

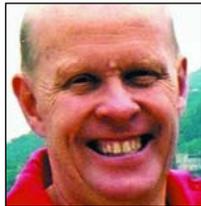
# The myth of evidence-based psychotherapy

**E**VIDENCE-based psychotherapy seems a reasonable aspiration. There are many weird and wonderful treatments in the field; surely it makes sense to know whether or not they work? This was the rationale behind the Department of Health's Task Force on the Psychotherapies, which I was briefly part of. It led to an impressively documented book by Fonagy and Roth (1996) in which the research supporting various psychotherapies was presented and thoroughly analysed, and conclusions were drawn about specific treatments for specific conditions. Yet I want to argue that evidence-based psychotherapy is a myth.

I am not against scientific research in psychotherapy. On the contrary, I believe that scientific advances in psychology and related disciplines are important to the development of psychological therapies. But that is different from claiming that what psychotherapists do is, or should be, securely founded in evidence of effectiveness; that, for example, we can say with authority that depressed people are most likely to benefit from cognitive therapy or that research has shown that 90 per cent of people with panic attacks will recover with anxiety management. Such claims are in my view misleading and simplistic, and it is this 'outcome research' I have a problem with. It does justice neither to the complexity of people's psychology nor to the intricacies of psychotherapy.

## The problem with psychiatric diagnosis

To carry out outcome research one needs to categorise conditions in a reliable and valid way, for the obvious reason that research findings need to be generalised. Psychotherapy research uses one of two parallel psychiatric classifications systems – the American Psychiatric Association's *Diagnostic and Statistical Manual (DSM)* or the World Health Organization's *International Classification of Diseases*.



**JOHN MARZILLIER** argues against 'outcome research'.

These classifications have been derived from original diagnostic distinctions made by Emil Kraepelin in the 19th century that, as Richard Bentall (2003) has recently shown, were fundamentally flawed. The lines drawn to distinguish different psychiatric conditions are far from firm. There is a huge overlap of symptoms between so-called illnesses. There is a strong consensus element in defining some conditions as a psychiatric illness, most obvious when in 1974 members of the American Psychiatric Association voted that homosexuality should no longer be in the DSM lexicon.

But the most important point is that psychotherapists, anxious to prove that what they do works, have bought into a medicalised way of defining psychological experience. They act as though it is correct to state that people *have* depression or anxiety or schizophrenia like they have measles or diabetes or heart disease. But for all of these conditions, including the

more extreme psychotic states, it is impossible to divorce the condition from the person. The experiences that lead people to be diagnosed as 'mentally ill' are experiences that all of us can have in some form or at some stage. This is why, despite over a century or more of research, psychiatrists are no further forward in defining and understanding – let alone successfully treating – any major psychiatric 'illness'. If you don't believe me, read Bentall's excellent book, Part 1 in particular.

This uncomfortable fact opens up a huge black hole for outcome research into psychotherapy. For if one cannot validly categorise experiences as illnesses, how can we generalise what we find in any research study? If so-called symptoms spread across diagnostic categories like spilled ink flowing over paper, how do we reliably differentiate between conditions? If psychological problems are not treatable like medical ones, what sense does it make



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of the assertion that a treatment 'works'? This has always been obvious to anyone who has practised as a psychotherapist as opposed to researching into it. People who come for help for a specific problem almost invariably have other problems often to do with their personality, social conditions, emotional experiences or way of life.

As an illustration, take the two examples of phobic anxiety described in the box, both people I was seeing at the time of writing this article. They have different personalities, experiences and circumstances and respond differently to therapy. What psychological sense is there in throwing these people together as though their problems were solely defined by their 'symptoms'?

### The limitations of outcome research

In a survey of the Psychotherapy Division of the American Psychological Association about what psychotherapists found most useful to their practice, 48 per cent said clinical experience; only 4 per cent said research. Research publications came a lowly eighth out of ten most important influences on clinicians (Morrow-Bradley & Elliott, 1986).

This is not perversity on the part of psychotherapists. Drawing conclusions from outcome research into psychotherapy is highly problematic. Not only is it regularly shown in the academic literature that any given outcome study has significant faults, usually fatal to any conclusions, but also initially positive findings for a therapeutic approach can be reversed a few years later. This happened to Carl Rogers's claims for empathy, warmth and genuineness as the core conditions for all therapies. A 1971 review of research gave them the seal of approval, only to be retracted in a revised assessment six years later (Mitchell *et al.*, 1977).

