

## Psychotherapy: A Paradox

An editorial appeared in the September 27, 2012, issue of *Nature* entitled “Therapy Deficit: Studies to Enhance Psychological Treatments Are Scandalously Under-Supported” (1). Out of character for a leading basic science journal, it argued for the active consideration of psychotherapy for treatment and research, and it emphasized the funding disparities between psychotherapy and medication.

The editorial did not describe the psychotherapy paradox. While psychotherapy is fading from consciousness and practice in some developed countries, it is being enthusiastically embraced in developing countries hurt by HIV, natural disasters, wars, or political strife. For example, World Vision, one of the largest international philanthropies, funded two clinical trials of interpersonal psychotherapy for the treatment of depression in Uganda, a country devastated by HIV and civil war. The treatment’s positive results in reducing depression and sustaining the effects were widely disseminated (2–4). Another clinical trial was completed in Goa, India, using the initial phase of interpersonal psychotherapy to treat depression in primary care (5), and the results were the subject of a recent editorial that questioned whether psychiatrists were needed (6). Verdeli and I (7) responded strongly that psychiatrists were critical for overall quality control, patient evaluation, diagnosis, and program supervision. In fact, most of these global programs are led by psychiatrists.

Canada has awarded two \$1 million grants to a psychiatrist. The first grant is to train health workers in Ethiopia in administering interpersonal psychotherapy. The treatment is embedded in health care delivered by psychiatrists, family practitioners, and nurses and will reach 15,000 patients (P. Ravitz, personal communication, 2012; <https://www.mshfoundation.ca/page.aspx?pid=1822>). The second grant is to scale up a treatment for depression that includes brief psychotherapy used in a stepped-care model within the primary care network of Partners in Health in Haiti. In Brazil, physicians, nurses, and other health and mental health professionals are being trained in psychotherapy for women and children who have been sexually abused (M. Mello, personal communication, 2012).

A clinical trial of cognitive-behavioral therapy (CBT) by community health workers for depressed pregnant mothers was carried out in rural Pakistan (8). The study found a reduction in mothers’ symptoms at 6 months in the CBT group, and these results were sustained at 1 year. It also found a positive impact on health, including greater use of contraception. Birth spacing has been an important factor in reducing infant morbidity. A randomized controlled clinical trial of CBT for patients with repeated primary care consultations for medically unexplained symptoms in general medical clinics in Sri Lanka found that CBT was feasible and effective in reducing symptoms of distress and number of visits (9).

In 2008, the World Health Organization (WHO) launched the Mental Health Gap Action Program, which addresses the lack of care in resource-poor countries for people suffering from mental disorders (10). WHO noted that improvement in mental health care did not require expensive technologies, and the organization issued guidelines for managing care in nonspecialized health settings. Psychotherapy was strongly featured, and 11 psychotherapies were included in the WHO

guidelines. (See De Silva et al. [11] for a review of psychotherapy trials in low- and middle-income countries.)

Paradoxically, psychotherapy is becoming less accessible in the United States. The Sequenced Treatment Alternatives to Relieve Depression (STAR\*D) trial, the large multicenter study designed to define treatment strategies for patients with treatment-resistant depression, found that only one-third of the depressed patients treated with a widely used antidepressant were in remission by 3 months, and only 50%–60% achieved remission after 1 year of varying treatments (12, 13). CBT as a second-step treatment was as effective as medication, and introduced fewer side effects, but it took slightly longer for patients to achieve remission (14). Medication expenses were completely covered by the study, but psychotherapy was not. Therefore, fewer patients could afford to choose psychotherapy.

A survey of outpatient psychotherapy trends in the United States based on the Medical Expenditure Panel Survey revealed a decline in the annual percentage of individuals receiving outpatient psychotherapy for depression either alone (25% decline) or with medication (17% decline) between 1998 and 2007 and a concurrent decline in the mean number of psychotherapy visits per patient (from 9.7 to 7.9 visits). There was also a 35% decrease in total annual psychotherapy expenditures at the national level. During the same period, the use of psychotropic medication alone increased by over 23% (15).

