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Annotation

The Essential Psychotherapies

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Psychiatry is becoming increasingly confident about defining the benefits to be expected from each treatment (World Health Organization, 1991). The World Health Organization has published a list of essential drug treatments, but neither it nor any national regulatory body has ever examined non-drug treatments. This article examines the utility of the psychotherapies as treatments for persons with psychiatric disorders, and within a health service, whether supported by private insurance or by public taxation. It is not about the utility of psychotherapy paid for by an individual, for what people do with their own money is their own business. However, when deciding how to apportion a limited health budget, one should choose treatments that are more effective, safer, and cheaper than competing alternatives. Precisely how effectiveness, safety, and cost efficiency should be traded off against each other is a moot point, but there is agreement that treatments that are ineffective, harmful, and costly should not be used.

Dynamic psychotherapy

Freud formulated a theory of mental disorder, a method of investigating it, and a relevant treatment; he also contributed considerably to our understanding of human mental life, and his ideas have humanised society. However, the importance of his ideas does not mean that treatments derived from his work are automatically valid. Twelve years ago, Smith *et al* (1980) published a meta-analysis affirming the benefits of dynamic psychotherapy. They termed the dynamic psychotherapies 'developmental psychotherapies' – a better term because it accepts that many psychotherapists, from Freud and the post-Freudians through to Klein and Kohut, have conceptualised the goal of therapy as allowing the patient to remedy some maturational defect in personality development, thereby promoting emotional autonomy. The process of dynamic psychotherapy is characteristically unstructured, the diagnosis in dynamic terms becoming apparent as the therapist explores and clarifies the emotional experiences of the patient within the transference relationship, mapping what has been learned onto the theoretical framework being used.

Andrews & Harvey (1981) used the Smith *et al* data and restricted their reanalysis to 81 studies of patients with neurotic disorders, comparing the average progress of treated groups with waiting-list controls who had also sought therapy. The behavioural psychotherapies (effect size (ES) superiority over waiting list = 0.97) were on average superior to the verbal or dynamic psychotherapies (ES = 0.74), which were in turn estimated to be more effective than counselling (ES = 0.35) or placebo treatments (average ES superiority over waiting-list controls = 0.55). However, Prioleau *et al* (1983) disagreed. They selected 32 direct placebo-controlled trials of dynamic psychotherapy, irrespective of diagnosis or whether people had sought therapy, and found no evidence that dynamic psychotherapy was superior when directly compared with placebo. The commentaries and editorials that followed that article rightly pointed out that the studies they had analysed were trivial and did not represent the practice of dynamic psychotherapy. Most commentaries, including my own (Andrews, 1983), claimed that Prioleau *et al*'s conclusions were wrong, but did not cite any controlled trials to show that dynamic psychotherapy was superior to placebo. The Prioleau *et al* article, although based on poor data, is a challenge to show that better data exist – data that would show dynamic psychotherapy to be superior to placebo treatment, or routine good clinical care, or even advice from a kindly advisor (Strupp & Hadley, 1978).

Such data have not been forthcoming, and three recent reviews failed to find dynamic psychotherapy superior to placebo. Andrews (1991*a*) focused on studies and reviews published in 1989–90 and concluded that "dynamic psychotherapy, although popular with patients and therapists . . . has not been demonstrated to be superior to placebo in the neuroses or personality disorders. The case reports of improvement during long-term dynamic therapy for personality disorders may be due to the combined effects of normal maturation and the non-specific effects of continued clinical care". Svartberg & Stiles (1991) conducted a meta-analysis of the 19 clinically relevant comparative outcome studies published between 1978 and 1988, concluding that short-term psychodynamic psychotherapy was superior to having no treatment at the end of treatment, but not at follow-up 6 and 12 months later. It was inferior to alternative psychotherapies (63% of which were cognitive–behavioural) at the end of treatment, and this

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difference became more pronounced during follow-up. Crits-Christoph (1992) did not find brief dynamic psychotherapy significantly superior to placebo or specific treatments, only to patients placed on a waiting-list.

