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Where Has Psychotherapy Gone?

Stephen M. Strakowski, MD; John G. Gunderson, MD; David J. Reinhardt, PhD; Ruth R. Staten, PhD, APRN-CS

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Editor's Note: Medscape recently invited Dr. Stephen Strakowski to moderate a virtual discussion between psychiatrist John Gunderson, MD, psychologist David Reinhardt, PhD, and mental health nurse practitioner Ruth R. Staten, PhD, APRN-CS, on the decreasing use of psychotherapy by psychiatrists and how this development is impacting patient care. What follows is a transcript of their discussion.

Where Has Psychotherapy Gone? Introduction

Stephen M. Strakowski, MD: As you all are aware, studies suggest that psychotherapy is becoming an increasingly rare part of many if not most psychiatric practices.[1] What factors do you think are responsible for this decline, and is this change in practice important? How does it affect psychiatry's role and reputation in the United States?

Ruth R. Staten, PhD, ARNP-CS: It seems to me there are at least 3 factors that contribute to the changes in psychiatry: (1) demand/need for services, (2) complexity, and (3) economic/financial.

With an increased number of persons with psychiatric/behavioral disorders and a decline in the number of providers, the time that patients have to wait to see a psychiatrist can be unreasonably long -- sometimes up to 3 months. There are some areas of rural America that have few if no providers, but we all feel like clients should have timely access to care. This critical shortage is particularly true for medication management. Psychiatrists have had the struggle of having clients or other healthcare providers begging for persons in need to be seen more quickly. Additionally, once the client is in the care of the provider/psychiatrist, appointments may be needed on a fairly frequent basis, until the client is at least out of a crisis and moving toward stability.

Though caring for persons with psychiatric illness has been complex, with the multitude of medication treatment options and the degree of chronic illnesses and medications that often accompany those illnesses, providing medical management can be quite demanding. Evaluating their medical conditions, assessing medication interactions, and monitoring psychiatric, physical, and laboratory findings are quite time consuming. The majority of an hour session can be taken up with evaluation of these issues. This leaves little time for traditional psychotherapy. Additionally, we have some very specific psychotherapies that require a fair degree of time and are often "manualized" to be true to the therapy. One has to wonder if the more one has time to deliver these therapies, the better they would become, so those who focus solely on these therapies might be the best able to deliver them.

The economic/financial considerations are a constant battle -- changing regulations and reimbursements, the cost of just doing business and seeking reimbursements, the emphasis of reimbursement on procedures rather than specific outcomes -- and have fueled the need to maximize one's income just to cover expenses. There was an interesting article in the *New York Times* recently recounting a long-time psychiatrist's journey into 15-minute medication checks and all the thoughts and considerations that took him to that point.[2]

Having said all of this, I cannot imagine, and I do not hear from my colleagues, that given a perfect world, they would choose this situation of managing medicines and doing very little psychotherapy. It just doesn't seem very rewarding in the sense that we were drawn to this work because it connected us to people in ways that other areas of healthcare may not.

John G. Gunderson, MD: Ruth nicely identified 3 reasons for the change in psychiatric practice. I would add a fourth: resident training.

Training of residents occurs within institutions governed by managed care thereby relegating most interventions to changing or initiating medications. This then is what gets taught, this becomes the role modeling, and this is how institutional jobs are defined. Confounding this has been the fact that biological/psychopharmacological research has been the major avenue for gaining academic credentials and advancement, so that academic departments rarely have places for those who are primarily psychotherapists -- certainly not in positions of power. Once again, modeling and incentivizing residents towards psychopharmacological practices.

Having said this, I do not believe that most modern residents are different than those I did my training with 40 years ago. Most still choose psychiatry because it promises more personal and closer relationships with patients and a better understanding of the human condition than any other field of medicine. While psychiatry today does far more good and far less harm than when I started, it has done itself a disservice by not making the necessary effort to retain psychotherapeutic competence as a requirement of training. The ex-Massachusetts General Hospital/McLean resident in the *New York Times* captured this. He hadn't learned during his training that listening to his depressed patient's sad story would enrich his practice and be very helpful to his patient.

