An overview of the empirical evidence base for individual therapy

Abstract. This paper takes stock of what has been achieved in creating a consensually-agreed evidence base for individual psychotherapy. The aim is to ascertain if, and in what way, the evidence-base for individual therapy is converging. The paper makes a case for a greater focus on therapeutic processes in cognitive behavioural therapy (CBT).

Keywords: Outcome and process research, standardisation of methodology, systematic reviews.

Introduction

This paper investigates how outcome research is meeting its target of justifying therapies of choice. Generally, outcome research considers quantitative evidence that shows what is curative for clients with a single psychological problem. Currently, it answers one major research question: Research question 1. How should therapists practice effectively with specific disorders? The analysis below is proposed as a self-reflexive step in finding out how far outcome research has got in answering research question 1. Five nationally approved or otherwise renowned evidence-bases have been consulted including those from the American Psychiatric Association (Gabbard, 1995), Roth and Fonagy (1996), Nathan and Gorman (1998), the Clinical Psychology Division of the American Psychological Association (Chambless et al, 1998) and the UK Department of Health (2001).

Method

The method employed is to compare the references quoted to find out how much commonality there is among the recommendations. Entry into the results Tables, 1 and 2, was made in the following manner. If there are no results mentioned in the five sets of recommendations, a dash is entered. If there is only one finding for therapies of different sorts, then “no consensus” is entered. If there are two or more different papers agreed by separate recommendations, then each one is included in Tables 1 and 2. The evidence base converges when more than one recommendation has concluded that the same type of therapy, for the same disorder, is suitable. Only the briefest of comments are made on the five original bases.

Discussion

Overall, of the 186 papers cited by the five evidence bases, 164 (88.2%) are cognitive, behavioural or cognitive-behavioural. Eight (4.3%) are psychodynamic and six (3.2%) recommend interpersonal therapy. The remaining eight papers suggest relaxation skills, social skills, brief therapy and educative approaches as having been shown effective. The most obvious conclusion is that CBT is the most effective because it is the most researched type of practice.

One question is to think about reasons why there has not been any clear convergence among the five sets of recommendations concerning the specific versions of CBT. If it were generally the case that a specific type of therapeutic approach was suitable for a specific disorder, then such a finding would be replicated by more than one researcher. But this is not the case. The only cases where there is agreement on what is effective, with respect to the type of disorder, are those in Table 1. In comparison, there is little shown to be effective with the personality disorders (Table 2).

A second question concerns the difference between the quantitative outcome research model and other types of process research. Accordingly, further scrutiny of methodology of the approved types of evidence that are currently acceptable should inform the drive towards clinical governance, evidence-based practice, clinical reasoning and training in empirically-validated therapies. But RCT research is only focused on finding what are effective therapies from the standpoint of what is most effective of change on an averaged-out basis. Large numbers of participants are required. Four problems are distinguished in understanding psychotherapy research.

Problem 1: There is poor science at large amongst outcome research in therapy. Time and again, researchers break the basic rules of reasoning between hypothesis testing, the representative sample tested and in making inferences about the population at large.

One reading of Tables 1 to 5 is to consider that other uncontrolled variables are at play. Possibly, there is something amiss with the appliance of science in the creation of an evidence base for practice, funding, training and research because there is no guarantee that extraneous variables have been controlled to the same degree in each paper. There are concerns about non-standardised use of statistics, the inclusion and exclusion criteria for the participants and other matters. The scrutiny of these pertinent details within these evidence bases calls into question the coherence between differing standards employed in the original selection of research for each evidence base. Accordingly, to be precise about the claims given would take much more detailed comment than can be afforded in this introductory paper. Methodological evaluation could play a much greater role in research, and indeed that requirement is begged by this brief analysis. But just because a number of therapeutic approaches to a specific disorder may not have been researched, it does not mean that those approaches should

be discontinued. Nor just because a single RCT study has occurred does it mean that a specific form of therapy is a treatment of choice. Such a conclusion could only occur at the end of a standardised set of comparisons. Similarly, just because a specific brand name of therapy has been researched, it should not be concluded that it is the only suitable form of therapy for a specific disorder.

But if meaning-oriented and qualitative-research methods on assessment and therapy process are not valued, and, if they are not well organised, they are not able to argue their case. Within the five evidence bases there is an absence of attention to therapeutic process, particularly with respect to the increase in complexity of co-morbidity and the increase in inertia to change across the lifespan. One solution is to pose answerable research questions and use methods that temper the findings of outcome research. A useable result is one that could be rigorous about therapeutic process, assessment of client abilities. Three further problems are mentioned in passing.

