

The Psychotherapeutic Professions in the United States of America

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I. Current Situation of the Psychotherapeutic Professions

1. Identity of the psychotherapeutic professions.

The United States is a nation of 50 states and each state has a unique set of laws that regulate the practice of health care professionals. The groups that practice psychotherapy vary considerably in their educational backgrounds and their orientations to diagnosis and treatment of emotional disorders. This diversity of professions in addition to diversity of state regulations makes a discussion of psychotherapy practice in the United States a daunting task. Therefore, the following is a view of the practice of psychotherapy in the United States as seen from a high altitude; it does not draw the borders that define the states nor how psychotherapists study and work in those states.

The distinguishing feature of mental health professionals in the United States is the ability to bill and obtain reimbursement for services from private insurance companies and government agencies. The main professional groups that provide mental health services are psychiatrists, psychologists, nurses, clinical social workers, counselors, alcohol and drug counselors, and family therapists. Other groups, such as pastoral counselors, personal life coaches, and unlicensed individuals who identify themselves as psychotherapists, may provide

mental health services, but they are not permitted to bill private insurance companies or government agencies for reimbursement. A significant exception to this distinction is the physician who is not trained as a psychiatrist but can provide and bill for mental health services.

All of the following groups are trained and licensed to make diagnoses and provide psychotherapy to individuals, families and groups, in addition to other very specific functions. **Psychiatrists** are physicians who specialize in the diagnosis and treatment of behavioral and emotional illnesses. They are qualified to prescribe medications. **Psychologists** are mental health practitioners with a doctoral degree (Ph.D. or Psy.D.) in clinical or counseling psychology who are also trained to administer and interpret psychological tests. **Clinical social workers** hold a master's degree in social work. **Licensed professional counselors** and **mental health counselors** also hold a master's degree. **Certified alcohol and drug abuse counselors** specialize in the treatment of those specific problems. **Nurse practitioners** are registered nurses with specialized training in psychiatric and mental health nursing. **Marital and family therapists** hold a master's or doctor's degree with specialized training in marital and family therapy.

In addition to state licensing boards, the main professional groups have organizations at the state and national levels that advocate for their members. National organizations are responsible for accrediting programs at degree-granting educational institutions in order for their graduates to sit for state board licensing examinations.

Each of these groups is trained in psychotherapy in addition to other professional specialties; for example, the use of psychotropic medication by psychiatrists, psychological testing by psychologists, and the coordination of social services and case management by social worker and counselors. However, the data on the treatment of mental illness indicate that most

patients in the USA receive care from non-specialty physicians and psychiatrists who prescribe medication (Zuvekas & Meyerhoefer, 2006). Available studies indicate that psychiatrists treat over 90% of their patients with medication and 48% with psychotherapy and/or medication (Pincus et al., 1999). Psychologists whose practices in the past were exclusively devoted to psychotherapy have been forced to diversify their practices and are seeing fewer psychotherapy cases. Social workers are increasingly being employed by community agencies to practice psychotherapy in addition to providing social services.

At the present time, more psychologists and social workers are psychotherapy providers than any other group, and psychiatry as a profession has tended to deemphasize psychotherapeutic training and practice in favor of psychopharmacological treatments. Yet there is some indication that the pendulum is beginning to shift back in psychiatry towards greater interest in psychotherapy training by residents as they realize the limitations of pharmacotherapy and the lack of professional job satisfaction provided by writing prescriptions all day. Recent applicants to residency programs have looked for assurance of psychotherapy training, and the better programs are providing it.

2. Relations among the psychotherapeutic professions.

Historically, the greatest tension among psychotherapists was the exclusion of non-psychiatrists from psychoanalytic training programs. Legal action brought by the Division of Psychoanalysis of the American Psychological Association against the American Psychoanalytic Association led to an influx of psychologists and social workers into psychoanalytic training institutes (Wallerstein, 1998). Psychoanalytic treatment is no longer the dominant

psychotherapeutic paradigm and psychiatrists are no longer the dominant professional group that treats mental illness.

This change has led to considerable confusion in the general public about the different mental health professions. Both psychiatrists and psychologists are called “Doctor” and patients constantly ask what the difference is between them. Psychiatrists usually lead treatment teams and, by virtue of their medical training, have the greatest prestige and income. Psychologists are expanding their traditional role by seeking prescription privileges, traditionally the exclusive domain of physicians. Advanced nurse practitioners have already obtained such privileges in many states. Especially in hospital settings, relations among professional groups are generally cordial and respectful (Wolf, 2007).

Mental health professionals practice in agencies, such as hospitals and community mental health centers, and as independent practitioners. Agencies are managed by administrative directors in addition to medical directors, usually psychiatrists, to whom other mental health professionals report regarding the management and treatment of cases. In teaching hospitals, it is not unusual for psychologists and social workers to assume responsibility for training psychiatrists in the practice of psychotherapy. Independent practitioners see patients in private offices, although economic necessity has forced many independent practitioners to form cooperatives to share billing and office expenses. For individuals seeking treatment, reputation as a skilled psychotherapist tends to overshadow titles and prestige.