Moreover, paradoxically, the better quality the research, the less value is it to clinicians. For example, the Sheffield Psychotherapy Project had an exemplary research design (Shapiro & Firth, 1987). A selected sample of anxious and depressed individuals from the professional and managerial class was randomly assigned to two contrasting therapies, exploratory and prescriptive, in a crossover design, so that after eight sessions of one therapy the clients received eight sessions of the other. Therapists were carefully trained, followed

## A TALE OF TWO PHOBIAS – 'JACKIE' AND 'PENNY'

**Jackie**, a young mother of a two-year-old, referred herself to me for treatment of her panic attacks. She had a long-standing fear of people vomiting that was treated years ago, unsuccessfully, by behaviour therapy. She was now concerned about her husband or daughter vomiting and engaged in a plethora of 'safety behaviours'. Further assessment revealed chronic social anxiety, lack of self-confidence, dislike of her physical appearance and depression. She had been bullied at school. As the middle child she felt neglected by her parents, her mother being particularly critical of her. Since the birth of her own child, her relationship with her husband had become strained. When the husband attended, it was clear that Jackie's anxiety was far more extensive than she had first presented. She hadn't taken her daughter out for two weeks. She shouted at her husband if he talked to the next-door neighbour for fear that the neighbour would become too friendly. She refused to see any of her in-laws.

I felt that it might be difficult to help Jackie. Her anxieties were extensive, and previous therapy had failed to make an impact. Yet she was desperate. We began anxiety management. She did reasonably well initially, but her general anxiety remains high. She clings on to therapy, finding solace in the weekly support. I worry that when therapy ends, she may well lose the gains she has made, and I wonder how to prevent that happening.

**Penny**, a postgraduate student in her early twenties, sought help because of panic attacks. Since returning from her summer vacation she had experienced a number of panic attacks, once during an examination, then when giving a paper, and again during a seminar. On each occasion she became worried that she would need to leave to go to the loo but had never needed to do so. Characteristically, she had begun to be anxious about her anxiety. She had read about anxiety management and wondered if it might be helpful. I established that academically she was doing fine, having passed the exam, and she was enjoying doing her doctoral work. She came over as a self-assured, lively and insightful person. She was in a long-term relationship, which, while not perfect, was strong enough. There were past traumas that seemed a possible precursor of her presenting anxiety.

At Penny's request we began anxiety management, and within two weeks her anxiety had disappeared. Penny then talked about the trauma and later about her difficult relationship with her mother, her absent father and her boyfriend. She flirted with me in the sessions and expressed an interest in becoming a clinical psychologist. Aware of the transference elements, I suggested she might consider weekly psychodynamic therapy, but after reflection, she decided not to take up my offer.

specially written manuals and had all the sessions recorded and assessed. A battery of well-chosen assessments was used. The researchers were able to compare the effectiveness of the two therapies, the results slightly favouring the prescriptive therapies on some measures. To the clinician however these results mean very little. Not only was the subject sample highly selected at the outset, but 50 per cent of these did not get beyond the initial assessment. No therapist would switch therapies in mid-stream without recourse to the client's needs. And what about the effects of therapy manuals, continuous recording and frequent assessments on the whole process? The very procedures designed to improve the research distanced it from the realities of clinical work.

Few psychotherapists change their practices merely because research studies favour one therapy over another or show that a particular therapy does not work. Are they being blinkered? Perhaps. But mostly

their scepticism is justified. For example, there has been a recent backlash against psychological debriefing, the method of providing group psychological support for emergency personnel after trauma. It has been suggested that not only does it not work but also it can make people worse (see Wessely & Deahl, 2003, for a debate). Yet anyone studying the two controlled trials (yes, just two trials) with negative research findings will see a glaring lacuna. Neither used a group procedure, the essence of the psychological debriefing approach: people were seen for individual counselling. Do researchers want clinicians to believe that individual counselling is the same as group work? Should those of us who use group debriefings stop doing so on such flimsy and flawed evidence?

The aspiration to discover what works is laudable. The reality is very different. The whole business of categorising people's problems into quasi-medical and suspect diagnoses is psychologically

dubious, and outcome studies in psychotherapy tell clinicians nothing of value. In over 30 years of psychotherapeutic work not one outcome study has influenced my practice to any significant degree. The most one can say, cynically, is that it can be useful to cite outcome studies when defending one's practice against critics. The apogee of this self-serving stance came in a review of outcome research (Luborsky *et al.*, 1975) that concluded that all psychotherapies were more or less equally effective, or as their heading ironically stated, 'Everybody has won and all must have prizes'. It is of course vacuous nonsense to assert that all psychotherapies work equally well, though useful if third parties like insurance companies begin to cavil about paying for psychotherapy.

### An essentially personal relationship

Psychologists have largely ignored the essential component of psychotherapy, the personal relationship. There has been research seeking to link the personal qualities of therapists to outcome, usually unsuccessfully, but this is subject to the same problems and criticisms as outcome research. Like friendship, romance or chatting to someone in your local shop, psychotherapy is at heart a personal transaction. It has some special features, notably that it is a professional relationship, that one person remains more or less a stranger while the other may reveal very intimate matters. But at heart, the personal exchange defines psychotherapy. All else flows from it.

