PSYCHOTHERAPY ON TRIAL: MIXING ART WITH SCIENCE

Researchers are scrutinizing specific psychological treatments more closely than ever, but the verdict is not yet in on what works best for whom

By BRUCE BOWER

Psychotherapy and supermarket tabloids have more in common than you might think. They are both large industries with legions of devoted consumers who are often a little embarrassed about their psychological or literary choices. Although both products are winners in the marketplace, they lack one thing — widespread credibility.

That, however, is where the similarities end. The purveyors of celebrity gossip and miracle diets thrive on the suspension of rational thought, while psychotherapists are out to get a scientific stamp of approval with the help of increasingly sophisticated research efforts.

About 500 clinical trials over the past 25 years suggest that all sorts of psychological treatments are comparably effective and superior to no treatment. But an important question remains: What kinds of psychotherapy and psychotherapists are effective for what types of problems?

This question has acquired a sense of urgency in recent years as federal and private insurers have tightened health care payments and demanded "objective" data on the effectiveness of psychotherapy. Rigorous research has been spurred on by what psychiatrist Morris Parloff of Georgetown University in Washington, D.C., calls "our recent romp through the political mine fields."

Politics aside, clinical investigators face an enormous task. Psychotherapy is not a profession but an activity engaged in by members of many professions. Psychiatrists, psychologists, social workers, clergy and others do not undergo standardized "psychotherapy training." There are over 250 brand-name approaches to treating people who are seriously disturbed, mildly disturbed or seeking growth and "self-actualization."

Specific methods are receiving close scientific scrutiny, although Parloff cautions that a list of certified psychotherapy techniques to treat particular disorders is not imminent.

Two studies in the May ARCHIVES OF GENERAL PSYCHIATRY highlight the interplay of several factors that may help some people to benefit from psychotherapy.

Paul A. Pilkonis and colleagues at the University of Pittsburgh report that 64 patients with nondisabling neurotic disorders significantly improved whether they were assigned to individual, group or conjoint (usually with a spouse) psychotherapy. Six months after therapy ended, they still displayed better functioning and fewer neurotic symptoms than before treatment began.

The results indicate that the strength and nature of the relationship between patient and therapist is critical, say the researchers. Sometimes, for still unexplained reasons, patients with certain backgrounds respond more favorably to a specific approach. For example, the investigators find that individual psychotherapy is more successful in heightening self-awareness among lower-class patients; group and conjoint therapies have an advantage in lessening interpersonal problems among patients with longstanding disorders; and the benefits of conjoint therapy are greater when the participating spouse or "significant other" is older. A significant other was contacted for each person in the sample. This person's view of the patient and self-reported adjustment also affected treatment outcome.

Similarly, Mardi J. Horowitz and co-workers at the University of California at San Francisco find that a therapy's effectiveness depends not only on technique but on the initial disorder and personality characteristics of the patient and therapist. They report generally favorable outcomes for 52 patients suffering grief reactions who underwent 12 weeks of dynamic psychotherapy. In this approach, the therapist clarifies and interprets the patient's conscious and unconscious conflicts that are causing depression, anxiety and other symptoms.

Measures of the therapeutic relationship and therapists' actions were related to outcome only when patient characteristics were also considered. Patients with high motivation for therapy and stable self-concepts tended to benefit from a therapist's interpretations and probing of unconscious conflicts. A supportive and comforting approach, on the other hand, was more helpful for patients with lower motivation and less stable self-concepts.

Sidney Harris

The Pilkonis and Horowitz reports are not the first to challenge the "unscientific" reputation of psychotherapy, writes Richard M. Glass of the University of Chicago in an accompanying comment, but they show that numerous interactions between therapist and patient need to be studied carefully.

It should not be forgotten, he adds, that "the successful application of the therapeutic procedures to a particular patient is an art, even if the general efficacy of the procedures has been established by scientific studies."

The art of scientifically evaluating psychotherapy was discussed by several investigators at a recent seminar at Johns Hopkins University in Baltimore, held in honor of psychotherapy researcher and psychiatrist Jerome D. Frank.

Frank contends that people who seek psychotherapy suffer from "demoralization," by which he means a sense of helplessness, alienation and an inability to cope. If this is so, then all tested forms of psychotherapy are successful because they wittingly or unwittingly treat demoralization.

Yet, observes Parloff, "There is no consensus among psychotherapists on the nature of the problem being treated or studied." This makes it tempting for critics to

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argue that patients are merely renting a friend and showing improvement because someone is paying attention to them, not because of a therapist's technique or skills.

Studies conducted at the Pennsylvania Veterans Administration Hospital indicate, however, that some therapists are consistently more successful than others in treating patients, reports Lester Luborsky, a psychologist at the University of Pennsylvania in Philadelphia. For the past three years, he and his co-workers have followed nine therapists who are each treating ten patients with a drug abuse problem. Therapists who use "supportive-expressive" or "cognitive-behavioral" techniques have had more success than those employing counseling and advice-giving methods.

