

The efficacy of psychotherapy

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INTRODUCTION

Psychotherapy is a century old. Most of its hundred years have been dominated by psychoanalysis and psychodynamic psychotherapy, which have been passed from generation to generation almost as a creed. In effect, each analytic supervisor told his supervisee, «This is what I was taught, and what I believe works.» Notwithstanding occasional cautions that psychoanalysis was an exploratory process that promised no results, its efficacy was assumed.

Yet efficacy remained a belief, inasmuch as there were scarcely any attempts to empirically validate psychoanalytic treatment. The psychoanalytic literature consists of single case reports and small, uncontrolled case series. The complexity of psychoanalytic treatment was and is used to argue against testing its efficacy. Confident in their hegemony, and working in a paradigm removed from a formally scientific medical model, psychoanalysts felt little need to test their approach. Psychodynamic therapy was widespread, although controlled scientific evidence for its utility was nearly nonexistent.

In recent years much has changed (Russell & Orlinsky, 1996). In the 1960's and 1970's, researchers in psychiatry and psychology such as Aaron Beck, M.D., Gerald L. Klerman, M.D., and Lester Luborsky, Ph.D. began to assess psychotherapy outcome by scientific method rather than focusing, as had previous researchers, purely on psychotherapy process. Psychoanalysis retreated as alternatives and derivatives, including the tested time-limited psychotherapies (TLPs), took the field. In the last decade, social pressures to cut mental health costs in the United

States resulted in managed care (really *managed cost*), severely limiting the reimbursement of psychotherapy, and hence its length. American consumers (as patients are now frequently termed) also demand quicker and proven results. Fortunately, researchers have some evidence to show them.

What allowed the testing of psychotherapies? First, the development of nosological systems such as the Diagnostic and Statistical Manuals for Mental Disorders (DSM), beginning with DSM-III in 1980 (American Psychiatric Association, 1980), allowed reliable diagnosis of psychiatric syndromes. These diagnoses defined target disorders for testing of psychotherapeutic interventions. Second, psychotherapies were codified in manuals for research treatments, and treatment sessions were recorded by audiotape or videotape and monitored for adherence. Relatively (not to say purely) homogeneous diagnostic categories of patients, and relatively (not to say rigidly) homogeneous treatments, made it possible to measure the efficacy of psychotherapies for particular groups of patients.

(This is a somewhat American perspective:) Based on psychotherapy outcome research of the past two decades, we now have some idea of which psychotherapies to prescribe for key DSM-IV (American Psychiatric Association, 1994) disorders, just as we do when prescribing pharmacotherapies. Psychotherapists should now consider diagnosis as well as character, and recognize that what looks like character may reflect the effect of state on trait (Hirschfeld *et al.*, 1983). A major shift in outlook since DSM-III gives Axis I diagnoses like major depression or dysthymic disorder primacy over characterological, psychodynamic formulations, since treatment of the seemingly *superficial* mood disorder may profoundly improve or eliminate what had looked like character pathology. Axis I psychiatric diagnoses should not lead therapists to dehumanize patients or to ignore their idiosyncrasies, but they should strongly influence treatment selection. Treatment choice should depend on scientific knowledge, not therapists' ideolo-

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gy. To ignore these developments in knowledge is a therapeutic indulgence that will increasingly be condemned, both by reimbursement agencies and by ever more educated patients (consumers) themselves.

Assessment of psychotherapy outcome is a relatively new phenomenon, and much remains unknown. Nonetheless, we know far more now than twenty years ago. Empirical evidence supports the efficacy of several TLPs as treatments of mood disorders, anxiety disorders, and other conditions. There are even some data on *differential therapeutics* (Frances *et al.*, 1984), the science of treatment selection – e.g., of psychotherapies for depression (Sotsky *et al.*, 1991). We still know little about the efficacy of longer term psychotherapies, but one state-of-the-art treatment study does address maintenance psychotherapy for depressed patients (Frank *et al.*, 1990).