There is some room for hope in the greater cooperation of the different mental health professions in the training and practice of psychotherapy. A recently published text for training psychotherapy residents in the practice of psychotherapy (Beitman & Yue, 2004) is grounded in

the psychotherapy research frequently done by psychologists. Clinical trials for the treatment of psychiatric disorders more frequently include psychological treatments with medications trials. The Accreditation Council for Graduate Medical Education program requirements for psychiatry residents mandate training in “applying supportive, psychodynamic, and cognitive-behavioral psychotherapies to both brief and long-term individual practice, as well as to assuring exposure to family, couples, group and other individual evidence-based psychotherapies (Accreditation Council for Graduate Medical Education, 2008).”

3. Relations of the professions to health care and/or social services.

Reimbursement for health care services by private insurance and government agencies is differentiated into medical benefits and mental health benefits, which are far more restrictive. For example, while there is no limit to how many times diabetic patients can be seen by their medical providers, a patient treated for depression may only see their psychiatrist for medication and their psychologist for psychotherapy for a total of 20 sessions in a calendar year. Some regulations are absurd: because a patient is not allowed to be seen twice on the same day for the treatment of a mental health diagnosis, they need to schedule appointments on separate days to see their psychiatrist and psychologist.

II. Future Prospects of the Psychotherapeutic Professions

4. Factors instigating change in the psychotherapeutic professions.

Recently enacted state and national laws -- parity legislation -- strive for a more equitable reimbursement of medical and mental health treatments. Nevertheless, these new laws have serious limitations (Buchmueller et al., 2007).

The National Institute of Health's Roadmap for Medical Research (2008) emphasizes translational research to more closely connect research to clinical practice. Professional mental health organizations have published 'best practice' evidence-based treatment guidelines. The impressive body of research on specific psychological interventions has established the credibility of professional psychologists. Yet, many psychologists resist using this research as a basis for making clinical decisions, seeing it a method for insurance companies to constrain their clinical autonomy by imposing restrictive guidelines. Psychologists who are primarily in professional practice typically do not see psychotherapy measures outcome as tools to plan and monitor treatment but rather as devices to identify low scoring practitioners and exclude them from participating in insurance panels.

5. Basic skills to be required for training and practice in the psychotherapeutic professions.

Given the diversity of mental health professions and how they compete for a shrinking mental health dollar, it is not likely that professional organizations will be willing to agree on a common set of principles for the training of new professionals in the practice of psychotherapy. Even among psychologists there is a considerable tension between those who advocate for specific psychological interventions versus those who view the psychotherapy relationship as contributing to positive outcomes (Goodheart et al., 2006). Ultimately, it will be individual professional groups that identify the necessary skill sets for the practice of psychotherapy. Nevertheless, the ascendancy of the evidence-based paradigm in health care may force these diverse and fiercely independent professional groups to conform to a common set of guidelines.

6. Relations of psychotherapeutic research to the psychotherapeutic professions.

The application of research findings to clinical practice is complex. Some fields like oncology and critical care incorporate new findings more quickly than other. Clinical psychology has a long history of conflict between practicing clinicians who advocate for a case-based, “experience near” approach to the assessment and treatment of psychopathology versus academic researchers who advocate for a data-based approach (Meehl, 1954). This tension continues between those who contend that psychotherapy is a science and who support the implementation of evidence-based guidelines versus those who insist that psychotherapy is an art that cannot be based on manuals.

A new factor has reframed this internecine professional struggle. The evidence base of medical research has exploded and created a new paradigm for understanding the assessment and treatment of pathology based on a spectrum of evidence with the randomized clinical trial as the ‘gold standard’. The body of evidence is distilled by professional groups to create ‘best practices’. In order for psychotherapy to establish and maintain its credibility as a legitimate approach to the treatment of mental illness, it has had to create a body of similar evidence. Rather than reflecting descriptive summaries of ongoing research, these have been proposed as guidelines to clinical treatment and adopted as standards for reimbursement. Research is no longer solely a means to knowledge but is utilized for political and economic ends.

Psychotherapy like medicine identifies itself as an art and a science, but perhaps they are neither. While medicine and psychotherapy both possess a scientific basis and both can be practiced with grace and elegance, a more appropriate perspective is that they are clinical practices. They are more like crafts that are performed with skill. A skilled practitioner does not

rely solely on techniques and generalized rules but understands the context driven nature of clinical work and how to apply guidelines to individual cases. In other words, adherence to guidelines may be a necessary but not a sufficient condition for clinical competence.

What does this bode for the future of the practice of psychology in the United States? Almost 50 million individuals, over 15% of the population of the United States, have no health care insurance coverage. Economic considerations have and will continue to be the overriding factor in the practice of psychotherapy. Mental health professionals continue to look at the future of their professions with apprehension.

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