David J. Reinhardt, PhD: I did an informal telephone survey for the National Alliance of Professional Psychological Providers researching the length of time involved to secure a new patient first appointment. I was gladdened that insurance coverage was not an important determinant; in those instances when we stated there was no insurance, we were not brushed off but given cost information and an opportunity to book. Time to first appointment ran a minimum of 6 weeks to as much as 3 months.

The knowledge of physical contributors to psychiatric disorders and the specialized knowledge needed to treat have mushroomed in the last 40 years, and so has our understanding of psychological insights and treatments. We are well past the age of the pastor/counselor as effective psychotherapist and have refined the application of a much larger "grab bag" of tools and techniques. As with physical medicine, the volume of knowledge demands increasing specialization if we are to be truly competent.

Insurance companies have limited reimbursement for psychotherapy to brief therapy, 4-8 sessions, which has not been, in my opinion, a bad thing. Still, this intense level of interaction, in addition to medication management and other physical medicine

issues, seems more than can be accomplished in a therapy hour, and it is unlikely clients or insurance companies would agree to reimburse for longer sessions.

Could Some Patients Benefit From Multiple Caregivers?

Dr. Staten: This is a great conversation. It seems we are seeing things in pretty much the same way. I do wonder what current psychiatric residents think about their experiences. We who were trained years ago, with psychotherapy being central to our education and practice, mourn the loss of this approach to treatment. However, it seems that newer generations experience and accept the new reality. I cannot imagine that being a "prescriber" only would be rewarding in anyway, but I am not sure that the same would be true for new practitioners. This brings me to my other strand of thinking.

It seems we have not necessarily documented through research which patients might most benefit from having a provider who can provide medication management and psychotherapy and those who might do well with 2 different providers. I wonder if clients with numerous medical problems and psychiatric problems might best benefit from a provider who can do both -- assuming that there are so many interactions among all conditions and treatments that it would take one person to make all the necessary observations and interventions work together.

Often times these are the subjects who are excluded from the studies of particular interventions -- medication related or psychotherapy -- but may be just the patients who need a practitioner who can do both. We could ask the same of persons who may need very intensive psychotherapy and a little bit of medication. Perhaps they would best benefit from 2 different providers, each practicing from their greatest strength, one as a therapist and one as a medication manager. I'm saying all of this just to make the point that we really don't understand very well which patients need what level/type of care, and at what point they can return to their primary care provider for continued treatment.

The changes that are abreast give us some opportunity to think about things differently. However, I cannot imagine psychiatrists without some degree of psychotherapy preparation and skill. That might be the question -- not should they or shouldn't they, but what training should they receive? In psychiatric nursing, we have just gone through several years of review of advanced practice psychiatric nursing education and concluded that psychotherapy must continue to be an essential component of education and practice. How do we maintain these opportunities in a practice world that wants, needs, and rewards prescribing?

Psychotherapy: Where Are the Data?

Dr. Strakowski: I agree with John about residency training; it requires an institutional commitment to provide this type of instruction. In our own department, we are fortunate to maintain a strong relationship with our local psychoanalytic institute, in which many of the members are volunteer faculty who love to mentor and teach. We also have a good cadre of cognitive behavioral therapy (CBT) practitioners in the department. To capitalize on these opportunities, we created a resident psychotherapy clinic with a sliding scale out-of-pocket payment schedule, which permits us to teach therapy without entangling with insurance companies. I believe this approach provides a reasonable model within the economic factors that drive training; more relevant is that our example suggests that there are solutions that facilitate psychotherapy training. This approach is just one.

