EDITORIAL

Evaluation of psychotherapy

Of all forms of treatment, in all of medicine, psychotherapy is perhaps the hardest to comprehend. In its most extensive meaning, its history is as old, and its scope as wide, as medicine itself, and it is practised with more or less awareness by all doctors. The concept is difficult to elucidate at this level; and though most would regard its importance as self-evident, it is not susceptible to rigorous evaluation except perhaps in those limited situations where automation precludes the inevitability of a doctor–patient relationship. In a stricter sense, psychotherapy comprises an assemblage of methods and skills, important in helping patients whose illnesses have evident psychological causes and manifestations, which can be designated—rather unsatisfactorily—as the directive and supportive psychotherapies. These methods, closely interwoven into general psychiatric practice, lay emphasis on the painstaking application of such imponderables as friendly interest, concern, sensitivity and responsiveness to the patient's feelings, empathy, informed judgment, reflective advice, practical suggestions, and manifest respect for the patient's individuality. Their value in principle seems clear enough. Although these and similar variables can be studied, and to some extent measured and manipulated in clinical research, their absolute withdrawal for experimental purposes would generally be unethical. In its third, and most restricted usage, psychotherapy denotes highly developed and skilled psychological techniques for treating certain patients with specified disabilities. Behavioural therapies can be included under this heading. So are formal, analytic or 'dynamic' psychotherapies—the adjectives are here used synonymously—which are practised mainly by those with a special training, often involving a personal psychoanalysis. The techniques of dynamic psychotherapy, like those of behaviour therapy, are based on theoretical postulates and directed towards helping defined groups of patients; they are specific forms of treatment and, therefore, their effectiveness should be demonstrable.

These three domains of psychotherapy, each distinguished from the others by the context in which it is practised and by its manifest purpose, share much common ground. Transactions between doctors and patients—like all but the most casual of relationships—have always been affected, in conspicuous or hidden ways, by those beliefs and attitudes which are fashionable in a society. And the contemporary climate of opinion in most Western societies has been deeply influenced by the emergence of psychoanalysis as a model or metaphor for understanding human experience, relationships, development, and behaviour.

Partly as a consequence of this, two claims are made for the relevance of modern psychodynamic concepts to medicine. One is that they have a very wide significance in the management of patients, and therefore a large value in medical education. According to this idea, the practice of medicine in general, and psychiatry in particular, makes demands on certain important qualities of the practitioners. These qualities, it is suggested, can be communicated, evoked or facilitated during training, specifically by exposure to specialized teaching in psychodynamics, and by this means alone. The other claim is that dynamic psychotherapy is an effective and important specific treatment for certain patients. Both claims are so far-reaching as to call for close and dispassionate study. The need for careful examination of these intricate matters becomes even more clamant when seen in the light of developments in undergraduate medical education, postgraduate education in psychiatry, and in the planning of psychiatric services.

In evaluating dynamic psychotherapy, five questions are at issue. Do patients chosen for this type of treatment fare better than they would if treated differently? What components of treatment determine its effectiveness? What proportion of patients with defined forms of
disability are suitable for one or other kind of
dynamic psychotherapy, and how may they be
identified? For how many suitable patients is
this treatment available? Finally, when dynamic
psychotherapy is available to a community, are
matters of suitability and responsiveness to be
regarded as stable qualities, or are they subject
to subcultural influences such as the caprices of
fashion and other psychosocial variables? The
last four questions are cogent only if an affirm-
ative answer to the first is demonstrated or
assumed.

Many formidable difficulties are involved in
investigating the effectiveness of dynamic psycho-
therapy. The most outstanding are those of
specifying, with sufficient exactitude, the com-
ponents of treatment, the disabilities for which
they are employed, and the objectives to be
attained. Dynamic psychotherapy is the name
given to a large class of treatments, in which the
most obvious feature is that the patient has more
and longer interviews than is the rule with
treatments more generally available in the
National Health Service. Less conspicuously, a
special kind of relationship develops between
the therapist and the patient (or group of
patients), in which complex verbal exchanges
and emotional interactions take place; and
treatment is conducted in accordance with
certain postulates deriving ultimately from
psychoanalytic theory. Within the class are
many sub-classes of treatment, each more or less
distinguishable from the others by its techniques,
scope, goals, and hypothetical substructure.
And within any sub-class the therapist himself
is an important variable. Certain characteristics
of the patient, the therapist, the setting, and the
way these interact, determine what actually
happens. The individuality of each sequence of
psychotherapy is often seen as its most important
feature. The instrument of treatment works
differently in different hands and with different
patients. Evaluative procedures must take cog-
niscence of this individuality, yet at the same
time they must specify as closely as possible the
general principles and techniques, so that these
can be replicated.

