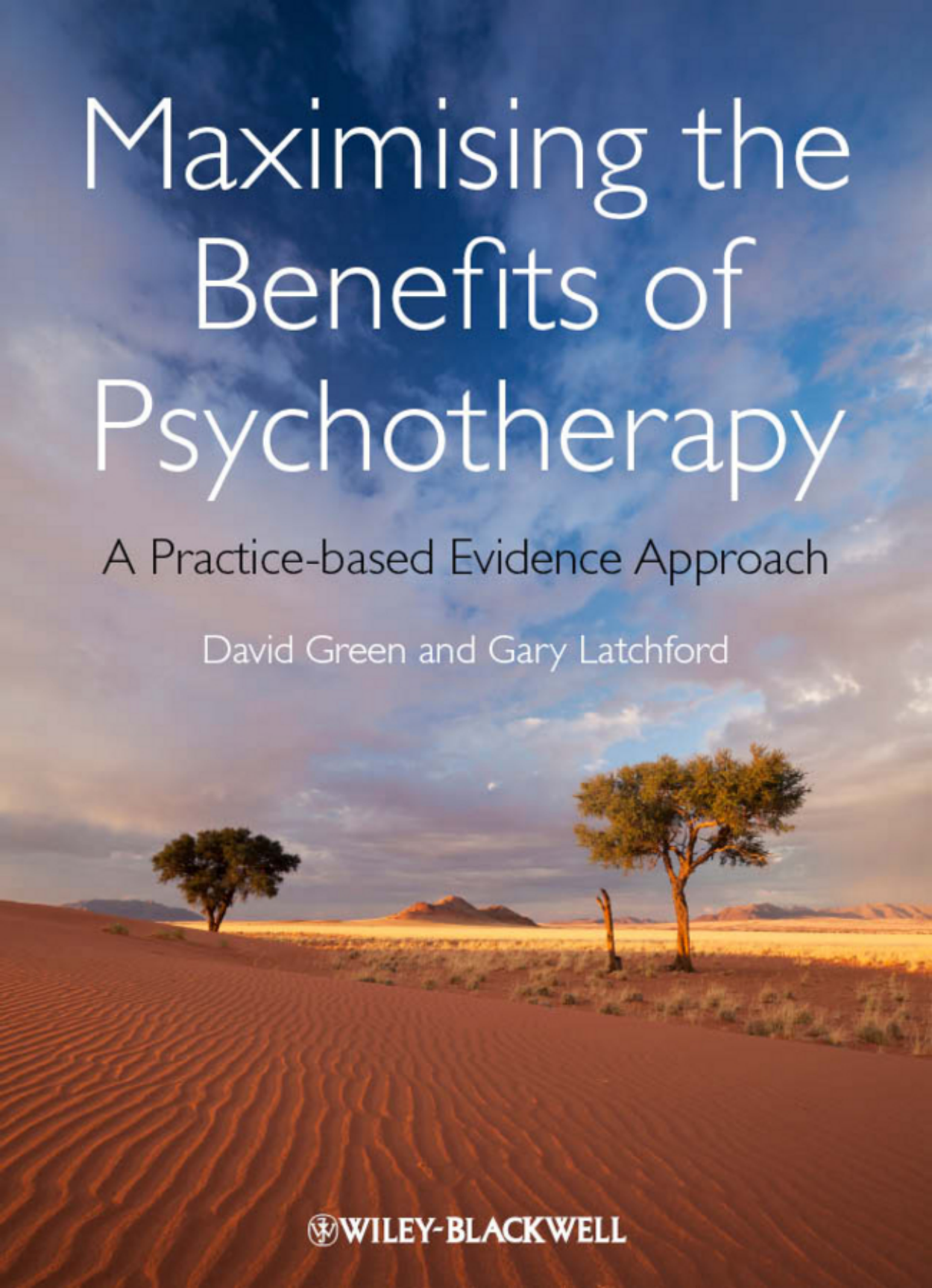


Maximising the Benefits of Psychotherapy

A Practice-based Evidence Approach

David Green and Gary Latchford



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D.G. and G.L.