To comment on another point, I agree with Ruth that initial psychopharmacology visits can take an hour just to make diagnostic assessments and establish medication regimens. As patients stabilize, medication follow-up alone can be relatively brief (our family practice colleagues often spend less than 10 minutes with their patients). Consequently, in my own practice with a 30-minute medication/psychotherapy visit (code 90805), it is easily possible to provide 20 minutes or of therapy (I typically do CBT). As Ruth suggests, for patients who need more frequent therapy visits or more complicated therapy than I can provide, I then refer the patient to work with one of the therapists in the department, and we use a team approach. Our financial calculations suggest to us that this approach optimizes the quality of treatment with the revenue generated so that we can afford to actually provide care. However, we don't take a number of insurances because reimbursement is so poor.

One of the problems with psychotherapy is that the research base is insufficient, other than perhaps CBT. We don't really know how to define who will most likely benefit and from which therapy approach and what the right 'dose' is (Why weekly? Why 50-minutes session instead of 25-minute sessions?). I frequently challenge my analytic colleagues to start producing some outcomes data. I don't buy the argument that psychotherapy research is "too hard to do," that I hear so often. It is incumbent on the field to start producing some data.

Dr. Staten: Yes, this raises some critical questions about training and how we best prepare practitioners for the current and future realities of the need for mental health services. I have been involved with, reading about, and implementing primary/behavior health integration. It makes me think that for some people, a model for medication management will be to stabilize the patients and return them to their primary care provider, continue to see them for brief psychotherapy and medication management, or send them to a therapist (and primary care or behavioral health manage medications). One concern I have is that we may be holding on to persons who are stable on medications who could be managed by primary care and then not having enough accessible appointments for patients who need to be seen more frequently while they are being stabilized or are so complex, needing additional or more frequent time. I know this conversation may be getting away from the topic a little, but it does seem to have been a major influence in how/why things have changed.

I completely agree that we must generate some data. There are too few mental health provider resources and the dollars are too precious; we must be efficient and effective in how we deliver services to maximize the outcomes.

Are Today's Psychiatrists Qualified?

Dr. Reinhardt: Please bear with me as I vent a bit.

I'm a bit in the dark on a couple of things. A general practitioner (GP) sends a patient to another physician (a surgeon or a psychiatrist) when they lack sufficient training to do the work themselves. The GP did have "basic training" consisting in, I assume, at least a few classes in surgery, and perhaps one formal class in psychiatry. The GP could, with the same reasoning that I'm seeing here, have opened a free clinic to practice a bit and develop expertise in surgery or psychiatry. This would in no way qualify them, in my mind at least, to practice those specialties. Are we all agreed that GPs should not be handing out antipsychotics without adequate training? Yet I'm reading here that the role of psychotherapist is a part time gig. Please allow me to fill you in a bit on psychology.

As a psychologist, I have taken 4 years of classes, 8 semesters of formal education in *just* the brain and mind, including 8 full semester classes in statistics and study design. That is not including on-the-job training, internship or clerkship, although we do have an additional 3 years of that. These are required classes. The field of psychology is not as "unscientific" as one might suppose. Review, for example, the bylines of most of the articles appearing in neurology and psychiatry journals. Competent psychotherapy is not something you pick up from a 9-session class on the brain, nor from practicing at a clinic until you get it right. If a psychiatrist desires to be a competent psychotherapist they should consider investing in more than a couple of weekend classes in the specialty. Yes, many psychiatrists do seek out additional training, although I suspect this is a very small percentage of the whole.

This does take us back to the question of if psychiatrists should do psychotherapy without extensive formal training in this specialty. Hopefully, you have the same strong feelings about GPs being competent psychiatrists without more training.