Problem 2: There is a further distance between RCT outcome research and research into therapeutic process across the lifetime of clients with co-morbidity. Such questions can only be asked through a different type of question and answer. Accordingly, RCT outcome findings are not focused on meaning and process, so cannot answer the more detailed questions that practitioners would like to know concerning assessment and client suitability for specific types of therapy.

Problem 3: There is no place for a self-reflexive understanding of how to interpret the results of outcome research currently. What perspective qualifies an answer? It is the place of inference and methods of the interpretation of results to weigh up meanings and emphases.

Problem 4: There is no consensus on what constitutes the appraisal process of statistics and interpreting the findings of outcome research. There are no standard forms of analysing meta-analyses, providing systematic reviews and creating RCTs in the first place.

Closing remarks

Perhaps it is the role of RCT research to make one type of contribution that needs to be aided by contributions from qualitative, psychopathological and service-provision perspectives. It is also necessary to consider how clients appear with novel patterns of need, ability and personal history. There are research questions posed in assessment and answered by referral. What is required is justification of the assessment protocol and the clinical reasoning that accompanies it.

It is a matter of interpretation as to what the votes of Tables 1 and 2 mean. It is possible to think about tendencies that appear between the lines of what has been shown effective. Perhaps, CBT contains within it principles that define good practice for all forms of individual therapy. For instance, encouraging clients to be self-caring, becoming informed about the principles of their therapy and being active outside of the session are general principles that might make all forms of therapy more effective. Reviewing clients' perspectives at the end of each session, and asking them to recap the principles by which they understand cause and effect operating in their problems might also help clients in other forms of therapy work towards a positive outcome. Another possibility, within the results of Table 1, is that clients may need to test themselves and their beliefs in problematic situations by reducing safety behaviours and increasing exposure. If such interventions were accepted as a core theoretical principles for any

therapy, it would mean that all forms of therapy might include some behavioural task-setting as part of the work.

There are self-reflexive and self-regulatory components of research, its self-understanding. With a preference for therapeutic process, it is not clear to what extent qualitative research can contribute to the aims of answering research question 1: "How should therapists practice effectively with specific disorders?" Secondly, at the time of assessment, questions concerning effectiveness are used to answer practical questions concerning where clients are placed between primary, secondary and tertiary services. These questions concern where to place clients according to the amount of previous help they have received and estimates of their level of disability. Further practical questions are:

Research question 2. How should the services, and access to them, be structured? This question could be answered according to some estimate of the severity of disability, distress and co-morbidity of the occurrence of axis I and II disorders across the lifespan.

Research question 3. How can qualitative research into therapeutic processes and relapse prevention be given a remit with respect to quantitative outcome research?

Research question 4. How can identifiably different clients best use which specific types of therapy? In addition, for what optimum length of time? The question concerns how to best place clients within the range of services that are on offer.

Research question 5. How can process and outcome findings be used to inform therapy concerning how the troubled mind works and suggest how therapy helps with different forms of distress?

Perhaps the guiding research question of Paul needs to be recast. Originally he stated it as: "*What* treatment, by *whom,* is most effective for *this* individual, with *that* specific problem, and under *which* set of life circumstances" (1967, p 111). It could

become: "*What* principles of cause and effect, for *which individual occurrence of a problem* are most effective for *this* individual's ability to participate in *what* type of therapy, in *which* set of life circumstances?" There are differences in the quality of evidence used for justification and making important decision-making in outcome research. The inclusion of more practical concerns would further the theory and practice of CBT.

References

CHAMBLESS, D.L., BAKER, M.J., BAUCOM, D.H., BEUTLER, L.E., CALHOUN, K.S., CRITS-CHRISTOPH, P., DAIUTO, A., DeRUBEIS, R., DETWELLER, J., HAAGA, D.A.F., JOHNOSON, S.B., McCURRY, S., MUESER, K.T., POPE, K.S., SANDERSON, W.C., SHOHAM, V., STICKLE, T., WILLIAMS, W.C. & WOODY, S.R. (1988). Update on empirically validated therapies II. *The Clinical Psychologist*, *51*, 3-16.

DEPARTMENT of HEALTH (2001). *Treatment choice in the psychological therapies and counselling: Evidence based clinical practice guideline.* London: Department of Health.

GABBARD, G.O. (Ed.) (1995). *Treatments of psychiatric disorders, 2 vols (2nd ed).* Washington: American Psychiatric Press.

PAUL, G.L. (1967). Strategy outcome research in psychotherapy. *Journal of Consulting Psychology, 31*, 109-119.

ROTH, A. & FONAGY, P. (1996). *What works for whom? A critical review of psychotherapy research*. New York: Guilford Press.