



The Cost-Effectiveness of Intensive Psychotherapy

Longer term and intensive psychotherapies are cost-effective....

- Long-term treatment is associated with reductions in hospital days, medical consultations, medication users, and in days of sick leave.
- These savings are still apparent years later; the “break-even point for benefits and treatment costs was approximately three years after treatment termination.”³
- Patients in poorer neighborhoods ... incur increased overall expenses in emergency care and hospitalization, by more than is saved in outpatient costs.¹¹
- “Health insurance records show evidence of a lasting and remarkably stable reduction in work absenteeism and a low level of inpatient treatments.”³⁷
- Countries with centralized government-controlled single payer medical programs which have experimented with limitations to outpatient psychotherapy find a resulting increase in their overall medical, emergency and hospitalization budgets.^{11,39,40}

...because they are effective.

There is a significant body of research confirming the equivalent efficacy of psychodynamic psychotherapy to cognitive behavioral approaches and its superior usefulness for chronic patients with interpersonal difficulties.²⁷⁻³²

And likely *more* effective than cognitive-behavioral approaches, especially over the long term, as CBT treatments are ineffective for many.

- Brief manualized CBT trials are generally conducted with subjects with the sole diagnosis under investigation and are not typical of most psychiatric patients who have more complex conditions and frequent comorbidity.
- Reviews of manualized brief treatments for depressive and anxiety disorders have found only short-lived benefits:
 - More than half in patient cohorts seeking treatment again within 6 to 12 months,¹
 - Most required more therapy to achieve remission²
 - A full 75% did not get well.²

- “Brief, “‘evidence-based’ therapies are ineffective for most people most of the time.”³
- Study design flaws and publication bias also undermine claims of “findings of efficacy.”^{4,5} Such studies undermine the relevance of such therapies to most patients’ clinical needs or appropriateness in shaping policy or insurance coverage protocols.

Individuals with behavioral health diagnoses have disproportionately high healthcare costs.

- They account for the majority of healthcare spending dollars.
- Average annual costs for their medical/surgical treatments are 2.8 - 6.2 times higher than costs for those without behavioral health diagnoses.

But these expenditures are NOT for mental health care!

- Half of those in the high-cost behavioral subgroup spent less than \$95/year on mental health services.
- Half of those with any behavioral health diagnosis spent less than \$66/year on mental health services.

People use extended psychotherapy because they need it. They are not in treatment to take unnecessary advantage of any overly generous insurance benefit.

- Long term psychotherapy is not an elective treatment. Even decades ago, when long-term therapy was more available and supported, the patients who used it were more distressed, in poorer general health, had higher general medical costs and more functional impairment, and were more likely to use psychotropic medication and to have a psychiatric hospitalization than short-term therapy patients.^{6,7}
- Currently, mental health spending constitutes only 4.4% of total health care spending.
- The Rand Health Experiment found that even when psychotherapy is free, 4% of an insured population access it and the average length of care is 11 sessions.⁸
- *A higher cost burden for outpatient psychiatric care turns away very ill patients who most need treatment, but then must forego it.^{9,10}

Who requires extended psychotherapy?

- Those with chronic severe anxiety and depression, personality disorders, and multiple chronic psychiatric disorders, who are extremely costly to society in unemployment, high rates of drug problems, interpersonal problems, suicide attempts, child abuse, criminal behavior and heavy use of health care.

- All of these chronic patients require more than brief treatment and can improve with extended psychotherapy in which longer duration and increased frequency have independent positive effects on outcome.¹⁹⁻²³
- A lack of appropriate support for psychotherapy leads to insufficient treatment and is a hidden multiplier of morbidity, disability, and overall health care expenses compared to those without psychiatric illness.²⁴⁻²⁶

The short budgetary horizons of insurance companies likely discourage them from viewing psychotherapy as a crucial aspect of cost-effective preventive care.

- Wage and salaried workers change jobs increasingly frequently so that the duration of an average subscriber's time with a particular employment-based private insurance company has been declining (from 4.6 years in 2014 to 4.2 years in 2016³⁸).
- Insurance companies focused on their own immediate cost savings have little interest in the eventual cost-offset provided by comprehensive treatment. Nor are they concerned about future increased medical costs that will fall on other parties, or the ongoing illness and disability resulting from inadequate treatment for the large cohort of patients who need more.