Dr. Staten: One of the aspects I have enjoyed most about being in psychiatry/mental health/behavioral health for 30+ years is the interdisciplinary approach to care, both inpatient and outpatient. I love working with students to help them understand this unique care/team approach -- that is not always a part of other disciplines. The common threads of our (psychiatrists, psychiatric nurses, psychologists, social worker, and others) preparation make for a wonderful foundation for caring for persons with behavioral health problems. For the most part, we hold the same core values and approaches to care, yet our differences bring such strength to what we offer to patients and each other. After being in a situation for many years where I was one of the few mental health professionals -- always trying to explain what we do, why we do it and why it is important to overall health -- I am in heaven to now be in a behavioral health department where we all value the same things and have a core set of skills that are common (basic psychotherapy skills) and unique talents that provide the best care one could hope for.

Having said all that, most of us do recognize individuals and professional groups for what they do bring to patient/client care. At this point, I do believe that all psychiatric/mental health/behavioral health disciplines should educate and prepare their students to engage in a certain level of psychotherapy. I think about all the underserved areas of our country that would be lucky to have one provider; if the provider could do little but offer medications, I think that would be a huge disservice to those for whom we care for.

I see the change moving toward levels of intervention and psychotherapy. We see brief interventions being applied by nonmental health providers in a variety of settings; a next level is being provided by mental health professionals who have

backgrounds that are suitable to delivering both medication management and psychotherapy, and others who are experts in providing psychotherapy to the very difficult to treat patients (as well as others). I have a perfect example of a client who had as severe obsessive compulsive disorder (among other things) as I have seen in years. His first appointments were made with myself (a seasoned therapist and medication provider) and a therapist (a very seasoned, skilled one), but the client recognized that he needed someone more skilled in psychotherapy, so an appointment was made with a very experienced psychologist. I am hopeful that between some serious psychopharmacology and some very high level intense psychotherapy he will find some relief.

This is a critical conversation for psychiatry and psychiatrists, in terms of the way we all work together. I really just can't imagine a psychiatrist without psychotherapy skills, but that does seem to be a trend. We will lose something in the foundation of our work without that. I don't want to get off track, but I have some concern that this change has also affected -- to the detriment -- the inpatient care that patients receive. There are lots of reasons that inpatient care has changed, but I would like to see it be a more therapeutic environment all together.

A Reimbursement Quandary

Dr. Gunderson: I often get impatient with therapies where there is not visible progress. Mostly, though, ineffective therapies don't endure. There is, in any event, something inherent in the therapeutic exercise that is valuable in the absence of outcome data. Patients deserve to be listened to, and they remain our primary resource for their understanding. If those processes get short-changed because we don't have outcome data, then who gains what? If they get prolonged because a doctor or patient likes it too much, who loses? Third party payors? Certainly. Psychiatry's integrity? I'm not so sure. Healthcare costs? Probably not, if I remember correctly from a *Consumer Report* a few years back.

With respect to psychoanalysis, I think it can enrich one's life but it is not a treatment for the mentally ill. It does not belong in the reimbursement debate.

While the current growth of evidence-based therapies (EBTs) provides a rationale for reimbursement and can assure more uniform benefits, these studies rarely if ever measure a comparator therapy provided by clinicians with any extended experience working with the designated patient type. It was therefore instructive that in a large multisite randomized controlled trial (RCT), the borderline patients treated by a self-selected psychiatrist with 5 or more years experience did as well as those treated with good quality dialectical behavior therapy.[3] My point is that dedicated therapists get better with time and learning the specifics of an EBT expedites the learning, but their effectiveness doesn't mean that such training is necessary.

Do others think that reimbursement for psychotherapy should be limited to instances where the therapist has been certified as competent in an RCT-validated therapy? Very few therapists could meet this standard.

Dr. Staten: Two thoughts to this discussion are one having to do with basic preparation in psychotherapy and the other with utilization of psychiatric services, specifically, the medication/psychotherapy brief visit.