The Equivalence of Psychotherapies

'Why,' said the Dodo, 'the best way to explain it is to do it.' (Lewis Carroll [1896] *Alice's Adventures in Wonderland*)

Introduction

In October 2009, *Newsweek* magazine in the United States published an article by Sharon Begley called 'ignoring the evidence'. In it, psychotherapy researchers are quoted berating psychotherapists for taking no notice of science and instead treating patients with whatever intervention they are familiar. There is a 'widening gulf between researcher and clinician'. One researcher, Timothy Baker, argues that clinicians 'give more weight to their personal experiences than to science'. The tone of the article is that this is clearly a bad thing. The implication is that science has progressed since the early days of therapy, and that we now know more about what therapies work and why. Clinicians should, therefore, keep up to date in their knowledge and change their practice accordingly.

If this is all true, it is pretty damning. The truth, though, is a bit more complicated.

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Psychotherapists naturally want to be good at their job, and their clients equally naturally want to see someone who has the best chance of helping them. What is the most important factor in success? It's a reasonable assumption that this is the particular form of psychotherapy or counselling being provided. If so, can science tell us which therapies have been shown to be best? Is the *Newsweek* article right? Should therapists be directed to follow the science and train in whatever therapy has the best evidence? Are newer therapies more effective than older ones?

It's very tempting to assume that anything newer must be better. The belief in progress is perhaps strongest in medicine. Although this can sometimes lead to unrealistically optimistic expectations of the power of modern medicine to cure, there have undoubtedly been some striking and high-profile successes such as transplant surgery. In medicine a great deal of effort has gone into finding ways to evaluate and improve treatments, and then to disseminate scientific findings to clinicians in the form of guidelines.

Psychotherapy and counselling are now well established as effective frontline treatments for mental health problems. In many countries they are seen as being a part of the framework of mental health services and often offered as an alternative to drug treatments. We usually think of psychotherapy, then, as being a kind of medical intervention often (but not always) delivered alongside other forms of treatment in health settings. It's not surprising, then, that questions about effectiveness and cost benefits asked of medical treatments should also be asked of psychotherapy. It is also understandable that the same methods used to evaluate medical treatments should be used to evaluate psychotherapies. Such an approach leads directly to the views expressed in the *Newsweek* article. Therapists who do not change their practice in line with science, this argument goes, are like medical doctors prescribing out-of-date medication. At best they are less effective than they should be, at worst they are dangerous.

So what is a therapist to do? It all hinges, of course, on what the evidence actually says, and whether the evidence is reliable. The next chapter will look at whether the research methods we use to evaluate

therapy are fit for purpose, and will explore some of the controversies in the area. This chapter will go straight to the heart of the matter: what is the evidence that some therapies are better than others?

Guidelines and Evidence-Based Practice

If I have diabetes and of the two drugs available one has been shown in scientific research to be better for the condition and with fewer side effects, that's the one I'd want my doctor to be aware of and to prescribe for me. How can we make sure that doctors are kept informed about best practice, and don't rely solely on their own experience (which might be out of date)? This issue has been the focus of the evidence-based practice movement. It has had two aims: to improve the quality of research and to develop methods of combining findings so that dissemination is more efficient. Perhaps the group most associated with this movement is the Cochrane Collaboration, founded in 1993. This is a not-for-profit international group of specialists who conduct systematic reviews – 'critical summaries' – of different areas of healthcare to establish current evidence for treatment and prevention. It is named after Scottish epidemiologist Archie Cochrane who is recognised as giving the initial impetus for the movement in his book *Effectiveness and Efficiency* in 1972.

The most notable impact of the evidence-based practice movement for clinicians has been the emergence of guidelines that review the current research evidence and direct them on which treatments to use. This is massively influential in medicine, providing an up-to-date overview of research that was previously beyond the scope of any individual doctor.