But the most striking differences are between therapists, not techniques, he says. "We find that certain therapists establish better relationships with patients, and the patients say that these therapists provide better treatment." Professional peers also judged the successful therapists to be the better practitioners before the study began.

Psychotherapists have rarely been evaluated for competence and skill. "Therapists are threatened by researchers taking a closer look at their good and bad qualities," points out Frank.

Psychologist Hans Strupp of Vanderbilt University in Nashville, Tenn., adds that most studies to date have been comparable to "looking at a surgeon's scalpel to see what an operation might be like, when we need to look at the qualities of the surgeon who will be performing the operation."

This misdirection, even at the cutting edge of psychotherapy research, stems from several common fallacies, says Strupp. Many investigators fail to assess therapy skills and strategies because they think therapy has general, not specific, effects; they assume psychotherapy is a medical treatment when it is primarily educational and psychological; and they figure that short-term outcomes are the final word rather than limited indicators.

The reasons for the success of a therapeutic approach are often enigmatic, holds psychiatrist Leon Eisenberg of Harvard Medical School. "Are you replacing a patient's myth for functioning with a new myth that he can use to control formerly overwhelming emotions?" he asks. If so, how does one accurately measure differences between therapists' techniques?

It seems that even good results are not all they are cracked up to be in psychotherapy research. Many studies have been performed by promoters of the treatment in question, says Stanley D. Imber of the University of Pittsburgh. You do not need a Ph.D. to predict what they found.

Only a few researchers have looked at the negative effects of psychotherapy, adds Imber, as if there is a fear that "bad effects will wipe out any demonstrated good effects."

In addition, little is known about outcomes for long-term psychotherapy since researchers typically study patients during several months of treatment and conduct follow-up examinations about six months later. Efforts are underway to examine patients with "borderline" personality disorders receiving years of therapy, says psychiatrist Otto Kernberg of Cornell University in Ithaca, N.Y. These people suffer from more than demoralization, he explains. They react negatively to human warmth and "kick you when you're nice to them."

Add up the preceding scientific drawbacks and it is easy to see why psychotherapy research has not kindled economic warmth among federal and private insurers. In the June 1982 AMERICAN JOURNAL OF PSYCHIATRY, Parloff writes that "research findings can be expected to exert all the impact of a quixotic Bambi planted firmly in the path of the onrushing Godzilla of cost-containment policies."

In spite of this striking mismatch, policy makers and the public need to recognize the intrinsic value of psychotherapy, contends Strupp, just as they see value in supporting education.

Until then, he says, all is not lost. "Psychotherapists are secular priests in our society," he observes, "who will attract patients with or without insurance coverage." □

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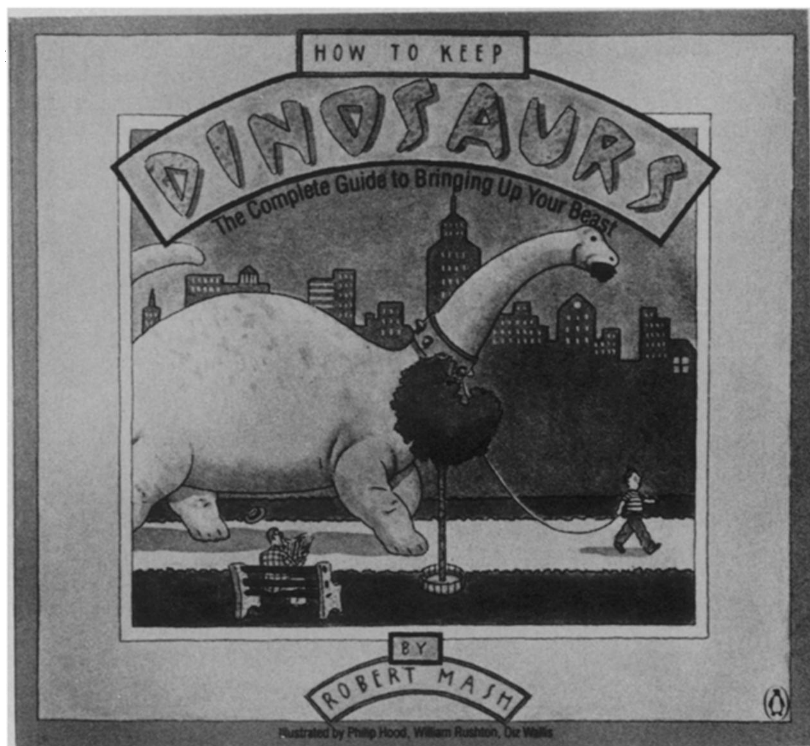

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