Our discussion leads us to the conclusion that all mental health providers need some level of psychotherapy training in their basic programs, including psychiatrists. There are 2 reasons for this. The first, I mentioned before: to continue the strong foundation of common values, experiences, and understanding across mental health providers. Training and education in psychotherapy not only provides a skill but also instills certain beliefs in the human experience and in the importance and dynamics of the therapeutic relationship beyond basic interpersonal communication. I hope we will hang on to this. When the psychiatrist does not have that background, it changes the dialogue among the disciplines but it doesn't add much to the mix beyond the family practice physician, except additional expertise in the myriad of medication combinations. I would hope that someone seeing a psychiatrist for medication management (even for the billing code 90805) would have a somewhat different experience than a visit to the family practice provider. Hopefully, that does not sound too harsh -- I really don't mean for it to. I work with 7 or 8 psychiatrists from fairly new to very seasoned and they all have roots in psychotherapy, so I am not completely sure how it plays out when that is absent or minimal.

This brings me to the question that John posed regarding the need for certification in specific therapeutic modalities for there to be reimbursement. I am not sure there is a simple answer to this question, and there are variables to be considered. Many of the psychotherapies build on some basic concepts and skills and can be enhanced or broadened to other EBTs through a variety of formats: reading, DVDs, supervision, CME, etc. While others (for example, eye movement desensitization and

reprocessing) require some very specific knowledge, background, and practice to be safe and effective. There would be very few therapists or practitioners who could meet the standard for being certified -- think of the twist and turns some of the therapies have; would one have to be certified in each of these nuanced modalities?

I appreciate John's comments on the research behind our work, the problems with the way we have conducted RCTs , and the limits of these trials to real patients, providers, and situations. The exclusion criteria alone can make application to real, complex patients with complex lives difficult. Of course, I support creating a scientific base for what we do, but taking it to the next step with adequate comparisons and translating into practice settings is critical. Sadly, I have known therapists to avail themselves to many certificate programs while lacking some of the basics, which allow for connection with the patients. There has to be some balance in the approach to this part of the question.

I can't even really weigh in on the psychoanalysis question. One of the things I am becoming acutely aware of -- especially, when we keep persons too long in therapy or under psychiatric care -- is are we creating a self-image that takes on an "illness image" that might not be healthy for the patient? When could some of these clients be stabilized and returned to their primary care providers for continued treatment? These are great questions. I think finding some answers would help us get patients to the right providers and the right treatments and more effectively and efficiently utilize our limited mental health resources.

So Who's Responsible for What?

Dr. Strakowski: In response to Ruth's and Dave's last emails, I'm not sure where the impression arose that psychiatrists don't get psychotherapy training. Psychotherapy supervision and delivery remain a major part of our training program, particularly in the 3rd and 4th years, and I would assume it's similar elsewhere. As noted previously, we have a specific clinic to attract good therapy patients for our residents. In response to Dave's comments, I have chaired a number of clinical psychologist graduate student dissertation committees, and the level of psychotherapy expertise that they exhibit at graduation is not particularly different than our senior residents. As John said, in the end, though, much of the training really occurs after residency/doctoral dissertation and is dependent on how much individuals, regardless of their professional stripe, want to learn about therapy and apply it in their practice.

Dr. Reinhardt: Thank you for your response, Stephen. Yes, certainly I agree that predoctoral psychology students, having not experienced intense on-the-job" training, are unlikely to have substantially more clinical expertise than a post degree, final year resident medical trainee. They will, however, have received 4 solid years of didactic training in mental health, disorders, and therapy approaches.

I have the utmost respect for a quality psychiatrist. Before taking on the role of another specialty, the role of psychiatrist in the treatment milieu may need better definition.

As I and my physician friends see it, the role of the psychiatrist is to be aware and look for medical causes of mood and behavioral issues, using the ever-expanding database of contributors, then refer back for treatment of suspected medical issues, or select and guide use of appropriate psychotropics, and refer to that other specialist, the psychotherapist.