Dynamic psychotherapy is most extensively
used for patients suffering from neurotic dis-
abilities. The phenomena of such disorders
consist not only of symptoms in the strict sense
but also, and often more prominently, include
problems in personal adjustment, attitudes, and
relationships, which are difficult to estimate in a
reliable fashion. Moreover, and this is crucial to
dynamic psychotherapy, the symptoms and overt
evidences of maladjustment can be seen as sub-
ordinate to, and deriving from, forces below the
surface which can be conceptualized as intra-
psychic disturbances. These underlying variables
are, by their very nature, inaccessible to direct
expression and measurement. So if dynamic
psychotherapy is being investigated, serial assess-
ments of the patient are required at three distinct
levels. Symptoms and signs must be specified
clearly; adequate methods are needed to ascer-
tain attitudes and adjustment to life circum-
stances, and the circumstances themselves; and
there must also be some communicable, reliable,
and consistent criteria for describing the psycho-
dynamic configurations which are hypothesized
in any particular case, and which the therapist is
seeking to change in order to help his patient. To
avoid bias and contamination of criteria, data
must come from several independent sources.
These include the patient himself, a relative or
other significant person, the therapist, a general
psychiatric examination, and a dynamic assess-
ment. The criteria should be demonstrably
sensitive but not capricious, and their inter-
relationships should be studied. Moreover, they
should be such as to permit a clear specification,
at the outset, of the objectives of treatment in the
individual case. Their application must allow
not only for the uniqueness of the patient's
problems and their context but also for the
possibility of differential improvement and
qualitative change in the style of the neurotic
disorder. For after any treatment, or with the
passage of time, symptoms may improve while
life adjustment becomes more restricted, or
certain qualities of life adjustment may improve
while symptoms remain. Improvement in either
or both may seem, to the dynamic psychiatrist,
sometimes to be firmly grounded and sometimes
to be a false solution associated with per-
sistence of hypothetical underlying conflicts. If
the system makes sense, it can be predicted that
these will manifest themselves sooner or later in
different guise.

How far may these exacting requirements be
met in practice? The controlled therapeutic
trial is the standard instrument for evaluating a treatment procedure. In its application to
dynamic psychotherapy, a series of patients, all
demonstrably suitable for the treatment accord-
ing to explicit criteria, could be randomly
allocated to treatment and control groups and
assessed comprehensively at various stages
before, during, and after treatment. Patients in
one control group could have the same amount
of a doctor’s attention as those in the treatment
group, while other control patients could have
standard treatment as available in the National
Health Service. Such a trial would call for close
collaboration between many people with diverse
skills. The methodological problems should be
settled at the outset, and enormous (but not
insuperable) practical difficulties could be antici-
pated. The Medical Research Council is
currently supporting a small-scale exploration
into the feasibility of this sort of inquiry. The
investigators, from the Maudsley Hospital and
the Tavistock Clinic, will shortly present their
report, which may be expected to give perspec-
tive to some of the central issues.

But the controlled therapeutic trial is not the
only, or necessarily the best, way of examining the
case for dynamic psychotherapy. Programmes of
empirical research are being implemented on an
impressive scale in the United States; and some
of their findings have highlighted themes which
deserve exploration in the very different con-
ditions prevailing in Britain. Close and detailed
studies of single cases before, during, and after
treatment may yield fruitful hypotheses about
the processes and results of treatment, and set
the stage for investigating larger series of patients.
The development of indices for describing the
salient variables in patient, therapist, and treat-
ment is the special province of such studies.
Applications of the methods of epidemiology
and social psychology could throw light on the
place occupied by dynamic psychotherapy in
the contemporary medical services. It would be
valuable, for example, to know something about
the various barriers and screening procedures
through which patients must pass before being
selected for psychotherapy; about the apparent
success or failure of other treatments prescribed
before and after psychotherapy; about the
extent to which various types of patients persist
in psychotherapy once they have started; and
about the outcome of neurotic disabilities in
patients treated by routine measures.

Philosophical debate about the scientific
status of psychoanalysis can do nothing to
promote or dismiss the case for its relevance to
medicine. What is needed is a concerted attempt
to clarify the problems of psychotherapy in
practice by high-quality collaborative research
which is truly relevant to its subject-matter. Many
psychotherapists still tend to invoke authority
and to give their language private meanings
embodying indistinct assumptions about issues
of profound and signal importance. They do less
than justice to these matters, and thereby provide
nourishment for those who find destructive
criticism an absorbing activity. From whatever
standpoint the situation is regarded, all should
welcome reasoned and impartial inquiry into the
efficacy of psychotherapy. Such inquiry is bound
to be elaborate and expensive. The sad thing is
that the impediments to progress may be attri-
buted not so much to lack of funds as to the
common tendency to pre-judge the issue.

ROBERT CAWLEY