Given such a universally bleak conclusion, it is important to be clear about two things: the representativeness of the dynamic psychotherapy being researched and the criteria on which effectiveness might be judged. These three reviews identified studies that had compared a dynamic psychotherapy with a placebo treatment or with another form of psychotherapy. Since long-term therapy is rarely the subject of research, the information in these studies refers, in the main, to shorter periods of treatment. These may be representative of dynamic psychotherapy practice when not supported by health insurance (Howard *et al*, 1986), but are only one-tenth of the average duration of dynamic psychotherapy when there is unlimited health insurance (Andrews & Hadzi-Pavlovic, 1988).

The strategies for evaluating a form of psychotherapy are well established (Andrews, 1989). At the end of treatment, symptoms as rated by doctors and complaints as recorded by patients should all be lessened. The ability both to work and to relate should be improved, and risk factors, such as personality vulnerabilities that could lead to relapse, should also be reduced. Reliable and valid measures are available for all these. Improvement should continue after treatment has ended and be shown to be greater than three possible confounding effects: spontaneous remission, regression to the mean, and response to a placebo or non-specific clinical care acting over a similar period. A waiting-list or no-treatment group is necessary to control for the first two confounding effects, and a placebo condition for all three. Good clinical care would be an ethically acceptable quasi placebo-control condition for long-term psychotherapy. There is a further caveat. As there are now many studies of unsuccessful dynamic psychotherapy, both published and unpublished, a single study reporting success should initially be regarded as simply a false positive, since at conventional significance levels, positive results will be obtained by chance 5% of the time.

There is a study demonstrating that research in long-term psychotherapy is practicable, and illustrating the need for control groups. Stevenson & Meares (1992) produced one standard deviation improvement after 100 hours of dynamic psychotherapy in patients with borderline personality disorders. I have argued (Andrews, 1992) that 50% of adults with borderline personality disorder will no longer meet those criteria after ten years. Given that patients begin therapy when their symptoms are worst and respond to the placebo of good clinical care, then the one standard deviation improvement over the two years that Stevenson & Meares found could be attributed to the effect of these three confounding effects. Only if they get a positive result in a placebo-controlled study, and have this replicated in a number of centres, will their psychotherapy technique be proven to be effective.

Dynamic psychotherapists have always argued that their treatment is of benefit. Many treatments in medicine lack formal proof of efficacy, why then the concern about long-term dynamic psychotherapy? There are two reasons – concern about safety, and concern about cost. The therapeutic relationship in long-term psychotherapy is very intimate, and psychotherapists have been reported to influence patients' ethical and moral values (Kelly, 1990). Masson's (1990) accounts against therapy make one wonder how dynamic psychotherapists could behave so badly, but an account of patients' experiences in therapy (Dinnage, 1988) shows that unexceptional dynamic psychotherapy can also harm by stealing hope and inhibiting ordinary recovery. Psychiatrists who have had years of personal therapy or analysis are two and a half times more likely to admit to having sexual relations with patients (Gartrell *et al*, 1986; Pope, 1990). As 10% of mental health professionals report that their own therapy harmed them (Lambert *et al*, 1986), the number of patients harmed who do not complain might be considerable.

Long-term dynamic psychotherapy is expensive. In Australia, it has been estimated that 15% of psychiatrists are occupied in long-term dynamic therapy, and that an average of 330 hours is spent with each psychotherapy patient (Andrews & Hadzi-Pavlovic, 1988). Given that there are 1600 persons with neuroses or personality disorders per 100 000 in treatment with psychiatrists, psychologists, community mental health teams, and general practitioners (Andrews, 1991*b*), then Australian dynamic psychotherapists can only complete treatment of 0.5% of such patients each year. It is costly to have 15% of psychiatrists devoted to the 0.5% of patients who are not the most ill. In summary, the lack of evidence for efficacy despite considerable research, the real possibility of harm, and the high cost, all make long-term dynamic psychotherapy unlikely to be a preferred option of a health service or health insurer. In the present medicolegal climate, the possibility of doing further psychotherapy

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research without a very explicit and cautionary consent form seems remote.

Cognitive–behaviour therapy

Cognitive–behaviour therapy developed from original and quite separate work by psychologists, psychiatrists, and psychoanalysts. The development was piecemeal, sometimes informed by theory, but often on an *ad hoc* basis. However, despite the lack of a central theory, it is possible to discern the characteristics that define cognitive–behaviour therapy.