The success of the approach has inevitably led to it being applied to other areas of practice, including psychotherapy. In the United Kingdom, this has most prominently been in the form of guidelines from the National Institute for Health and Clinical Excellence (NICE) on the treatment of various mental illnesses. The depression guideline revised in 2009, for example, recommends cognitive behavioural

therapy (CBT), interpersonal therapy (IPT), behavioural activation and couples therapy. No other therapies are supported, though the guidelines admit that counselling and short-term psychodynamic psychotherapy are ‘limited options’ for those people who refuse one of the recommended treatments, and go on to make it clear that the therapist needs to discuss the lack of evidence for these approaches with the patient before starting therapy. Whether therapists really tell their clients they are about to offer a treatment that NICE thinks won’t work is not known.

Meanwhile in the United States, in 1994, Division 12 (Clinical Psychology) of the American Psychological Association published a list of empirically supported Treatments (ESTs) – psychotherapies for which there was thought to be supporting evidence (Chambless *et al.*, 1998). Significantly, they used the same criteria for evaluating psychotherapies as the US Food and Drug Administration (FDA) uses for drug trials – for example, at least two trials showing that the therapy is better than no treatment or produces equivalent results to any established treatment. There are now around 300 officially sanctioned ESTs, and the Division lists which therapies are recommended for particular conditions such as depression.

The key question, of course, is whether the evidence informing these guidelines – and the *Newsweek* article – is convincing. Is there clear evidence for the superiority of any one psychotherapy over another? Curiously, although this has been the focus of a growing debate since the 1970s, the question was first asked of psychotherapy in 1936, and the answer given then remains as relevant today as it was when it was written.

Saul Rosenzweig, Dodos and Common Factors

Saul Rosenzweig got his doctorate from Harvard in 1932 and remained active in psychological research until shortly before his death 72 years later. His most influential paper – ‘Some implicit common factors in diverse methods of psychotherapy’ was published in 1936. Just to give some context, one of Rosenzweig’s classmates at Harvard was B.F. Skinner, one of the founders of

behaviourism. Rosenzweig's paper was a response to the claims of proponents of the various psychotherapies popular at the time that their particular therapy was more effective than all the others, and that the reason for this was that the theory of change on which their therapy was based was right (and the others wrong).

In contrast, Rosenzweig was the first to propose that the mechanisms of change in psychotherapy might not be specific to the form of therapy, but instead be agents of change common to all therapies, which he termed 'the common factors'. It is tempting to think that one of the reasons this paper is still regularly cited in contemporary research is the quotation with which it begins: 'At last the Dodo said, "Everybody has won, and *all* must have prizes."'

The allusion was to the caucus race in Lewis Carroll's 1865 book *Alice in Wonderland*, in which the Dodo instigates a confused race with no rules in order for the participants to shake themselves dry. Rosenzweig argued that competition between different schools of therapy was similarly misguided, because all were equally effective. This became known as 'the dodo bird hypothesis', a poetic touch that we suspect has captured the imagination of many subsequent researchers.

Rosenzweig's paper was a reflective one – it contained no data to support his assertions. Reading it now, in some ways it also seems very dated – the psychotherapies mentioned include psychoanalysis and Christian Science rather than CBT and IPT, for example. In other ways, however, it has not dated at all. Rosenzweig's opening argument is that all proponents of psychotherapies can produce successful cases to support assertions that they work. Unfortunately, he argues, they tend then to imply that this evidence also demonstrates that their own brand of therapy is better than the others. As someone surveying this from a more detached position, he argues that the logical conclusion to reach is that, if so many different therapies based on conflicting theoretical approaches can produce successful outcomes, then the reasons for success are unlikely to lie within any one theory.

His basic logical point was that the success of any therapy cannot be used as evidence that the therapy has brought about change in the way it claims to – it provides evidence that the therapy works,

but not why it works. Rosenzweig's belief was that therapies that appeared to be very different actually had more in common than the proponents realised – that the effectiveness of therapies was a result of unrecognised factors common to them all.