It is a further paradox that the research efforts to improve psychotherapy in underdeveloped countries are not mirrored by efforts in the developed world. A program in the

---

*It is a further paradox that the research efforts to improve psychotherapy in underdeveloped countries are not mirrored by efforts in the developed world.*

---

United Kingdom to improve access to psychotherapy, which has increased the number of CBT therapists by several thousand, has provided more than 600,000 people with access to services. Since its inception, however, the U.K. government has prevented funds from this program from being used for research (1).

Not surprisingly, the rate of full psychotherapy training in accredited graduate programs in the United States for psychiatrists, psychologists, and social workers—the main providers of psychotherapy—is low (16). A 2006 survey of training program directors in the United States revealed that most psychiatry residency programs offered didactics in the psychotherapies. However, a little more than 50% of the programs required both didactics and clinical supervision. This combination is the gold standard for psychotherapy training. For the other mental health disciplines, the percentages were far lower. Only about 25% of Ph.D. psychology programs and social work programs required didactics and clinical supervision in one or more psychotherapies.

In addition to the traditional efficacy trials, which could move some widely used but untested psychotherapies into the evidence base, there are several areas of potential research for the United States. The Affordable Care Act is designed to concentrate care in a “patient-centered medical home” providing comprehensive medical care. Partnerships among patients, physicians, and patients’ families, with a team of individuals at the practice level collectively taking responsibility for ongoing care, will increase awareness of psychiatric problems. What type of psychotherapy, who should administer it for patients under stress,

and what its efficacy and effectiveness are in this delivery system, are researchable questions.

When evaluating a new patient, clinicians cannot easily predict which evidence-based treatment will work. Efforts are under way to improve medication selection and remission rates with personalized treatment based on biomarkers of genetic, brain imaging, or clinical profiles. This research should also include the personalizing of psychotherapy to determine specific differential patient responses (17).

The hypothesis that psychotherapy may have a direct effect on gene expression through learning, by altering the strength of the synaptic connections between neurons or producing changes in neurons, disputes the dichotomized view of psychotherapy as psychologically based and medication as biologically based (18). Functional neuroimaging and positron emission tomography have made it possible to study changes in the brain related to experience. Studies of changes in the brain during psychotherapy may aid in understanding these effects (19).

The reduction of psychotherapy practice, training, and research in the United States is often explained by economic forces. But if underdeveloped countries find it economical, why can't we figure out how to make it cost-effective and researchable for ourselves?