Consider these micro-examples, all taken from my own experience. A woman whose husband committed suicide breaks into uncontrollable sobbing. I feel uncomfortable leaving her to cry without making some attempt to console her. A man, who is very acerbic in his manner, ridicules all my therapeutic comments as 'typical rubbish that psychologists spout', making me feel angry and frustrated. A woman, experienced in psychotherapy, comes in with a gift of homegrown tomatoes to thank me for my help and is furious when I politely decline the gift. A man, starting a course of exploratory psychotherapy, wants me to start the session off, claiming the silence at the beginning is persecutory. A man writes me a heartfelt letter wondering if he is depressed and wanting to know more about



**Even something as small as the decision by a therapist to accept or decline a gift of homegrown tomatoes can influence the way the relationship develops**

what depression is. I could go on. These examples of the minutiae of the therapy process illustrate how limited a textbook or therapist's manual is. In each case the therapist's personal response will greatly influence the way the relationship develops. Imagine the difference between hugging the bereaved woman and sitting back and saying nothing. Or accepting the gift of the tomatoes. Or offering to start the session oneself. The personalities of both the therapist and the client exercise a huge influence on what can be achieved and how.

How the therapist responds to clients is as much dependent on his or her skills and style as any technique. How can such complexity be reduced to a set of predetermined treatments or manualised procedures? When I am asked to recommend a therapist to someone, my first thought is about the personal qualities of the therapist. My next is about how experienced they are and whether they would suit the client and help them with their problems. Not very scientific, but pretty sensible all the same. Recently I overheard a conversation between psychologists in training in which one said if she had therapy herself, she would go to a psychodynamic therapist. Why, said the other, if cognitive therapy is so successful? Because with a psychodynamic therapist you would be able to explore what really mattered to you, you can tell your story.

Over years of working as a psychotherapist I have come to realise that what many people need is to tell their story. I have become adept at attentive listening. Not just to the litany of symptoms or problems, but to the nature of the person, the context, their hopes and desires. I try to help them make sense of what is happening

to them, and not just label their experiences as symptoms and try to get control of them. I establish a carefully bounded personal relationship. I get to like my clients, some of them more than others. Most I can help in some way, judging by what they say to me. Some I can't help, but not for want of trying. I seek to behave honestly and treat people in a way that merits the confidence they show in me. Sometimes, despite myself, I act as a quasi-doctor dispensing advice and practical help, giving self-help booklets or relaxation tapes. Sometimes well-worn phrases or oft-repeated stories fall from my lips, reassuring like the sound of rushing water and probably as effective. At other times I find myself engaged in an engrossing struggle where emotions run high and the relationship is repeatedly challenged. These actions cannot be reduced to a series of technical procedures, nor can they be scientifically proved, just as you cannot prove scientifically the value of friendship or a good marriage.

You are probably thinking that I have become one of those people who airily claim that psychotherapy is an art and that science has no part to play in it. Clearly I do think there is an art to therapy, to do with personalities, human relations and engagement in the world. But this does not mean that scientific research has no part to play in exploring these processes. Graham Davey (2003), in his Presidential Address, outlined the way psychological research can be conducted into psychopathology to provide clinicians with insight into underlying processes. In ruminative anxiety, for example, psychologists have examined the way certain 'stop-rules' – that is, cognitions that influence whether ruminations continue or not – are affected

by mood, thereby helping clinicians unpick what happens in the complex transaction between thoughts and feelings. It is useful to know this, not because the research provides definitive answers, but because it offers a way of understanding a complex process (ruminations) and some new information (under conditions of high anxiety a particular stop-rule leads to further ruminations). In the experimental lab hypotheses can be tested scientifically. In therapy they can be tried out clinically. The interaction between the two can lead to both theory development and new therapeutic practices. The psychotherapist need not give up being a psychologist. This sort of psychological research – exploratory, to do with processes, human experience, personal interaction, underlying mechanisms – is obviously relevant to therapists since that is what they deal with every day.

Many years ago Jerome Frank (1961) pointed out the close parallels between psychotherapy and other forms of persuasion and healing, stressing what he

called ‘non-specific factors’ as the main agents of its effectiveness. The personal power of the healer, the beliefs of the therapist, the perceived credibility of the knowledge base, the ritual of the procedures, the place of safety where the therapy takes place. All of these are of course psychological, yet psychologists have generally turned their backs on these factors. Instead they rushed into the blind alley of outcome research in the vain hope

that, like their medical colleagues, they could claim scientific justification for the practice of psychotherapy. Is it not about time we acknowledged the error and admit that evidence-based psychotherapy is a myth?

■ *John Marzillier is a clinical psychologist and psychotherapist in Oxford. E-mail: john.marzillier@ntlworld.com.*

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Empirical evidence supports the efficacy of psychodynamic therapy. Effect sizes for psychodynamic therapy are as large as those reported for other therapies that have been actively promoted as "empirically supported" and "evidence based."<sup>1</sup> Psychodynamic or psychoanalytic psychotherapy refers to a range of treatments based on psychoanalytic concepts and methods that involve less frequent meetings and may be considerably briefer than psychoanalysis proper. Session frequency is typically once or twice per week, and the treatment may be either time limited or open ended.<sup>2</sup> To help dispel possible myths and facilitate greater understanding of psychodynamic practice, in this section I review core features of contemporary psychodynamic technique.