Too much psychotherapy outcome research exists to catalogue here. Instead, I shall describe some principles of TLPs employed in research, and highlight a few key studies that may be less familiar in Italy than in the United States. I shall also focus on interpersonal psychotherapy (IPT) (Klerman *et al.*, 1984), as I know from recent workshops in Italy that it has received less exposure here than have psychodynamic and cognitive therapies.

TIME-LIMITED PSYCHOTHERAPIES

Table I lists characteristics common to TLPs used in research studies.

Table I. - *Characteristics of research-tested time-limited psychotherapies.*

Manual-based, with specific training and supervision of therapists
Adherence ratings (sessions often audiotaped or videotaped)
Time-limited (generally 12-20 sessions in a similar number of weeks)
Optimistic (rather than neutral)
Present-focused (rather than past)
Diagnosis-focused
Diagnostic rationale
Particular techniques (interpersonal, cognitive, core conflictual relationship theme, etc.)
Non-specific factors

The use of time limits in psychotherapy outcome research partly reflects the need to compare psychotherapies to pharmacotherapy. Yet the brevity of treatment is not simply an accommodation to re-

search design. The time limit forces both patient and therapist to work fast: it conveys the urgency of treatment and of rapid results. The time limit often catalyzes treatment outcome.

Time-limited therapies tend to be *optimistic* – an important factor in countering the pessimism and nihilism of depressed patients. They focus on the *present*, the «here and now»: on the patient's current situation, rather than on the remote past. IPT addresses the «here and now» in the patient's life *outside* the office, as opposed to transference within it. Time-limited psychotherapies tend to have been developed to treat specific psychiatric disorders (although, once successful for one syndrome, they are sometimes adapted to treat others). Hence they often provide a rationale specific to the disorder. In IPT, treatment of depression focuses on the connection between the patient's mood disorder, defined as a medical illness, and recent life events and social functioning. Cognitive behavioral therapy (CBT; Beck *et al.*, 1979; Dobson, 1989) focuses on irrational, but mood-congruent and hence believable, negative thoughts that arise in and compound depressive disorders.

Time-limited therapies also include so-called *non-specific* psychotherapeutic techniques that most psychotherapies share. Although these ingredients have not formally been researched, psychotherapists could hardly envision psychotherapy without them: an *emotionally-charged, confiding relationship*; provision of new information about the patient's problems and their potential relief; strengthening of patient expectations for help; success experiences during the therapy; and emotional arousal (Frank, 1971). How much of the efficacy of TLPs derives from specific, and how much from non-specific, factors remains unclear.

TREATMENT STUDIES

Mood disorders

Numerous studies have demonstrated the efficacy of CBT and IPT in treating major depressive episodes. A landmark American study, the *Treatment of Depression Collaborative Research Program* (TDCRP) (Elkin *et al.*, 1989; 1994), compared sixteen week, randomly assigned interventions of IPT, CBT, imipramine (IMI), and pill placebo (PLA) for 250 depressed patients. Imi-

pramine and placebo were accompanied by *clinical management* (CM), which proscribed most psychotherapeutic techniques but did offer warmth, empathy, doctorly advice, a biochemical rationale for medication treatment, and checking of side effects. Because the PLA/CM cell did fairly well, there was no overall statistical difference among treatments. On closer analysis, however, all therapies worked equally well for mildly depressed patients, but differences appeared for more severely depressed patients (those with a Hamilton Depression score [Ham-D; Hamilton, 1960] score of ≥ 20). For more severely depressed patients, IMI/CM and IPT were both statistically superior to PLA/CM, whereas CBT stood intermediate, not statistically separable from the others.

The TDCRP study analyzed patient characteristics predictive of differential outcome across therapies. Low baseline level of social dysfunction predicted a good antidepressant response to IPT; high initial severity of depression and impaired functioning predicted superior response to IPT and to IMI (6). IPT appeared a better choice than CBT for patients with high symptomatic severity and cognitive dysfunction; by contrast, patients displaying a severe lack of social skills – what in IPT would be called *interpersonal deficits* – might have been better candidates for CBT.