(a) Therapy is centred on current problems agreed between patient and therapist. A behavioural analysis of these problems defines the antecedents, consequences, and mediating thoughts and beliefs. This analysis is discussed with the patient.

(b) The rationale for treatment is discussed with the patient in advance. Therapy is structured, with an agenda set for each session. In therapy, the patient develops control over the problems and is able to use these skills to cope with future difficulties.

(c) Three basic methods are used to enhance problem-related coping skills: modification of emotional responses, modification of behaviour, and modification of irrational or unproductive thoughts or beliefs.

(d) Techniques are empirically tested in both single-case and controlled trials. The target problems are measured before, during, and after therapy.

Thus, the problem, the treatment plan, and the techniques used are specified before treatment and the results are assessed after treatment has concluded. Do these techniques really work? There are meta-analyses that show cognitive–behaviour therapy to be superior to placebo treatment in neurotic patients (Andrews & Harvey, 1981; Clum & Bowers, 1990), but the real strength is the independent evidence available for each mental disorder. Dobson (1989) reported on 28 studies of Beck cognitive therapy in depression and found it to be two standard deviations (s.d.) better than no treatment, and half a s.d. better than competing treatments. Robinson *et al* (1990), in a more wide-ranging study, reported that cognitive–behavioural therapies were half a s.d. better than verbal psychotherapies, which did not differ from placebo. From the NIMH multicentre depression trial (Elkin *et al*, 1989) we have calculated that patients on clinical management plus placebo (the placebo condition) improved by two s.d.s, while the psychotherapies, which were largely cognitive–behavioural, added a further 0.3 s.d. As Gelder (1990) said, such treatments are particularly helpful for patients who cannot, or do not wish to, take drugs.

Since the pioneering work of Marks, it has been obvious that the behaviour therapies have much to offer patients with phobic disorders. Two recent studies also show the power of such treatments in panic/agoraphobia. Klosko *et al* (1990) and Michelson *et al* (1990) reported that 23 of their 25 patients were free of spontaneous panic attacks at the end of treatment. Mattick *et al* (1990) published a meta-analytic review of the treatment of panic and agoraphobia that also identified concomitant changes in personality vulnerability that improved coping and reduced the propensity to relapse. Cognitive–behaviour therapy appears to be the treatment of choice in generalised anxiety disorder (Hunt & Singh, 1991), obsessive–compulsive disorders (Christensen *et al*, 1987), and social phobia (Mattick & Newman, 1991), with superiority over credible alternative treatments being established. Empirically based aetiological models are being developed, and classical treatments can be identified (Andrews, 1991*c*); improvement has been shown to persist for many years after treatment has ended.

Behavioural family interventions reduce the re-admission rate in schizophrenia (Andrews *et al*, 1985), and the cognitive–behavioural therapies show promise in the management of marital and sexual difficulties, in bulimia but not in anorexia, in chronic pain syndromes, and in many emotional disorders of childhood. The main residual problem is the personality disorders but even in these, Linehan (1987) and Alden (1989) have been able to ameliorate key symptoms.

Given that the cognitive–behavioural therapies are effective and superior to placebo treatment, what about safety and cost? There are, as yet, no substantiated reports of significant harm, in part because these therapies are so new and in part because the modesty of the goals and the briefness of the therapy reduces the transference and counter-transference problems that can give rise to harm. These therapies are brief, 10 to 30 hours for most problems, although more may be required for more difficult problems. Their cost is also reduced because they can be carried out expertly by staff other than consultant psychiatrists. Treatment manuals exist for many disorders (Goldfried *et al*, 1990), some treatment programmes can be delivered by computer (Selmi *et al*, 1990), and even psychopharmacologically orientated clinicians can be taught to be effective therapists (Welkowitz *et al*, 1991).

