THE RESEARCH LITERATURE on EFFECTIVENESS of PSYCHOTHERAPEUTIC TREATMENTS in PSYCHIATRY

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"Research over the past forty years has established that psychotherapy works (Tillett, 1996); indeed "it seems that psychotherapy is one of the best documented medical interventions in history" (Howard et al, 1994)."

Two articles in the British Journal of Psychiatry (Howard et al. 1994 and Tillett 1996) address the related questions of clinically relevant outcome research in individual psychotherapy and assessment and treatment selection for psychotherapeutic treatment. While they both assert that psychotherapy "works", they state that this is akin to saying antibiotics "work".

"It doesn't make sense to set up an efficacy horse race between therapies that treat different conditions, and such comparisons should be taken with a grain of salt" (Doidge, 1996).

The task has been to elucidate what kind of psychotherapy works for what disorders, and what "doses" (frequency of sessions) are effective in what conditions.

This current-day research task is best accomplished by Review Articles, several of which have appeared in the recent literature.

Three such will be mainly drawn upon for the purposes of this paper. One is authored by Dr. Anthony Roth and Professor Peter Fonagy (Research on the efficacy and effectiveness of the psychotherapies - A report to the [U.K.] Department of Health), another by Norman Doidge, M.D. (1996) and the third by Gabbard et al.

The currently available therapies in clinical psychiatry can be broadly grouped under:

- o psychopharmalogical (medication)
- o psychophysical (ECT)
- o psychotherapeutic (the "talking therapies")

Under "psychotherapeutic" are grouped:

- o behavioural
- o cognitive
- o psychodynamic (including individual, group and family modalities)

It can be broadly generalised that:

(i) for the major affective disorders and the major psychoses, psychopharmacological treatments are the treatments of choice.

(ii) for the symptomatic anxiety-based disorders (Phobias, Generalised Anxiety Disorders, Panic Disorder, Obsessive-Compulsive Disorder Post-traumatic Stress Disorder), behavioural and cognitive techniques bring about the quickest results

(iii) for Personality Disorders, longer-term relationship based therapies appear to be required

(iv) for complex and co-morbid conditions, where an underlying personality disorder is most often present, longer-term relationship based therapies are necessary if maximum benefits of treatment are to be obtained.

It can be fairly asserted that after an initial heavy reliance on either or both behavioural and cognitive techniques as a means of radically shortening the treatment of what were earlier regarded as the "neurotic" group of disorders (now the anxiety-based disorders), psychiatrists practicing these techniques are

recognising the importance of relationship factors in both the production of short-term effectiveness and longer term maintenance of improvements.

Equally, the administration of psychopharmacological agents is best accomplished in the context of an awareness of relationship factors.

Further, there is a growing recognition that appropriate use of medication can enhance the effectiveness of psychotherapeutic techniques in a variety of disorders.

Thus, the importance of the psychiatrist-patient relationship is paramount in the vast majority of clinical situations.

Much of current understanding of the complexities of these therapeutic relationships has been gained through longer-term, intensive relationship based treatment with the more severely disturbed groups of patients. This knowledge informs the current clinical psychiatric practice in the western world.

In recent years, attempts have been made to combine what are thought to be the "effective ingredients" of both the psychodynamic and cognitive-behavioural approaches to treatment. Such "hybrids" have emerged as "Cognitive-Analytic Therapy" (C.A.T.) and "Dialectic Behavioural Therapy" (D.B.T.).

Thus, following Roth and Fonagy, the following can be summarised:

1. For the more symptomatically based syndromes of both anxiety and depression, shorter-term cognitive and behavioural psychotherapeutic techniques obtain the best short-term outcomes.

2. Of the personality disorders, Avoidant Personality Disorder appears to respond best to social skills training or cognitive techniques.

3. For the remaining personality disorders (and especially the Borderline and Narcissistic Personality Disorders), longer-term psychodynamic techniques appear to be the only treatments which offer any possibility of longer-term resolution.

4. Importantly, prevention of the known "downhill" trajectories (clinical decline) in many of these disorders should be accepted as cost-beneficial outcomes.

"The Doidge Review"

Doidge's yet-to-be-published review of this field (pages 126-137), concerns itself more with the longer-term, definitively psychoanalytic-based treatments. The following statements are of relevance:

1."Longer is better - for some patients"

1.1. 82% of psychoanalytic patients had already tried briefer forms of treatment or medication

1.2. When one considers the chief indications for psychoanalytic treatment are chronic conditions, a number of years is not an unreasonable amount of time to treat conditions associated with significant morbidity (many chronic conditions e.g. diabetes, call for life-long medical attention. Analytic treatment is long - but not forever !)

1.3. The extensive contemporary literature dealing with borderline conditions and narcissistic personality disorders is almost entirely devoted to long-term intensive therapy

2. Dose and frequency of sessions

2.1. Reported gains from "low dose" (fewer sessions) treatments appear to be overestimated. Even so, such gains appear not to endure to longer-term follow up.

