

mindovermatter

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Selecting psychotherapy

If seeking a psychotherapy for a mood disorder, is there a preferred 'type'?

PSYCHOTHERAPY REDUX

PSYCHOTHERAPY was once the mainstay treatment provided by psychiatrists and many other mental health professionals.

It waned for a number of reasons, including increasing challenges to its validity and utility, other treatments (especially psychotropic medication) accruing evidence-based support, and the therapeutic trend moving more from the 'mind' to the 'brain'.

One of the criticisms aimed at psychotherapy decades ago was that it was of little 'specific' benefit. Instead, if people improved, the suggestion was that this largely reflected 'common factors', which included the therapist providing a cogent explanation and, as a human being, providing empathy as well as activating the patient's sense of hope in dealing with their problems.

Two psychotherapies – cognitive behaviour therapy (CBT) and interpersonal psychother-

apy (IPT) – have achieved the status of evidence-based psychotherapies (EBPTs), suggesting they are superior to other psychotherapies.

For mood disorders, the EBPTs (especially CBT) are first-line therapy for mild and moderate depression and, according to some writers, are universal treatments for mood disorders across the spectrum.

Thus, not only are they viewed as having relevance to unipolar disorders, but as having definitive benefits to those with bipolar conditions.

The positioning of the EBPTs reflects political correctness as well as reference to an evidence base. Their status implies the 'other psychotherapies' have neither an evidence base nor are as effective.

In 2007, we overviewed the EBPTs, now noting some components of that review.¹

THE EVIDENCE
While there have been numerous studies evaluating CBT and IPT for depression alone, their true efficacy remains difficult to establish. This firstly reflects the efficacy paradigm adopted. They tend to be formally evaluated using strategies adopted for antidepressant drug trials, which tend to focus simply on 'responder' status (an improvement of at least 50%), rather than consider their benefits across broader parameters.

They also tend to be evaluated as having 'universal' application rather than as best operating within their *a priori* 'ecological niche'. In efficacy analyses, their superiority and cachet value have generally been achieved by comparison against inappropriate comparators, such as waitlist assignment (merely left on a waitlist to later receive an intervention), or implausible control strategies.

In fact, when CBT and IPT are compared against 'other psychotherapies' that are cogent and plausible, few differences emerge. In essence, the conclusion is that psychotherapies intended to be therapeutic produce similar results.

Secondly, there's little evidence that the benefits of EBPTs emerge from specific ingredients.

This conclusion arises from several findings. Firstly, that most of the improvement occurs prior to formal delivery of specific components. Secondly, 'deconstruction' studies suggest the treatments

designed to address the specific problems are no more effective than treatments having no such design objectives.

Why? Several important reviews have suggested that 'common factors' (that are shared across the EBPTs and other psychotherapies) account for up to nine times more variability in outcome than specific ingredients.

One meta-analysis quantified specific therapeutic effects as accounting for only 8% of the outcome variance, predictably making it difficult for any 'specific' therapy to demonstrate superiority.

'Therapy allegiance' is also linked to outcome. In essence, a therapist believing in a particular therapy (be it a psychotherapy or a drug therapy) will generate a superior result compared to sanguine or non-aligned therapists.

In essence, the earlier critique of psychotherapy can


be rephrased. While the EBPTs have generated distinctive advocacy, they do not appear to be necessarily superior to other psychotherapies provided congruently. The improvement that occurs during such psychotherapies is again a consequence of non-specific or common factors.

It may well be that the EBPTs are superior to 'other psychotherapies' but, as they tend to be evaluated as universal therapies, their context-specific benefits continue to escape clarification.

On theoretical grounds, we might anticipate that CBT would be of specific utility for depressed patients with predisposing cognitive schema (a strong tendency to evaluate themselves, the world and their future in a negative way), while IPT might be of specific relevance to those who are going through stressful life events and role changes.

Until the EBPTs – as for all treatments for depression – are evaluated to determine their specific utilities, we should be cautious in considering their benefits.

Claims about EBPTs often make 'counselling', 'problem solving' and other straightforward strategies appear 'soft'. This is unwise as many of these approaches to assisting people with depression also have their context-specific advantages.

While there is no need to throw the baby out with the bath water, EBPTs must be cautious in claiming universal application and superiority over other treatments. 

Reference

1. *Acta Psychiatrica Scandinavica* 2007;115:352-59.

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