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# Editorial

## Innovative contemporary psychotherapies

Mark Aveline

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Early in the 20th century, three men led the development of psychotherapy theory and practice: Freud, Jung and Adler. Adler's name does not have the instant recognition in psychotherapy circles of his illustrious contemporaries, but his innovations were significant. These innovations have laid down the foundation for family and social therapy; emphasised the interpersonal in a line of therapy development that ran through Karen Horney and Harry Stack Sullivan to modern theorists using circumplex models of personality; and stressed the importance of the present and the future, a feature of cognitive-behavioural therapy, which arrived later. His dictum, 'not whence but wither', says it all. Consider behaviour as goal-directed and future-directed, he urged. Address this to help the individual change the future that he or she is creating.

Beginning in this issue of *APT* (Denman, 2001), four innovative contemporary psychotherapies will be described, the first two were developed in the UK (cognitive-analytic therapy and very brief dynamic therapy; Aveline, 2001), the third arises from cognitive-behavioural principles on either side of the Atlantic (problem-solving therapy; Mynors-Wallis, 2001) and the fourth (dialectical-behavioural therapy; Palmer, 2001) is an import from the USA. Each draws on the incremental literature on effective elements in psychotherapy. Although Adler is not specifically acknowledged, his lineage lives on.

The research base for each of these therapies is slight, which is surprising in the cases of cognitive-analytic therapy and dialectical-behavioural therapy, given their popularity in the UK and US, respectively. One reason for this lies in the multitude

of brand-name psychotherapies (upwards of 500 on a recent count). Therapies tend to get tested once or not at all in the gold-standard format of the randomised controlled trial and are rarely retested in replica trials or in other settings. Lack of time and research resources and an overvaluing of small differences militate against systematic test and retest. Yet all is not lost. The large psychotherapy research literature repeatedly demonstrates effect sizes of around 0.8 across seemingly diverse therapies and the importance of common or non-specific therapeutic factors. In addition, some therapy-specific effects on particular syndromes, such as phobias and obsessive-compulsive disorder, are emerging. Our knowledge of what is central to change in psychotherapy and what is window-dressing is gathering by the day. It would appear that effective therapies incorporate known effective elements, assemble them in appealing and coherent ways and have particular strengths for different patient populations (Lambert & Bergin, 1994).

These four contemporary therapies have different purposes in mind. Problem-solving therapy is advocated for the busy general psychiatrist. As Mynors-Wallis (2001) states, it fosters an alternative form of engagement when so much of general psychiatric practice is about medication and risk management. It reintroduces the mind into the brain. The tone is upbeat. Useful gains can be, and undoubtedly are, made through solving current problems, identified by the patient, and collaboratively worked on. Little time is spent dwelling on how the patient arrived at his or her predicament, a weakness in the model in my view when personality

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factors start to loom large in the genesis and maintenance of recurrent problems in living.

In very brief dynamic therapy, issues of personal responsibility and choice are addressed. In the context of a specialist psychotherapy service, a four-session intervention over 3 months in a three-plus-one format is not sufficient in itself to resolve chronic significant problems in interaction. Like most explorative therapies, it provides a framework for self-reflection and potential change that may be taken forward through many life experiences and actions. In a specialist psychotherapy service it may be a prelude to more extended work. Many patients will not want to take up that challenge or, indeed, be advised to do so.

With cognitive–analytic therapy and dialectical–behavioural therapy, the stakes are raised yet higher. In the former, personally characteristic patterns of interaction are made explicit in a diagrammatic reformulation of reciprocal and complementary reactions. This is at once supportive and challenging. It addresses how a person manages his or her life.

Dialectical behavioural therapy arose from a treatment necessity to do something useful to help people with borderline personality disorder. By definition, this patient group is difficult to help; they are people who find it almost impossible to lead steady, stable lives. The synthesis of opposites that the word ‘dialectical’ implies is manifest in a therapy that both confronts and contains. Amid the chaos there is hope and belief in the individuals’ capacity to heal themselves. The therapeutic stance

is maintained by teamwork and the involvement of other services.

A major guide by the UK Department of Health to treatment choice in psychological therapies has just been published (Parry, 2001). Two of its recommendations are: effectiveness of therapy depends on the patient and therapist forming a good working relationship, and complex problems require more skilled therapists and longer interventions than simple ones.

The four psychotherapies to be considered in *APT* illustrate a range of interventions in contemporary practice and flesh out our understanding of what type of intervention is need for what problem. In aggregate, they point towards future more-refined integrations of effective therapy elements.

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