2.2. Long-term gains are only obtained when there is sufficient opportunity for "working through" of complex underlying issues

2.3. Several studies comparing higher frequency per week with lower frequency per week treatments suggest greater improvement on a wider range of indicators for the higher frequency treatment patients

2.4. Referring patients who require long-term intensive treatment for severe character pathology to a short-term treatment may lead to extended suffering and wasted years of potential health, not to mention wasted resources.

3. Intensive treatments for children and adolescents

Special mention needs to be made of Target and Fonagy's (1994) retrospective study of 763 cases for whom extensive data was available. They showed:

3.1 higher frequency of sessions led to greater improvement in all age groups

3.2 this effect was more pronounced with the more disturbed children

3.3 younger children did best of all with the intensive treatment

3.4 adolescents appeared to do better with the lower frequency treatment, perhaps because the needs of adolescence ran counter to the regressive aspects of the intensive treatment

4. Health care costs and psychoanalytic therapy and psychoanalysis

4.1 Long-term psychotherapies lead to decreased physical morbidity in patients

4.2 Patients who have undergone psychotherapies use medical care facilities far less the general population (see especially Duehrssen (1957, 1972) and Mumford et al. (1984)

A unique opportunity to compare costs of providing health care services between two socio-economically comparable countries was investigated by Andrews (1989). He concluded that

"The Australian combination of more psychiatrists in private office practice and fewer public hospital beds costs less than the New Zealand system, which supports only public-sector, hospital based systems."

He showed Australia utilising 74 beds per 100,000 population at a cost of $4 million, in comparison to New Zealand's needing to use 128 beds per 100,000 population at a cost of $7 million.

(It should be interpolated here that many individuals with severe personality disorder find themselves being caught up in the criminal justice system and being "treated" in gaol for their gross psychopathology. New Zealand's gaols are in all likelihood repositories of many who more properly should be seen as "patients" rather than "criminals" as a result of a lower availability of appropriate psychiatric services. Although not adequately documented, even in Australia, much of the cost to the community of the incidence of severe personality disorder is likely hidden in the criminal justice system.)

Although clearly demonstrating the cost-benefit to the Australian economy of the availability of a private, insurance funded, psychiatric service, and acknowledging "the value of long-term psychotherapy for many patients", Andrews here and elsewhere argues for thresholds on re-imbursement of fees for private psychotherapeutic treatment "unless justified by the clinical needs of the patient and the competence of the therapist".

The Gabbard at al. study

In all areas of clinical medicine, study of almost any disorder has begun with intensive investigation of the most advanced and severe instances of the disorder. Thus, progress in treatment has resulted from understanding of the pathology of tertiary pathology. From this has resulted earlier and earlier intervention, with the ultimate goal of prevention. For example, much heart disease has become preventable on the basis of understanding severe cardiac pathology resultant on severe hypertension and severe lipid disturbance.

So too, much infective disease has been eliminated from western communities.

Similarly, much of current understanding of psychopathology has resulted from intensive involvement in the treatment of severe character pathology, especially that involving somatisation disorders.

Application of briefer psychodynamic techniques to a variety of clinical conditions has resulted from this clinical psychiatric research.

Gabbard et al. have extensively reviewed cost-effectiveness and cost-offset of a range of treatment programs based on psychodynamically derived techniques.

They particularly focus on studies demonstrating cost-offset benefits deriving from psychotherapeutic treatment against control groups where such treatment was not used. Further, they show that psychotherapy benefits patients with major depression in respect of decreased hospitalisation, relapse prevention and maintenance of occupational status. A wide variety of medical conditions are likewise benefited by adjunctive psychotherapeutic interventions, and considerable cost-offset benefits accrue.

Gabbard et al. also review the available literature in respect of the personality disorders and come to similar conclusions as do both Roth and Fonagy and Doidge.

Reviewing the field in the context of the American climate of managed care, Gabbard et al. conclude

"When applied to appropriate patients with specific diagnoses, psychotherapy may reduce overall health expenditures and deserves consideration as a feature of a comprehensive benefits package." (emphasis added).

CONCLUSIONS

Given that the three major review papers drawn upon for this paper are authored in America, Canada and the U.K. it is worthy of note that a majority of major studies reviewed are included in each of the three studies, and that the conclusions arrived at by each are largely in accord with one another.

There is agreement largely that:

1. Psychotherapy "works". It is now possible to specify what kind of psychotherapy works for what diagnosis or disorder.

2. Considerable cost-benefit and cost-offset advantages accrue when appropriate psychotherapeutic treatments are used in a variety of prevalent conditions.

3. Both short-term and longer-term psychotherapeutic treatments should be available as part of publicly funded health care services - both mental and physical.

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(26th September, 1996)