they want.) Psychologists felt that point-of-service was a good quality check on managed care; if someone was willing to pay more to go outside the system, the implication was that the managed care system may not have been providing quality care. Owing to managed care lobbying, however, that provision was taken out of the Gephardt Bill late in the Congressional session.

A sadly naive mental health lobby fell for the seductive allure of managed health care's argument that, if we just manage care, we can ultimately have "total parity" with insurance coverage for other illnesses. As a result, there was no concerted mental health opposition to managed care other than the combined efforts of the American Psychoanalytic Association, the Private Practice Psychiatrists Association, and the American Psychological Association.

Well, none of the health care bills passed. Was it something more than the interesting history of a failed legislative process? Yes, it was. The change in attitude toward mental health is permanent. The current erosion of health care continues, as does the proliferation of managed care. Gradually, the government will play an increasing role in health care—it will shape the mental health reimbursement of the future.

## IT'S PARITY THAT NO ONE UNDERSTANDS

This same naiveté was evident in the euphoria over the mental health "parity" legislation passed in 1996. While the mental health lobby sold it to its members as an "important first step" toward ending discrimination against mental health care, legislative committee language expressly conditioned the legislation on the company's right to comprehensively "manage" the mental health benefit. For psychologists and non-M.D. mental health professionals, it also reopened the whole issue of who provides what service by permitting the Health Care Finance Administration and state governments to define "mental illness" and "treatments."

## MANAGED CARE REFORM

The problem confronting the managed care industry is REALITY. As Abraham Lincoln said, "You can fool all the people some of the time and some of the people all of the time. But you can't fool all the people all the time." Reality intrudes and the devastation that managed care has wreaked is now permeating the public consciousness.

And it is with exposure of the deception that the seeds for the destruction of managed care have been sown. Every major media source now appreciates the enormous scandal in our health care system; the stories they encounter pull at the heartstrings of their viewing public.

The simple fact is that the American public has never signed off on inferior health care systems. The American people care about two things: 1) schools for their children and 2) health care. In the early days of managed care, it was easy to promise them more for less. People are gullible and quite willing to believe in such utopian fantasies.

Chickens come home to roost. The growing public relations debacle confronting the managed care industry will not go away. It is inherent to the system, and, as the system grows, more and more abuse will be exposed.

As powerful as the public relations developments are, probably even more significant are changes in the legal system. A Supreme Court Justice once said, "Justice is like a train that is nearly always late." So it is with managed care. From 1985 to 1995, there was very little the courts were able to do about managed care. They were slow to recognize that managed care companies, despite their disavowals, were really practicing medicine when they made determinations of "medical necessity." Further, when they prospectively denied insurance benefits, they effectively denied treatment.

That legal myopia has changed, and attorneys are now able to file suits on the basis of malpractice, bad faith insurance denial, tortuous interference with doctor–patient relationships, breach of contract, and a variety of other traditionally common law causes of action.

Equally important, an arcane federal statute that had been insulating many of the managed care companies from legal liability slowly began to erode. The Employee Retirement Income Security Act (ERISA) of 1974 preempted all state laws that "relate to" employee benefit plans. The phrase "relate to" had been so broadly interpreted by courts that it was virtually impossible to sue ERISA managed care health plans, no matter how egregious their behavior. Since 1995 there have been a number of significant Supreme Court and Federal Circuit Court of Appeals decisions that clarified that the "relate to" clause should not be interpreted so broadly that it wipes out all the aforementioned state causes of action.

These developments in the legal realm, coupled with the public attention the managed care industry received, created a veritable ground swell of interest in managed care litigation in the legal field. It is this combination of public outcry and growing legal pressure that will make it increasingly difficult for employers and political figures to support the once-believed deception of the managed care industry, to wit, that it is saving money by virtue of prevention and careful management.

The truth is out. Having once betrayed the American public, it will

be very difficult for the managed care industry to regain that trust. Make no mistake about it, they will try. And be assured that their efforts will be characterized by the very same emphasis on deception that spawned the managed care industry. HMOs advertise their "accreditation" by the National Commission on Quality Assurance (NCQA), a transparent, whitewashing organization established by the managed care industry itself to create the illusion of standard setting.

The NCQA standards pertain largely to demands that the managed care company should make on its providers. Thus, the NCQA, while presented as a quality-control device, is really an insidious means of harassing providers and making it more difficult to provide care. The standards do not address such real quality issues as making appropriate numbers of treatment resources available to patients.

The managed care industry is not going to like its growing legal liability. It is for this reason that they and other large corporate interests in America have been sponsoring efforts to "end frivolous lawsuits." What they are not telling the public is that the specific reform efforts, known as "tort reform," do little to prevent frivolous lawsuits, but, instead, make it very difficult for the average person to obtain any justice from large corporate players not matter how egregious, calculating, or diabolical their behavior.

Managed care will not go quietly into the night. It is, however, terminally ill. The reality principle has to hold sway, and we are already seeing it emerge in the evolution of the managed care industry. How quickly the demise occurs depends on the role that concerned professionals play in forcefully advocating for their patients and exposing the sham of managed care.

If there is one lesson psychologists have learned from the past decade, it is that psychoanalysis will be greatly affected by the political and legal processes. Who can practice? What will the reimbursement and delivery system be like? How much intrusion will there be into the doctor–patient relationship? Will the managed care profiteers be held accountable for the people they hurt, or will their health system continue to reward those who exploit people in need of mental health care?

What can one do? There is only one thing they can do: participate in the political process. What's going to happen with psychology's national organization? How prepared are psychologists to fight a battle about what the American Psychological Association does and does not do to protect patients? How easily beguiled will psychologists be by information that is fed to them?

All those questions have to be answered if psychologists are to be effective participants in the political process. But politics now defines mental

health care in this country, and it is going to do so for as long as psychologists are present. Nor will the psychologist's struggle be over even when these current questions have been answered. For their struggle is Sysiphysian in nature—it is never won and is always ongoing. Psychologists can no more avoid and neglect the political realm than they can walk out on their patients in the consulting room. It is the Reality Principle.