In the recent article published on Medscape Psychiatry, a study was reported strengthening evidence that selective serotonin reuptake inhibitors carry a risk for birth defects. Another article detailed the usefulness of anti-inflammatories in treating depression, and the usefulness of soy in treating menopausal cognitive and mood symptoms. Sleep disturbance, linked to many psychiatric conditions, is shown to be influenced by blood sugar issues. Allergies are linked to depression and suicide completion. Finally, the Neurontin marketing issues, along with the recent reports of antidepressants as a class being essentially worse than useless in most cases spotlight the need for a statistically sophisticated approach to guiding medication selection and management. The reality that a finding of "significance" in a study only gives you an idea of any effect vs chance effect and tells nothing about effect size or usefulness of a particular chemical is often lost on those with only basic (or no) education in statistics. Competent psychiatry requires a great deal of education, continuing education, and experience.

When a depressed patient comes to me for that "other" kind of treatment, I want to feel reassured that medical issues such as hypothyroidism have been ruled out. My GP friends know they themselves lack expertise in these areas. They do not send patients to psychiatrists just to get a psychotropic ordered. This all ties into the concern voiced by Ruth, that patients may be followed too long for medication management.

Thank you for opening up the question regarding the amount of training received. It may be that I am making assumptions about this issue. Several years ago, when I was working with a large psychiatric practice, I was given the task of providing the training to third-year medical students as a clerkship site. For 30 days, these wide-eyed preclinicians would follow me around, observing, asking questions, and trying to become familiar with what mental health treatment was all about. Maybe things have changed, and I am misjudging.

Steve, what is the extent of formal psychiatric training? Harvard Medical School (HMS) lists as required courses 4 weeks of psychiatry "rotation," in addition to a total of 136 hours of classroom training in "Nervous System and Behavior," and 39 classroom hours in "Psychopathology & Introduction to Clinical Psychiatry." Is HMS unusual in this regard?

As I pointed out in my earlier post, each specialty has its unique training and place in the milieu. Little is gained by downplaying the importance of this training just because they are seen as competition.

Dr. Strakowski: Dave, I think there is some misunderstanding about how psychiatrists are trained. Medical school and psychology graduate school really don't align similarly. Psychology graduate school (plus internship) is more like psychiatry residency. Medical school trains students to be physicians, but residency trains them to be specialists, eg, psychiatry. During residency, trainees receive 4 intensive years of didactics and "apprenticeship" in psychopharmacology and psychotherapy. Having trained both psychologists and psychiatrists (I have appointments in both departments here), at the time both groups come out of residency (psychiatrists) and internship (psychologists) they are similarly trained. As Ruth and I observed earlier, it is really the subsequent years post-training (in post-docs, practice, etc) that really refine their skills.

Dr. Staten: It is interesting to notice the twist that our conversation took from the original question that Steve posed to the current dialogue about training. if we can track back through our conversation -- and how quickly we turned to current curricular-training issues -- it seems that the perceptions about psychiatry and psychotherapy are quickly changing. If in practice, "psychotherapy is becoming increasingly rare," then the give and take between reality and what is taught (and valued) begins to take shape. Over time, will the fact that "psychotherapy is becoming an increasingly rare part of psychiatrist practice," influence or diminish what is taught in residencies, etc? Could it be a matter of degree (emphasis--not education)? Yes, psychotherapy should remain a part of psychiatric education and practice, but would it be at the same level as 1960 or 1970 or 1980 (with the changes and discoveries in neurosciences)? Likely not. Then how that plays out in one's practice or career will vary widely regardless of the discipline.

It seems at this point in time, to some degree all disciplines are exposed to practice and training in some type of psychotherapy(ies), but I concur with Steve's response, "much of the training really occurs after residency/doctoral dissertation and is dependent on how much individuals, regardless of their professional stripe, want to learn about therapy and apply it in their practice."

I sense that we are all seasoned practitioners who have seen the ebb and flow of our own careers be influenced by opportunities and interests that have varied over time. Thus our expertise has shifted and developed and has likely given us wonderful variety in what we have been able to do professionally. Whether psychologist, psychiatrist, advanced practice psychiatric nurse, or other mental health practitioner, we hope that the basic preparation and values and beliefs instilled in that process do give us flexibility for the changing demands and needs of those we serve and the opportunities that come our way.