In sum, it is short-sighted in the extreme, and in violation of the contractual and legal obligation to the subscriber for an insurance program, to limit care that results in greatly increased medical costs in addition to the increases in disability, lost lives, and patient suffering that ensue.

Adapted from Susan G. Lazar, MD
Bethesda, MD

References

1. Westen D, Novotny C, Thompson-Brenner H. The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin*. 2004;130(4):631-663.

2. Driessen E, Van H, Don F, Peen J, Kool S, Westra D et al. The efficacy of cognitive-behavioral therapy and psychodynamic therapy in the outpatient treatment of major depression: a randomized clinical trial. *FOCUS*. 2014;12(3):324-335.
3. Shedler J. Where is the evidence for “evidence-based” therapy?. *Psychiatric Clinics of North America*. 2018;41(2):319-329.
4. Wampold B, Budge S, Laska K, Del Re A, Baardseth T, Flückiger C et al. Evidence-based treatments for depression and anxiety versus treatment-as-usual: A meta-analysis of direct comparisons. *Clinical Psychology Review*. 2011;31(8):1304-1312.
5. Cuijpers P, Smit F, Bohlmeijer E, Hollon S, Andersson G. Efficacy of cognitive-behavioural therapy and other psychological treatments for adult depression: meta-analytic study of publication bias. *British Journal of Psychiatry*. 2010;196(3):173-178
6. Olfson M, Pincus H. Outpatient psychotherapy in the United States, I: Volume, costs, and user characteristics. *American Journal of Psychiatry*. 1994;151(9):1281-1288.
7. Olfson M, Pincus H. Outpatient psychotherapy in the United States, II: Patterns of utilization. *American Journal of Psychiatry*. 1994;151(9):1289-1294.
8. Manning W, Wells K, Duan N, Newhouse J, Ware, Jr. J. How cost sharing affects the use of ambulatory mental health services. *JAMA: The Journal of the American Medical Association*. 1986;256(14):1930-1934.
9. Simon G, Grothaus L, Durham M et al. Impact of visit copayments on outpatient mental health utilization by members of a health maintenance organization. *American Journal of Psychiatry*. 1996;153(3):331-338.
10. Landerman L, Burns B, Swartz M et al. The relationship between insurance coverage and psychiatric disorder in predicting use of mental health services. *American Journal of Psychiatry*. 1994;151(12):1785-1790.
11. Ravesteijn B, Schachar E, Beekman A, Janssen R, Jeurissen P. Association of cost sharing with mental health care use, Involuntary Commitment, and Acute Care. *JAMA Psychiatry*. 2017;74(9):932.
12. Reich J, Yates W, Nduaguba M. Prevalence of DSM-III personality disorders in the community. *Social Psychiatry and Psychiatric Epidemiology*. 1989;24(1):12-16.
13. Casey P, Tyrer P. Personality, functioning and symptomatology. *Journal of Psychiatric Research*. 1986;20(4):363-374.
14. Maier W, Lichtermann D, Klingler T, Heun R, Hallmayer J. Prevalences of personality disorders (DSM-III-R) in the community. *Journal of Personality Disorders*. 1992;6(3):187-196.
15. Zimmerman M, Coryell W. Diagnosing personality disorders in the community. *Archives of General Psychiatry*. 1990;47(6):527-531.
16. Lenzenweger M. Epidemiology of personality disorders. *Psychiatric Clinics of North America*. 2008;31(3):395-403.
17. Kessler R, Berglund P, Demler O, Jin R, Merikangas K, Walters E. Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*. 2005;62(6):593.
18. World Health Organization. *The global burden of disease 2004*. Geneva: World Health Organization; 2008.
19. Rudolf G, Manz R, Ori C. Ergebnisse psychoanalytischer therapie. [Outcome of psychoanalytic therapy]. *Z Psychosom Med Psychother*. 1994;40:25-40.
20. Sandell R, Blomberg J, Lazar A, Carlsson J, Broberg J, Schubert J. Varieties of long-term outcome among patients in psychoanalysis and long-term psychotherapy: a review of findings in the Stockholm Outcome of Psychoanalysis and Psychotherapy Project (STOPPP). *The International Journal of Psychoanalysis*. 2000;81(5):921-942.
21. Grande T, Dilg R, Jakobsen T, Keller W, Krawietz B, Langer M et al. Differential effects of two forms of psychoanalytic therapy: Results of the Heidelberg-Berlin Study. *Psychotherapy Research*. 2006;16(4):470-485.