Good clinical care

There is now sufficient literature to conclude that cognitive–behaviour therapy, but not dynamic psychotherapy, is useful. Choosing a psychotherapy

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should therefore be straightforward, even if polemical. The problem is that polemics distract from the essential task of psychiatry, which is to deliver care to the 2700 per 100 000 of the population who are being treated for their psychiatric disorder (see Andrews (1991*d*) for the detailed calculations). For a catchment area of 100 000 persons, this 2700 would include 1600 being treated for neuroses or personality disorders, although this treatment is often poor because too few staff know precisely what to do. We have already calculated that the dynamic psychotherapists could only see 0.5%, and even given six cognitive–behaviour therapists per 100 000, this would only allow an extra 20% of patients to be treated appropriately. Drug therapy is no panacea, curing only some anxiety and depressive disorders. There have to be other ways to improve the treatment of the remainder of these 1600 patients.

Sixty years ago, before there were many specific remedies in medicine, doctors were in great demand to explain, reassure, clarify, and teach people how to cope with illnesses that were either incurable or would sooner or later run their course. Good clinical care of this type is very important; it is what every patient still hopes to get from their doctor. The problem is that, seduced by the promises of the specific treatments, we often forget to train our younger staff in how to provide good clinical care. I am unable to refer readers to a modern manual that would describe good clinical care for patients with neurosis and personality disorders.

Gradual remission is usual in the majority of neuroses and personality disorders, but even in patients in whom this is delayed, regression to the mean and the placebo response give the doctor an opportunity to influence the patient towards health. Ellard (1987) stressed the importance of explaining to people what is wrong with them. If this is carried out properly, the patient will be reassured, feeling less helpless and more in control, and this is good for both progress and for the self-esteem of both doctor and patient. Like Socrates, Ellard also thought that careful questioning may help patients to clarify their problems, and enable them to do something effective about them. If the doctor finds Socratic dialogue difficult, then the structured problem-solving procedure should be used (D'Urzilla, 1986). This has the added advantage of improving appraisal and facilitating problem-focused coping, thereby promoting patient autonomy. Carl Rogers also thought that therapist genuineness, empathy, and non-possessive warmth allowed troubled patients to experiment with problems that had seemed too disturbing to think about alone. Lastly, psychiatrists should be prepared to teach patients obvious things; for example, that they should not tackle important tasks while disabled by anxiety, that activity can lessen depression, and that relaxation is possible without using drugs or alcohol.

There are three domains of information that inform good clinical care. Psychopathological understanding can alert the clinician that what the patient says and does may be overdetermined – relevant to the past as well as to the present; that awareness of the defences used may enable one to see behind provocative or difficult behaviour; and that transference, properly handled, can be an important ally, whereas excessive countertransference is usually a sign to take counsel from a colleague. The cognitive–behaviour therapy approach encourages one to analyse the major problem, identify the axis 1 and 2 diagnoses present and develop a therapy plan that specifies the goals of therapy and the treatments to be used, as well as evaluating outcome. The community support model (Test & Scott, 1990; World Health Organization, 1991) encourages the therapist to provide patients with continuing help with crises, activities of daily living, housing, employment, finance management, medical care for physical illnesses, together with support and guidance on social and recreational activities.

Good clinical care is therefore an amalgam of four steps: establishing a good professional relationship with the patient; understanding the undercurrents in the relationship; being professional and enthusiastic about specific strategies and treatments for treatable syndromes; and providing the broad-based support and care that are needed until the principal disorder remits. Given remission, regression to the mean, and placebo response, much progress should be apparent. If this does not occur, the diagnosis and treatment plan should be reviewed and if nothing seems amiss there, a second opinion from a colleague with a different orientation from one's own should be sought. Good clinical care, because of breadth and flexibility, is likely to prove more effective, cheaper, and less harmful than dynamic psychotherapy, and less efficacious but more broadly applicable and comparable in safety and cost to cognitive–behaviour therapy. Treating slow-to-improve patients this way is onerous, but when demoralised by the load of chronic patients, a clinician should do a follow-up study to learn that as one's successes move on, future successes, still looking like failures, fill the waiting room. If the Royal Colleges fostered training in good clinical care with the same fervour with which they examine candidates in psychopharmacology or psychotherapy, demoralisation in doctors might be less of a problem and chronicity in

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patients less endemic; and both outcomes would be pleasing.

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