What did he think these factors might be? Rosenzweig makes a few suggestions. He argues that the relationship with the therapist may allow for some social reconditioning to occur, and also suggests that catharsis may be a common consequence of different therapeutic approaches. He also focuses on the effect of the therapist's personality. Though hard to quantify, he argues that there is a shared understanding of the qualities needed in a good therapist, and that good therapists are distributed across different schools of therapy.

Interestingly, his next possible factor is the coherent structure for understanding that all therapies offer. Rosenzweig describes this in terms of personality – that therapies offer a consistent and persuasive schema for the client to achieve greater personality organisation. In 1936 personality was a key concept in psychotherapy – Rosenzweig's definition of an established psychotherapy was one based on a general theory of personality, and he refers to mental disorder as a conflict of disintegrated personality constituents. Although the terminology of therapy has changed over the years, the notion that therapies may be providing a coherent and believable structure by which clients can begin to understand and solve their problems remains a persuasive idea.

Rosenzweig's next argument comes even now as a refreshing acknowledgement of the complexity of psychological problems and the limits of our understanding. Put bluntly, he argues that psychological events are so complex that many different, equally justified formulations are possible, and that each may contain a certain amount that is accurate. Thus no one therapy or interpretation has a monopoly on truth. In addition, personality is so complex that it is likely that there are very many ways to effect a change in organisation. Again, to put it bluntly, different therapies may target different aspects but have a similar overall impact. The implication is that therapists' formulations do not have to be completely accurate to

have a therapeutic effect, and that different foci in therapy can bring about similar therapeutic change.

Rosenzweig's paper is still immensely provocative. Though not based on research itself, it anticipates much of the psychotherapy research to take place over the subsequent 70 years – from studies comparing different therapies, examining the therapeutic alliance or the accuracy of a formulation, to dismantling studies aiming to identify the active ingredients in therapy. It also anticipates many of the concepts which have become associated with the processes of therapy, most obviously the common or non-specific factors that may underlie effectiveness. He also stressed the importance of the confidence that therapist and client have in the therapy—that it needs to appear credible to the client and evoke allegiance in the therapist. Both of these factors are reflected in the consistency of the therapist in adhering to the treatment approach.

Three other things are worth noting from this paper. First, Rosenzweig recognised that equivalence of therapies was only true when they were appropriately used. He limits his conclusions to accepted therapies, competently applied. Second, he did not rule out the possibility that some forms of treatment may be better suited to particular kinds of cases. He also considers the potential importance of matching patient and therapist in terms of personality. Finally, there is another possible solution to the logical conundrum of many therapies claiming differential effectiveness but all producing successful outcomes: rather than the explanation being that success is due to non-specific factors common to them all, perhaps each type of therapy utilises specific and distinct factors, but these are equally effective. In Rosenzweig's terms, these factors may have an impact in different ways but produce similar overall changes. We'll return to this point later.

After Rosenzweig: Does Therapy Actually Work?

Although he had particular views about differences between therapies, Rosenzweig never doubted that psychotherapy was effective.

This has not always been accepted, however, and 20 years after his paper the majority opinion seemed to reject it. In two papers, Hans Eysenck (1952, 1965), perhaps the most famous psychologist of his generation, argued that 75% of patients get better regardless of whether they receive psychotherapy (though he was more hopeful for treatments based on ‘modern learning theory’). Although his conclusions were founded on reviews of a small number of studies, they were extremely influential at the time, leading many to conclude that traditional psychotherapy was ineffective. By the end of the 1960s, however, the weight of evidence was turning decisively against this view, as exemplified by Bergin’s (1971) review of a much larger number of well-conducted studies. By this time the methods used to study psychotherapy outcome had grown increasingly sophisticated, taking their lead from medical trials. Even so, reviews that listed the outcome of different studies tended to add to the debate about the effectiveness of psychotherapy rather than end it. The decisive blow finally came in the 1970s and was made not by a psychotherapy researcher, but by an educational psychologist called Gene Glass, whose innovation in the way information can be summarised from different studies would change not just psychotherapy, but the way the whole of medicine is practised. Before we come to this, we need to understand the methods for conducting research that had by then become increasingly popular, and that provided the raw data for Gene Glass’s innovation.