There is more than enough need for all of the mental health providers; figuring out which patients will benefit from what treatments delivered by whom, in an efficient and effective manner is important. Perhaps that is another question for another discussion.

Is There a Solution?

Dr. Strakowski: Ruth, thank you for your comments; they are particularly germane. The critical need is to provide high-quality healthcare throughout the United States, and this need is particularly acute in many places out of the large cities off the coasts. In the end, most patients require programmatic care that involves astute pharmacology, skilled psychotherapy, general healthcare measures, and life skills training. For more severe conditions, these skills inevitably need to be provided by a quality team, but in many parts of the country such a team is unavailable.

I think getting back to the original question, several factors we've discussed have impacted the amount of psychotherapy provided by psychiatrists including change in treatment emphasis, demand for pharmacology, reimbursement and finances of healthcare, and availability. Dave seems to think that psychiatrists should "leave the therapy to the psychologists," but that ignores the fact that there are good therapists among many disciplines -- in the department I head, we have several very good CBT providers that include psychologists, master's in social work therapists, and psychiatrists, all of whom have taken steps to achieve excellence, long after their training was complete (as Ruth noted).

Dr. Reinhardt: I agree that there are many good psychotherapists to be found among many disciplines. Those therapists that have not studied the psychodynamics of less simple disorders, such as Axis II disorders like borderline personality disorder, schizophrenia, and nonsituational depressions, are practicing an intuitive form of therapy. This is often effective but far from scientific, and it can sometimes lead to disastrous consequences.

Didactic training plays an important part of physical medicine. It plays an even larger role in training to become a competent psychotherapist. Unlike physical medicine, where an intern can learn to identify a particular type of wart during grand rounds, psychotherapy is an intensely personal experience for the patient, which does not lend itself to the medical school model of on-the-job instruction. There can be no "wise old physician" looking on and keeping the patient safe in a very private therapy office.

As a psychologist, I am concerned that psychiatrists are "biting off too much." I have worked for many years in acute, subacute, and skilled nursing environments as part of a treatment team. Each of us need the support (and reminders) of other team members to fully understand the patient and do the best job. It is common for a specialist, working independently, to fail to spot often simple drivers of mood and behavioral disorders. Psychiatrists have their unique skills and unique role.

GPs have neither the office face time or the specialized training to consider all of the factors that may contribute to a mental health condition such as simple depression. They rely on a psychiatrist to look for and test such things as thyroid issues, hypothalamic imbalance, cellular magnesium levels, and the contribution of drugs such as beta blockers. Conditions such as dementias and psychosis require a competent psychiatrist to do even more detective work. Psychologists trust that the physical aspects have been carefully considered by other team members, although we are often disappointed in this.

As a psychologist, I too have my unique skills. Most physicians have no trouble acknowledging this, including, for example, neurologists, who include a workup by a neuropsychologist as necessary for diagnosing dementia in the ANA treatment guidelines. Competent psychotherapy depends on competent psychology. "Intuitive talk therapy" by someone inadequately trained is not competent healthcare.

Dr. Staten: It is clear to me that there is support for the training and development of psychiatrists as psychotherapists, and that we all agree that we must do a better job with research and documentation of outcomes related to the most effective and efficient care.

It does appear that without specific effort that the perception of psychiatrists as not doing therapy or being trained in therapy could become reality. I hope that this conversation and others will support a clear and continued commitment to psychiatrists having psychotherapy skills.

I have enjoyed the conversation.

Dr. Strakowski: Thank you, Ruth, Dave, and John for a lively discussion. With psychiatric conditions being 5 of the top 10 most disabling illnesses in the world, there is clearly a need for more clinicians of all stripes.

Editor's Note:
Care to contribute your thoughts on the decreasing use of psychotherapy in psychiatry? Join the discussion in Medscape Connect.

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