There is as yet only one maintenance study of psychotherapy for depression: i.e., research therapy extending beyond six months. Frank and colleagues in Pittsburgh treated patients with high risk recurrent major depression (7). Patients who on average had had 7 major depressive episodes received both weekly IPT and IMI; 128 reached acute remission. Once stable for 4 months, patients were randomized to one of five three-year maintenance therapies: (1) IMI alone; (2) IMI plus monthly maintenance IPT (IPT-M); (3) IPT-M alone; (4) IPT-M plus placebo; and (5) PLA/CM.

Patients maintained on high dose imipramine (mean dose > 200 mg/day) did best, whether or not they received low doses of (monthly) ongoing IPT. Patients receiving only the monthly IPT, however, had a significantly better course than did those who received PLA/CM maintenance. This study is unique in having proscribed the *highest* maintenance doses of medication in history, and the *lowest* maintenance dosage of psychotherapy. Even for these high risk patients, a dilute monthly dosage of IPT provided enough protection for a woman of child-bearing age – the modal depressed patient – to have time off medication for pregnancy and some breast-

feeding before relapse would have occurred. Moreover, therapists who practiced *purer* IPT produced better outcomes than those who deviated from the treatment (Frank *et al.*, 1991).

Studies are currently underway addressing subtypes of mood disorders: e.g., IPT as treatment for major depression among geriatric (Reynolds *et al.*, 1992) and adolescent (Mufson *et al.*, 1993) patients; for dysthymic patients (Markowitz, 1994); and as adjunctive treatment for bipolar patients (Frank, 1991).

Anxiety disorders

Numerous studies have demonstrated the efficacy of behavioral and cognitive behavioral therapies for various anxiety disorders (Barlow & Lehman, 1996). Psychodynamic psychotherapy and IPT have not yet been tested, although trials are planned or underway.

Eating disorders

Research has demonstrated the efficacy of CBT as an acute treatment of bulimia. A fascinating study by Fairburn and colleagues compared CBT, IPT, and a behavioral control in treating non-depressed bulimic patients. CBT focused on thoughts about eating and body image, whereas IPT addressed interpersonal issues without emphasizing these topics or bulimia itself. CBT and IPT both proved superior to the control condition and yielded equivalent improvement, although IPT worked more slowly (Fairburn *et al.*, 1991; 1993).

DISCUSSION

Space limitations preclude discussion of other research on other psychotherapy outcome research. There has been significant research on substance abuse/dependence (McCrary & Langenbucher, 1996; Crits-Christoph & Siqueland, 1996), other Axis I syndromes, and Axis II diagnoses such as borderline personality disorder (Linehan *et al.*, 1991). Psychotherapy outcome research is still young (Russell & Orlinsky, 1996); we have learned much, but still know little.

We now know that particular treatments effecti-

vely treat particular syndromes. The high costs of psychotherapy research ensure that not all questions can be tested. Most studies have been acute, and there is a need for (unfortunately, more expensive) continuation and maintenance studies. Which therapies are best for which conditions? At which dosages? How long need they continue? When should psychotherapy and pharmacotherapy be combined (Klerman *et al.*, 1994)? Having demonstrated the basic efficacy of psychotherapies for certain syndromes, outcome research is only now beginning to look beyond symptoms to effects on social functioning, quality of life, cost benefits and cost effectiveness (Miller & Magruder, in press), and other important domains.

Current treatments provide limited claims for efficacy in acute treatment of specific syndromes. Yet TLPs are not the therapeutic answer to all psychiatric conditions. Longer term therapy seems warranted for personality disorders, and as adjunctive treatment for other chronic syndromes. Even where TLP has demonstrated efficacy, we know little about how efficacy under research conditions, with carefully trained therapists and selected patients, translates to clinical effectiveness under «real life,» quotidian conditions.

It may be confusing for some therapists to begin to think about psychotherapies as an array of different treatments, not as a *one size fits all* Procrustean therapy for all comers. Yet the idea of one therapy for all patients appears simplistic today, just as would the idea of a single pharmacotherapeutic panacea. The future of psychotherapy may require a more limited, but more sophisticated, role for numerous psychotherapies in circumscribed circumstances. This nuanced approach, and the research supporting it, represents not only scientific progress, but a necessary adjustment to the modern milieu of practice guidelines (Weissman & Markowitz, 1994) and managed care.

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