## References

1. Therapy deficit: studies to enhance psychological treatments are scandalously under-supported (editorial). *Nature* 2012; 489:473–474
2. Bolton P, Bass J, Neugebauer R, Verdelli H, Clougherty KF, Wickramaratne P, Speelman L, Ndogoni L, Weissman M: Group interpersonal psychotherapy for depression in rural Uganda: a randomized controlled trial. *JAMA* 2003; 289:3117–3124
3. Bass J, Neugebauer R, Clougherty KF, Verdelli H, Wickramaratne P, Ndogoni L, Speelman L, Weissman M, Bolton P: Group interpersonal psychotherapy for depression in rural Uganda: 6-month outcomes: randomized controlled trial. *Br J Psychiatry* 2006; 188:567–573
4. Bolton P, Bass J, Betancourt T, Speelman L, Onyango G, Clougherty KF, Neugebauer R, Murray L, Verdelli H: Interventions for depression symptoms among adolescent survivors of war and displacement in northern Uganda: a randomized controlled trial. *JAMA* 2007; 298:519–527
5. Patel V, Weiss HA, Chowdhary N, Naik S, Pednekar S, Chatterjee S, De Silva MJ, Bhat B, Araya R, King M, Simon G, Verdelli H, Kirkwood BR: Effectiveness of an intervention led by lay health counselors for depressive and anxiety disorders in primary care in Goa, India (MANAS): a cluster randomized controlled trial. *Lancet* 2010; 376:2086–2095
6. Miller G: Mental health care: who needs psychiatrists? *Science* 2012; 335:1294–1298
7. Weissman MM, Verdelli H: Outsourced psychiatry: experts still relevant. *Science* 2012; 336:152
8. Rahman A, Malik A, Sikander S, Roberts C, Creed F: Cognitive behavior therapy-based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a cluster-randomized controlled trial. *Lancet* 2008; 372:902–909
9. Sumathipala A, Hewege S, Hanwella R, Mann AH: Randomized controlled trial of cognitive behavior therapy for repeated consultations for medically unexplained complaints: a feasibility study in Sri Lanka. *Psychol Med* 2000; 30:747–757
10. World Health Organization: mhGAP Intervention Guide for Mental, Neurological, and Substance Use Disorders in Non-Specialized Health Settings. [http://www.who.int/mental\\_health/mhgap](http://www.who.int/mental_health/mhgap)
11. De Silva MJ, Cooper S, Li HL, Lund C, Patel V: Effect of psychosocial interventions on social functioning in depression and schizophrenia: meta-analysis. *Br J Psychiatry* 2013; 202:253–260
12. Rush AJ, Trivedi MH, Wisniewski SR, Nierenberg AA, Stewart JW, Warden D, Niederehe G, Thase ME, Lavori PW, Lebowitz BD, McGrath PJ, Rosenbaum JF, Sackeim HA, Kupfer DJ, Luther J, Fava M: Acute and longer-term outcomes in depressed outpatients requiring one or several treatment steps: a STAR\*D report. *Am J Psychiatry* 2006; 163:1905–1917
13. Rush AJ: STAR\*D: what have we learned? *Am J Psychiatry* 2007; 164:201–204
14. Thase ME, Friedman ES, Biggs MM, Wisniewski SR, Trivedi MH, Luther JF, Fava M, Nierenberg AA, McGrath PJ, Warden D, Niederehe G, Hollon SD, Rush AJ: Cognitive therapy versus medication in augmentation and switch strategies as second-step treatments: a STAR\*D report. *Am J Psychiatry* 2007; 164:739–752
15. Olfson M, Marcus SC: National trends in outpatient psychotherapy. *Am J Psychiatry* 2010; 167:1456–1463
16. Weissman MM, Verdelli H, Gameroff MJ, Bledsoe SE, Betts K, Mufson L, Fitterling H, Wickramaratne P: National survey of psychotherapy training in psychiatry, psychology, and social work. *Arch Gen Psychiatry* 2006; 63:925–934

17. McGrath CL, Kelley ME, Holtzheimer PE, Dunlop BW, Craighead WE, Franco AR, Craddock RC, Mayberg HS: Toward a neuroimaging treatment selection biomarker for major depressive disorder. *JAMA Psychiatry* (in press)
18. Kandel ER: A new intellectual framework for psychiatry. *Am J Psychiatry* 1998; 155:457–469
19. Karlsson H: How psychotherapy changes the brain: understanding the mechanisms. *Psychiatric Times*, Aug 11, 2011; 28

**MYRNA M. WEISSMAN, Ph.D.**

*From the Department of Epidemiology in Psychiatry, College of Physicians and Surgeons, Columbia University Mailman School of Public Health, and the Division of Epidemiology, New York State Psychiatric Institute, New York. Address correspondence to Dr. Weissman (mmw3@columbia.edu). Commentary accepted for publication March 2013 (doi: 10.1176/appi.ajp.2013.12111415).*

*Dr. Weissman has received funding from the Interstitial Cystitis Association, the Brain and Behavior Foundation (NARSAD), the National Institute on Drug Abuse, NIMH, the Sackler Foundation, and the Templeton Foundation and has received royalties from American Psychiatric Publishing, MultiHealth Systems, Oxford University Press, and Perseus Books. Dr. Freedman has reviewed this commentary and found no evidence of influence from these relationships.*

*The author thanks Robert Michels, M.D., and Robert Freedman, M.D., for their helpful comments and editing on the final drafts.*

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.