A Well-conducted Study: The Randomised Controlled Trial

What is a well-conducted study? How can a reader determine that an investigator’s conclusions are justified, that the research has been conducted without bias and presents a fair and truthful account? As psychotherapies became more popular, and increasingly formed an accepted part of mental health services, it was natural for investigators to draw on the research methods used to evaluate other interventions in health. In fact, medicine had addressed the problems of trustworthiness some time before with the randomised controlled

trial (RCT), and this became the method of choice for psychotherapy investigators looking at outcome.

The first RCT in medicine is usually thought to date from 1946 and examined whether streptomycin was an effective treatment for pulmonary tuberculosis. Since then countless RCTs have been conducted, and have undoubtedly made a huge contribution to the development of medical practice. Put simply, RCTs enable a fair and unbiased comparison of treatments for particular conditions so that policy makers and clinicians have evidence rather than opinion on which to base treatment decisions.

To illustrate, suppose that a new drug is invented to treat the common cold. In an RCT the experimenter attempts to control for all the things that can bias a fair comparison so that a treatment can be properly evaluated. First, the new treatment is compared with something else – usually an existing treatment, but sometimes no treatment. Second, the appropriate group is targeted – in this case, people with a cold. The treatment is designed for the common cold so it would be unhelpful and unfair to include patients with the 'flu. Third, everyone agreeing to take part is randomised – that is, they are randomly allocated to either the new treatment or the old one with everyone having an equal chance of being in either group. They are randomised so that the two groups are likely to be comparable, and no one group is stacked with body builders with a fierce resistance to the common cold, for example. This randomisation is double blind – neither the patient nor the experimenter knows which treatment they are getting. This is to prevent the knowledge influencing either the patient ('I'm on the new wonder drug so I must be feeling better') or the experimenter ('I've spent years researching this great new drug and they must be feeling better'). The trial is then carried out, with each group receiving one or other of the treatments. At the end of the trial, an appropriate assessment is taken – in this case, whether they still have a cold. At this point the experimenter is able to crack the code on who was receiving which treatment, and compares the two groups to see if one has better outcomes than the other. In RCTs, then, the aim is to eliminate potential confounds so that a pure comparison between two treatments can be carried out.

When reading an RCT, then, although the methodological rigour with which they are carried out can vary considerably, you may have a certain degree of confidence in the conclusions. It therefore seems absolutely appropriate to utilise these methods in evaluating psychotherapy. Unfortunately, techniques that are relatively unproblematic when comparing two drug treatments become much more complicated when comparing psychotherapies – but more on this later.

How have these methods been used in psychotherapy research? Generally, to show that a particular psychotherapy is effective (i.e., comparing it with a no-treatment control) or to compare two or more psychotherapies to see if one is differentially more effective. The latter, of course, also provides evidence about the effectiveness of psychotherapies in general

The problem with individual RCTs, however, is that even the best of them remains just a single study, and when the sample size is small the results are often inconclusive – traditional inferential statistics usually require quite large numbers of participants if there is to be a good chance of detecting a significant difference between groups. Worse, when several similar studies are carried out, it is not uncommon for the results to vary, making an objective interpretation difficult.

An obvious solution is to write reviews gathering together the results of many RCTs in order to summarise their results. The first reviews of existing research are now known as narrative reviews. In them, the authors (usually experts in the field) offer an overview and interpretation of the existing literature. Though such reviews can be valuable and interesting, the opinions are just opinions – there is no attempt to present a mathematical summary of the findings of previous studies. This means, of course, that two reviews may potentially feature very different opinions and reach opposite conclusions about what current research is saying.

In essence, this was the situation described earlier regarding the effectiveness of psychotherapy, with Eysenck reviewing research and finding no evidence for effectiveness, and others arguing the opposite.

An important way to improve reviews would be to find some way of representing the data from individual studies. Luborsky, Singer