22. Leichsenring F. Effectiveness of long-term psychodynamic psychotherapy. *JAMA*. 2008;300(13):1551.
23. Leichsenring F, Rabung S. Long-term psychodynamic psychotherapy in complex mental disorders: update of a meta-analysis. *British Journal of Psychiatry*. 2011;199(1):15-22.
24. Melek S, Norris D. Chronic conditions and comorbid psychological disorders. Seattle: Milliman; 2008
25. Luber M, Hollenberg J, Williams-Russo P, DiDomenico T, Meyers B, Alexopoulos G et al. Diagnosis, treatment, comorbidity, and resource utilization of depressed patients in a general medical practice. *The International Journal of Psychiatry in Medicine*. 2000;30(1):1-14.
26. Deykin E, Keane T, Kaloupek D, Fincke G, Rothendler J, Siegfried M et al. Posttraumatic stress disorder and the use of health services. *Psychosomatic Medicine*. 2001;63(5):835-841.
27. Levy K, Ehrenthal J, Yeomans F, Caligor E. The efficacy of psychotherapy: focus on psychodynamic psychotherapy as an example. *Psychodynamic Psychiatry*. 2014;42(3):377-421.
28. Steinert C, Munder T, Rabung S, et al. Psychodynamic therapy: as efficacious as other empirically supported treatments? A meta-analysis testing equivalence of outcomes. *Am J Psychiatry* 2017;174(10):943–53.
29. Leichsenring F, Steinert C. Is cognitive behavioral therapy the gold standard for psychotherapy?: the need for plurality in treatment and research. *JAMA* 2017; 318(14):1323–4.
30. Huber D, Zimmermann J, Henrich G, Klug G. Comparison of cognitive-behaviour therapy with psychoanalytic and psychodynamic therapy for depressed patients: a three-year follow-up study. *Zeitschrift für Psychosomatische Medizin und Psychotherapie*. 2012;58(3):299-316.
31. Levy K, Meehan K, Kelly K, Reynoso J, Weber M, Clarkin J et al. Change in attachment patterns and reflective function in a randomized control trial of transference-focused psychotherapy for borderline personality disorder. *Journal of Consulting and Clinical Psychology*. 2006;74(6):1027-1040.
32. Shedler J. The Efficacy of psychodynamic psychotherapy. *American Psychologist*. 2010;65(2):98-109.
33. de Maat S, Philipszoon F, Schoevers R, Dekker J, De Jonghe F. Costs and benefits of long-term psychoanalytic therapy: Changes in health care use and work impairment. *Harvard Review of Psychiatry*. 2007;15(6):289-300.
34. de Maat S, de Jonghe F, Schoevers R, Dekker J. The Effectiveness of Long-Term Psychoanalytic Therapy: A Systematic Review of Empirical Studies. *Harvard Review of Psychiatry*. 2009;17(1):1-23.
35. Berghout C, Zevalkink J, Hakkaart-van Roijen L. A cost-utility analysis of psychoanalysis versus psychoanalytic psychotherapy. *International Journal of Technology Assessment in Health Care*. 2010;26(1):3-10.
36. Berghout C, Zevalkink J, Hakkaart-Van Roijen L. The effects of long-term psychoanalytic treatment on healthcare utilization and work impairment and their associated costs. *Journal of Psychiatric Practice*. 2010;16(4):209-216.
37. Beutel M, Rasting M, Stuhr U et al. Assessing the impact of psychoanalyses and long-term psychoanalytic therapies on health care utilization and costs. *Psychotherapy Research*. 2004;14(2):146-160.
38. Bureau of Labor Statistics, US Department of Labor, Economic news release: employee tenure in 2016. Washington, DC: Bureau of Labor Statistics; September 2016. Available at: <https://www.bls.gov/news.release/tenure.nr0.htm>. Accessed March 19, 2018.
39. Duehrssen A. Katamnestiche Ergebnisse bei 1004 Patienten nach analytischer Psychotherapie. *Zeitschrift für psychosomatische Medizin* 1962;8:94–113.

40. Dossmann R, Kutter P, Heinzl R, Wurmser L. The long-term benefits of intensive psychotherapy: A view from Germany. *Psychoanalytic Inquiry*. 1997;17(sup001):74-86.